Michigan Minimally Invasive Neurosurgical Institute

Miguelangelo J. Perez-Cruet, M.D.

5220 Highland Road, Ste 210 Office Phone: 248-383-1030

Waterford, MI 48327 Fax: 248-383-1031

Dear Patient:

Thank you for selecting Michigan Minimally Invasive Neurosurgical Institute for your neurosurgical needs. We look forward to seeing you at your upcoming appointment on _____ at _____.

In order for our physician to give you the best care possible, it is necessary for you to bring the following items with you to your appointment:

- Driver's License
- Insurance card(s)
- Completed forms contained in this packet
- Insurance referral (if you have Blue Care Network , and all other out of network HMO's)
- All diagnostic studies that you have had (x-rays, MRIs, CTs, etc) MUST be brought on the CD disc or film

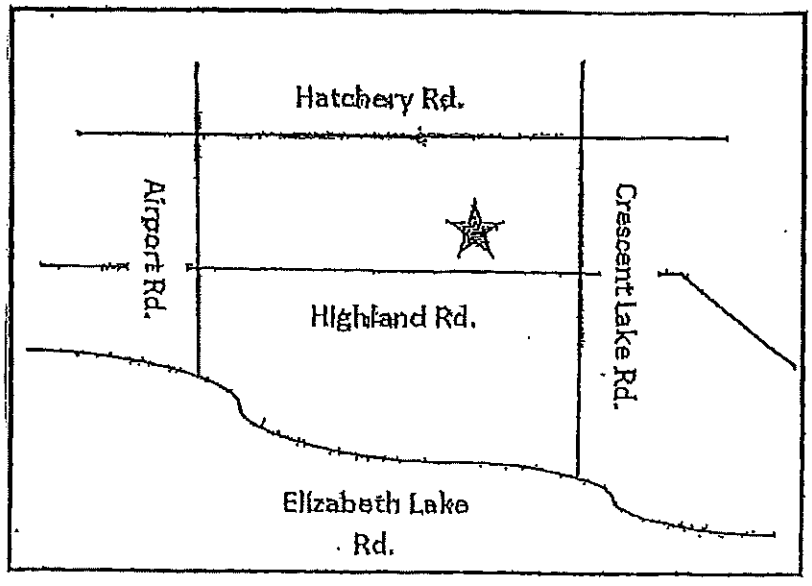
If you do not bring the items listed above, our physician will not be able to see you, and we will have to reschedule your appointment to another date and time. Thank you in advance for your cooperation in providing this information. If you have any questions, please do not hesitate to call our office.

HOURS OF OPERATION:

Monday – Thursday 9:00AM – 5:00PM

(Closed 12:00PM – 1:00PM for lunch)

Friday 9:00AM – 12:00PM



Michigan Minimally Invasive Neurosurgical Institute
MIGUELANGELO J. PEREZ-CRUET, M.D.

Today's Date_____

First Name_____ Last Name_____

Address_____ City _____ State _____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Date of Birth _____ Age _____ Sex_____ Marital Status_____

Email address_____ Social Security #_____

Referring Physician (name, address, phone number):_____

_____

Primary Care Physician (name, address, phone number):_____

_____

Employer_____ Job Title: _____

Employer's Address_____

Emergency Contact *[relative or friend not living with you]*

Name_____ Relationship_____ Phone_____

Primary Insurance Company_____

Subscriber Name_____ Subscriber Date of Birth_____

Contract Number_____ Group Number_____

Subscriber Soc Sec #_____ Patient Relationship to Subscriber_____

Subscriber's Employer / Retired From_____

Employer's Address and Phone Number_____

Secondary InsuranceCompany_____

Subscriber Name_____ Subscriber Date of Birth_____

Contract Number_____ Group Number_____

Subscriber Social Security #_____ Relationship to Subscriber_____

Subscriber's Employer / Retired From_____

Employer's Address and Phone Number_____

Michigan Minimally Invasive Neurosurgical Institute
MIGUELANGELO J. PEREZ-CRUET, M.D.

Reason for today's visit:

_____

When did this begin? Was there something that caused it?

_____

When were you first treated? By whom?_____

Please describe your symptoms in detail:

_____

_____

_____

If you are having pain, circle one number in each row that represents your pain levels.
0 is no pain and 10 is the worst pain imaginable

	☺					😐					☹
Typically my pain is about a...	0	1	2	3	4	5	6	7	8	9	10
At best, my pain is about a...	0	1	2	3	4	5	6	7	8	9	10
At worst, my pain is about a...	0	1	2	3	4	5	6	7	8	9	10

Have you participated in any of the following treatments in the past 12 months:

Physical Therapy

*Dates*_____

*Duration*_____

Any improvement?

_____

Pain Management Injections

*Dates*_____

*Duration*_____

Any improvement?

_____

Chiropractic

*Dates*_____

*Duration*_____

Any improvement?

_____

Past Medications (no longer taking)

_____

_____

Any improvement?

_____

Gender_____ Height_____ Weight_____ Right or Left Handed (circle one)

Michigan Minimally Invasive Neurosurgical Institute
MIGUELANGELO J. PEREZ-CRUET, M.D.

Please list any current or past illness (such as high blood pressure, diabetes, cancer, etc.)

_____

_____

Please list any previous surgeries with dates:

_____

_____

Please list all current medications with dose and frequency:

_____

_____

_____

Please list all ALLERGIES to medications and the reaction you have:

_____

Family History: (list illnesses or cause of death)

Mother _____

Father _____

Siblings _____

Social History

Occupation:_____

Marrital Status (circle one): Single Married Separated Divorced Other_____

How many children do you have? _____

Do you live alone? Yes or No

If no, who do you live with?_____

Alcohol Use (circle one) Daily Weekly Monthly Rare Never Other_____

Recreational Drug Use (circle one) Daily Weekly Monthly Rare Never Other_____

What type?_____

Do you currently smoke? (circle one) *YES* or *NO*

If yes, how many packs per day? _____ For how many years?_____

If no, have you smoked in the past? (circle one) *YES* or *NO*

How many packs/day? _____ How many years? _____ When did you quit? _____

Michigan Minimally Invasive Neurosurgical Institute
MIGUELANGELO J. PEREZ-CRUET, M.D.

Are you currently experiencing, or have you recently experienced, any of the following?

Constitutional			**Abdominal**			
Fever	Y	N	Nausea/Vomiting	Y	N	
Weight loss	Y	N	Abdominal pain	Y	N	
Fatigue	Y	N	Ulcers/Gastritis	Y	N	
Night sweats	Y	N	Reflux disease	Y	N	
			Liver disease	Y	N	
Eyes			Jaundice	Y	N	
Infections	Y	N	Colon Cancer	Y	N	
Glaucoma	Y	N				
			Genitourinary			
Ears, Nose Throat			Bladder infections	Y	N	
Hearing loss	Y	N	Incontinence to urine	Y	N	
Ear pain/infections	Y	N	Prostate Cancer	Y	N	n/a
Ringing in ears	Y	N	Uterine Cancer	Y	N	n/a
Nasal drainage	Y	N	Cervical Cancer	Y	N	n/a
Sinus problems	Y	N				
Sore throat	Y	N	**Musculoskeletal**			
			Neck pain	Y	N	
Cardiovascular			Arm weakness	Y	N	
Chest pain	Y	N	Back pain	Y	N	
High blood pressure	Y	N	Leg weakness	Y	N	
Irregular pulse	Y	N	Joint pain/swelling	Y	N	
Heart murmur	Y	N	Arthritis	Y	N	
Edema/leg swelling	Y	N	Numbness	Y	N	
High cholesterol	Y	N				
			Neurological			
Respiratory			Memory loss	Y	N	
Asthma	Y	N	Seizures	Y	N	
Emphysema	Y	N	Dizziness	Y	N	
COPD	Y	N	Syncope (fainting)	Y	N	
Shortness of breath	Y	N	Slurred speech	Y	N	
Lung Cancer	Y	N	Blurred vision	Y	N	
Chronic Bronchitis	Y	N	Loss of balance	Y	N	
			Facial weakness	Y	N	
Endocrine			Headaches	Y	N	
Thyroid Disease	Y	N	Brain tumor	Y	N	
Diabetes	Y	N	**Hematologic**			
Hormone problems	Y	N	Bleeding disorder	Y	N	
			Anemia	Y	N	

Other symptoms you feel are significant that are not listed anywhere else on this form:

_____

The above information is accurate to the best of my knowledge_____
(Signature)

Michigan Minimally Invasive Neurosurgical Institute
MIGUELANGELO J. PEREZ-CRUET, M.D.

For Auto Accident or Worker's Compensation Claims

Is this the result of an auto accident? *Circle One* YES NO
Is this a worker's compensation claim? *Circle One* YES NO

If **yes**, please provide the following information:

Name of Insurance Company_____ Date of Injury_____

Address of Claim Office_____

Name of Claim Adjustor_____ Phone_____

Claim Number_____ State Accident Occurred In_____

Attorney's Name_____ Phone_____

Authorization / Responsibility Agreement

1. I hereby authorize Michigan Minimally Invasive Neurosurgical Institute to receive or release any medical or other information that may be necessary for my medical care or in processing insurance applications. This includes the sharing of information with all parties involved in my care. All means of data exchange may be utilized, including electronic transmission.
2. I hereby authorize direct payment of medical benefits to Michigan Minimally Invasive Neurosurgical Institute for services rendered by one of their physicians or for services rendered under the supervision of a physician. I understand that I am financially responsible for any balance not covered by my insurance.
3. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.
4. I have been informed of the HIPAA Notice of Privacy.
5. Office visit co-pays are expected at the time of service. You are responsible for supplying us with correct insurance information for billing purposes. A delay in billing from incorrect information may cause the cost of your treatment to become your responsibility.
6. There is a $25.00 fee for copying medical records at the patient's request.
7. One insurance form may be completed at no charge. Additional forms $25 each.
8. Filling of prescriptions and refills are done at the discretion of the physician.

Patient Name (Print)_____

Patient Signature_____

Guardian's Name and Signature (if applicable)_____

Michigan Minimally Invasive Neurosurgical Institute

Miguelangelo J. Perez-Cruet. M.D.

MICHIGAN MINIMALLY INVASIVE NEUROSURGICAL INSTITUTE / CT SCANNING CTR

Acknowledgement of Availability of Notice of Privacy Practices of Michigan Minimally Invasive Neurosurgical Institute

I acknowledge,

A copy of Michigan Minimally Invasive Neurosurgical Institute/ CT Scanning Center Notice of Privacy Practices was made available to me at the place where I went for health care services.

The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

I know that I can ask for a copy of the Notice of Privacy Practices to take with me.

If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

Patient or Patient Representative Signature Date

If an acknowledgement is not obtained; document below the provider's good faith efforts to obtain the acknowledgement and the reasons why the acknowledgement was not obtained.

Signature of person documenting good faith efforts Date

Michigan Minimally Invasive Neurosurgical Institute

Miguelangelo J. Perez-Cruet, M.D.

FOR WORKER'S COMPENSATION & AUTO ACCIDENT PATIENTS ONLY

Lien Letter

Patient_____

Date of Birth_____

I acknowledge a lien on any monies I receive in settlement of my claim for injuries arising out of the _____

Date of Injury

_____

Episode

For medical expenses rendered to me by Miguelangelo J. Perez-Cruet, M.D. Michigan Minimally Invasive Neurosurgical Institute.

Patient Signature_____

Date_____

Michigan Minimally Invasive Neurosurgical Institute

Miguelangelo J. Perez-Cruet

NOTICE

Due to the constant changes in insurance, it is no longer possible to interpret each individual's policy. Although we try to stay aware of these changes. It is not possible.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE

There is no guarantee your insurance company will cover our services. All insurance policies have exclusions and most policies have deductibles and co-payments.

Please remember that your insurance policy IS between you and your insurance company and NOT between the insurance company and the doctor.

Signature of insured or responsible party

Date