******* IMPORTANT INFORMATION *******

WITHOUT THE APPROPRIATE INFORAMTION YOUR APPOINTMENT MAY BE DELAYED.

PLEASE FOLLOW THESE GUIDELINES:

The information that is requested in these forms **is required**, so that if our office needs to order any Radiology Imaging or you need any Surgical Intervention your insurance requires us to have this information to get your tests or surgery **approved**.

Remember if we can't get your test or surgery approved it will delay your care.

1. Please mail, fax or drop off the **Patient Information Forms** that we sent to you to complete. These forms **MUST** be completed. If you send them back not fully completed they will be given back to you to complete at your appointment which will delay your visit.
2. Insurance cards & Drivers License **MUST** be present at the time of your visit.
3. Please bring **ALL** Radiology Imaging that you have pertaining to your visit. This can include MRI's, CT scan, X-rays, Bone Scans…etc. This must be in CD or Film form with the report.
4. **A REFERRAL IS REQUIRED for anyone with HMO Insurance**. This might come from your PCP (family doctor) or it might have to come from your insurance company depending on what your insurance requires. **The patient** is responsible to know what is needed. **Please contact your Insurance Company to verify.**

If we are billing a **Workers Comp** or a **Motor Vehicle Claim**. **Patient is responsible** to have their Adjustor or Case Worker send us an **OPEN CLAIM LETTER** this can be faxed, mailed or emailed to our office. If we **DO NOT** have this letter we **CAN NOT SEE YOU**. Please contact your Adjustor or Case worker to have them send this information to our office as soon as your appointment has been made. This letter contains all the billing information needed for our office so we know how we should be billing your visit.

Thank you,
Dr. Vittorio Morreale M.D. Office
50505 Schoenherr Rd. Suite 200, Shelby Twp., Michigan 48315
586-803-1220 phone 586-803-1277 fax

VITTORIO M. MORREALE M.D., PLC Appointment Date: _____
50505 Schoenherr Rd, Suite 200, Shelby Township, MI 4831 Time: _____ **24 hour cancellation policy Phone#: (586)-803-1220 Fax #: (586)-803-1277**

PATIENT INFORMATION

*****ALL QUESTIONS MUST BE ANSWERED. PLEASE DO NOT LEAVE ANYTHING BLANK*****

Name (first, middle initial, last): _____
Address: _____ City: _____ Zip: _____
Home#: (_____) _____-_____ Cell#: (_____) _____-_____ Work#: (_____) _____-_____
Date of birth: _____/_____/_____ Sex: Male or Female
Social Sec #:_____-_____-_____ Language: _____ Race: _____ Ethnicity: _____
Marital Status: _____ Email address: _____

Emergency contact: _____ Relation: _____ Phone #: (____) _____ - ____ **Please DO NOT use home phone for EMERGENCY CONTACT!!

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PCP/Internist (Family doctor) Name: _____ Phone#: (_____) - _____ - _____

Ref. Physician Name: (if different) _____ Phone#: (_____)-_____-_____

****

Do you have a HMO Insurance? YES or NO (IF YES, YOU MUST HAVE YOUR REFERRAL OR YOUR APPOINTMENT WILL BE CANCELLED.) **Insurance Information:**

Primary Health Insurance: _____
Subscriber: _____
Group #_____
Subscriber ID#: _____
Subscriber's date of birth: _____

Secondary Health Insurance: _____
Subscriber: _____
Group #_____
Subscriber ID#: _____
Subscriber's date of birth: _____

****

AUTO AND WORK RELATED INJURIES

Is your injury the result of an AUTO accident? YES or NO (If so, please complete the following) Is there an Attorney involved? YES or NO
Attorney Name: _____ Phone #: (_____) - _____ - _____ Do you have a coordination of benefits with your auto coverage for health insurance? YES or NO

Name of Insurance Company: _____
Adjustor name: _____ Adjustor's phone#: (_____) - _____ - _____
Claim #: (a claim # must be given to be a valid claim) _____ Injury date: _____

****

Is this a WORKERS COMPENSATION claim? YES or NO (If so, please complete the following)
Name of Employer: _____
Contact: _____ Phone #: (_____) - _____ - _____
Claim #: (a claim # must be given to be a valid claim) _____ Injury date: _____

Past Medical History (please list **ALL** medical history below, such as high blood pressure, cholesterol, cancer, diabetes, heart disease, HIV, mental illness, stroke):

_____
_____
_____

Please list **ALL** medical conditions that run in your family and if they are **alive or deceased** (such as high blood pressure, cancer, diabetes, heart disease, stroke):

Father: _____
Mother: _____
Siblings:_____
Paternal Grandfather:_____ Grandmother:_____
Maternal Grandfather: _____ Grandmother:_____

(If applicable) Injuries related to any Auto or Workers Compensation Claims either past or present:

_____
_____
_____

Past Injuries:

_____
_____

Surgeries, dates, and any complications:

_____
_____
_____

Please list Medications and Vitamins that are taken on a daily basis:

Name of Medication	Amount / Dosage's	How often taken
(example) Motrin	**1 tablet(s) / 20 mg**	**twice daily**

PHARMACY INFORMATION
Pharmacy Name: _____ Address: _____
Pharmacy Phone#: _____ -_____ - _____

****

Please list all drug allergies:

_____

_____

Do you have Latex Allergies? _____ Do you have Adhesive tape Allergies? _____

****

Occupation (or if student, grade in school) _____
Highest level of education: _____

Tobacco Control

____ Current
____ Former Smoker
____ Nonsmoker

If current smoker: How often do you smoke?
____ every day
____ some days, but not every day

If current smoker: How many cigarettes a day do you smoke?
____ 5 or less
____ 6-10
____ 11-20
____ 21-30
____ 31 or more

If current smoker: How soon after you wake up do you smoke your first cigarette?
____ within 5 minutes
____ 6-30 minutes
____ 31-60 minutes
____ after 60 minutes

If current smoker: Are you interested in quitting?
____ Ready to quit
____ Thinking about quitting
____ Not ready to quit

If former smoker: How long has it been since you last smoked?
____ < 1 month ____3-6 months _____1-5 years _____ >10 years ____ 1-3 months
____6-12 months _____5-10 years

Alcohol Use

Did you have a drink containing alcohol in the past year? YES or NO

If yes: How often did you have a drink containing alcohol in the past year?

____ Never
____ Monthly or less
____ 2 to 4 times a month
____ 2 to 3 times a week
____ 4 or more times a week

If yes: How many drinks did you have on a typical day when you were drinking in the past year?

____ 1 or 2 drinks
____ 3 or 4 drinks
____ 5 or 6 drinks
____ 7 to 9 drinks
____ 10 or more drinks

If yes: How often did you have 6 or more drinks on one occasion in the past year?

____ Never
____ Less than Monthly
____ Monthly
____ Weekly
____ Daily or almost daily

Patient Questionnaire Immunizations

FLU shot (Influenza) for Patients 18 years of age and older
Have you had your FLU shot this year? YES or NO (if NO was it a medical reason YES___ or NO___)
If "YES" approximately when did you receive it (date)? _____
Who administered your FLU shot? _____
(for example your PCP, CVS, Rite Aid)
Pneumonia shot for Patients **(65 years of age and older)**
Have you had your Pneumonia Shot? YES or NO (if NO was it a medical reason YES___ or NO___)
If "YES" approximately when did you receive it (date)? _____
Who administered your PNEUMONIA shot? _____ (for example your PCP, CVS, Rite Aid)

Elder Maltreatment Screening
For patients that are **(65 YEARS OF AGE OR OLDER)**
Is there any abuse in the home? YES or NO

Are you the one making the medical decisions? YES or NO
If NO, who is _____ Relationship_____

The above information is accurate to the best of my knowledge. I hereby authorize the office of Dr.Morreale to release my medical information. I understand that there is a possibility that my insurance company may not cover all the charges related to my office visit(s) or other medical or surgical treatment(s). I understand that I am responsible for medical and/or surgical charges that my insurance does not cover.

I have read the above and agree:

Signature: _____ Date: _____