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

WITHOUT THE APPROPRIATE INFORMATION YOUR APPOINTMENT MAY BE DELAYED.

PLEASE FOLLOW THESE GUIDELINES:

The information that is requested in these forms **IS REQUIRED**, our office needs this information to order any Radiology Imaging and/or if any Surgical Intervention is needed. We must have this information to get all tests and/or surgery **APPROVED**.

1. Please complete **ALL** the **New patient forms** attached. Return to the office (1) week prior to the scheduled appointment. If they are not received the appointment will need to be rescheduled. **Note that our office requires a 24-hour cancellation policy.**
2. Insurance cards & driver's license **Must** be present at the time of your visit.
3. Please bring **ALL** Radiology Imaging (MRI, CT) that you have pertaining to your visit. This should be in CD form along with the report.
4. **A referral is REQUIRED** for anyone with an **HMO Insurance.** This might come from your PCP (Primary Care Physician) or from your Insurance Company depending on what your insurance requires. Insurance changes frequently. It is the patient's responsibility to verify their insurance coverage before scheduling an appointment.
   PLEASE CONTACT YOUR INSURANCE COMPANY TO VERIFY YOUR COVERAGE!!
5. Dr. Morreale is a private practice doctor whom performs surgery out of Henry Ford Macomb, we are not connected with MyChart.

If we are billing a **Workers Compensation** or **Motor Vehicle Claim**. **The patient is responsible** to have their Adjustor or Case Worker send us an **OPEN CLAIM LETTER**, this can be faxed to our office. If we **do not** receive this letter prior to your appointment, we will have to reschedule the appointment. Please contact your **Adjustor** or **Case Worker** to have them send this information to our office as soon as your appointment has been made. The **OPEN CLAIM LETTER** is for billing purposes.

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

Vittorio M. Morreale M.D., PLC
50505 Schoenherr Rd., Ste. 200
Shelby Township, Michigan 48315
586-803-1220 (phone) 586-803-1277 (fax)

For office use only

Appointment Date: _____________

Appointment Time: _____________

PATIENT INFORMATION

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

Name (first, middle, last): ____

Address: ____ City: ____________________ Zip: ___________

Home#: (______) _______-_______ Alternate #: (______) _______-________ cell or work (circle)

Date of birth: ______/______/______ Sex: Male or Female

Social Sec #: _____-_______-_______ Language: ___________ Race: ___________ Ethnicity: ___________

Marital Status: ____________________ Email address: ____

Emergency contact: ____________________ Relationship: ____________ Phone #: (_____) ______ - ______

****

Insurance Information: (MUST BE COMPLETED)

Primary Health Insurance: __________________
Subscriber: ______________________________
Group #_________________________________
Subscriber ID#: __________________________
Subscriber's date of birth: __________________

Secondary Health Insurance: _________________
Subscriber: _______________________________
Group #__________________________________
Subscriber ID#: ___________________________
Subscriber's date of birth: ___________________

FYI: If you have an **HMO** Insurance**. MOST HMO INSURANCES REQUIRE YOU TO HAVE A REFERRAL TO BE SEEN. (PLEASE CONTACT YOUR INSURANCE COMPANY TO FIND OUT WHAT TYPE OF REFERRAL IS NEEDED.)**

****

AUTO OR WORK-RELATED INJURIES

Is your injury the result of an **AUTO ACCIDENT** Yes or No

Is your injury the result of a **WORKER'S COMPENSATION ACCIDENT** Yes or No

(If yes, please complete the following)

Is there an Attorney involved? Yes or No

Attorney Name: ________________________________ Phone #: (______) - ________ - ________________

If AUTO related, do you have a coordination of benefits with your Auto Insurance Company? Yes or No

Name of Insurance Company: ____

Name of Adjustor or Case Worker: ___________________________ Phone#: (______) - ________ - _________

Claim #: (a claim # must be given to be a valid claim) ___________________ Injury date: ________________

****

PHARMACY INFORMATION

Pharmacy Name: _______________________ Address: ____

Pharmacy Phone#: _________ -___________ - ___________

Medication List

(If you have your own list or need more space, please add an additional page)

Name of Medication:	Amount/Dosage:	Frequency:	Use:
Example: Motrin	600 mg / 1 tablet(s)	Twice a day	Inflammation

Physician List:

PCP/Internist (Family doctor) Name: ______________________________ Phone#: (______) - _______ - _______

Ref. Physician Name: (if different) _________________________________ Phone#: (______) -________-_______

Cardiologist Name: (If Applicable) _________________________________ Phone#: (______) -________-_______

Pulmonologist Name (If Applicable): ________________________________ Phone#: (______) -________-______

Pain Management (If Applicable): _________________________________ Phone#: (______) -________-_______

Please note, we are NOT connected with MyChart. Please complete the following:

Medical History: Please list all diagnoses below (such as High Blood Pressure, Diabetes, High Cholesterol, etc.) (If more space is needed, please add an attachment)

____
____
____
____
____

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

____
____
____

Surgical History: (Please list dates and if any complications.)

____
____
____

****

DRUG ALLERGIES

____
____

Do you have Latex Allergies? ________________ Do you have Adhesive tape Allergies? ___________________

****

IMMUNIZATIONS

Did you get a flu shot this season? Yes or No (**If no**, was it for a medical reason? Yes or No)
If yes, when did you have it? ______________ Where was it administered:(i.e. Rite Aid, CVS, PCP) ______________

(Patients over the age of 65 only)
Did you have a pneumonia shot? Yes or No (**If no**, was it for a medical reason? Yes Or No)
If yes, when did you have it? ______________ Where was it administered:(i.e. Rite Aid, CVS, PCP) ______________

FAMILY MEDICAL HISTORY: **Please ✓ the corresponding boxes below** ☐ **Adopted**

	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness	Cancer	Other: (If applicable)	Please Circle:
Mother								Deceased Alive
Father								Deceased Alive
Maternal Grandfather								Deceased Alive
Maternal Grandmother								Deceased Alive
Paternal Grandfather								Deceased Alive
Paternal Grandmother								Deceased Alive
Siblings								Deceased Alive

****

TOBACCO CONTROL

____ Current
____ **Former Smoker (see below)**
____ 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?
____ less than month ____ 6-12 months
____ 1-3 months ____ 1-5 years ____ Greater than 10 years
____ 3-6 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 6 or more drinks on one occasion in the past year?

____ Never
____ Less than Monthly
____ 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 a drink containing alcohol in the past year?

____ Never
____ Monthly or less
____ 2 to 4 times a month
____ 2 to 3 times a week
____ Daily or almost daily

****

VITALS

Height: ___________ Weight: __________

****

Do you make your own Medical Decisions? Yes or No

If no, do you have a **Power of Attorney**? Yes or No

If yes, who is your **Power of Attorney**: Name: ____________________________________ Relationship: ______________

You will need to provide a copy of your POA for Healthcare for your file for your decision maker.

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: ____