Michigan Minimally Invasive Neurosurgical Institute

5220 Highland Road, Suite 210

Waterford, Michigan 48327

Phone: 248-383-1030 Fax: 248-383-1031

Mick J. Perez-Cruet, M.D., M.S.

Dear patient,

Thank you for selecting Michigan Minimally Invasive Neurosurgical Institute for your medical 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, CT scans, etc.) MUST be brought on the CD disc or film

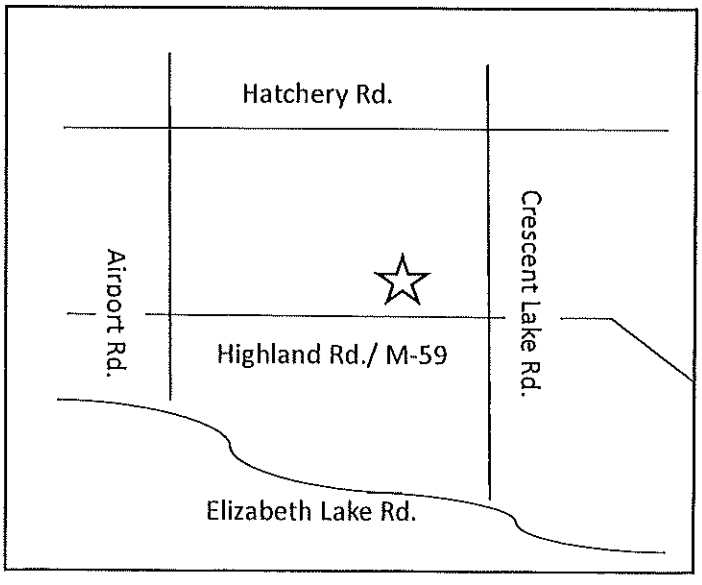
If you do not bring the items listed above, our physician will not be able to see you, and we will have to reschedule your appointment to another date and time. Thank you in advance for your cooperation in providing this information. If you have any questions, please do not hesitate to call our office.

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
MICK J. PEREZ-CRUET, M.D., M.S.

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Suite 210
Waterford, MI 48327
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Today's date: _____

First name: _____ Last name: _____

Address: _____ City: _____ State:_____ Zip:_____

Cell phone: _____ Home phone: _____ Work phone: _____

Date of birth: _____ Age: _____ Gender: _____ Marital Status: _____

Height: _____ Weight: _____ Social security # _____

Email address: _____

Referring physician (name, address, phone number):

_____

Primary care physician (name, address, phone number):

_____

Pharmacy name: _____

Address: _____ Phone number: _____

Employer: _____ Job Title: _____

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: _____

Subscribers employer/retired from: _____

Employer's address and phone number: _____

Secondary 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: _____

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For Auto Accident or Workers 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

Name of insurance company: _____ Date of injury: _____

Address of claim office: _____

Name of claim adjuster: _____

Claim number: _____ State accident occurred in: _____

Attorney's name: _____ Phone number: _____

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 HIPPA 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 patients request.
7. Our office will complete one insurance form for you at no charge. Any additional forms will require a payment of $25.00 for each form.
8. Filling of prescriptions and refills are done at the discretion of the physician.

Patient name (Print): _____

Guardian's name and signature (if applicable): _____

What is your What is your primary concern/problem today?

_____

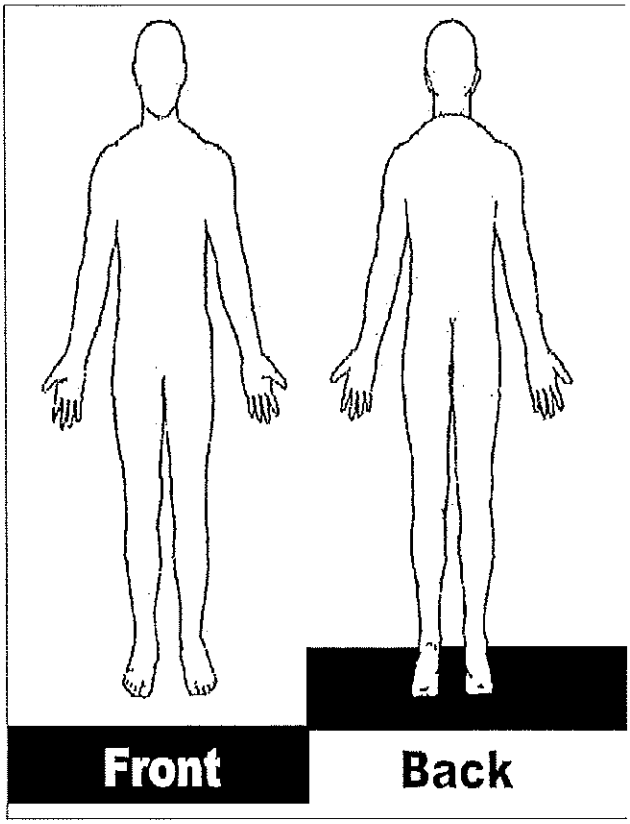
(body part)

When did your problem/symptoms begin?

_____ Days _____ Months _____ Years

Which side(s)? ☐ Right ☐ Left ☐ Both

Shade in the area(s) below where you experience pain:



Description of your symptoms/problem: (check **ALL** that apply)

- o Numb/Dull
- o Sharp
- o Tender
- o Shooting
- o Cramping
- o Exhausting/Tiring
- o Tingling
- o Aching
- o Heavy
- o Stabbing
- o Throbbing
- o Hot/Burning

How did your symptoms/problem start? (check **ALL** that apply)

- o Sudden with injury
- o Gradual with injury
- o Auto Accident
- o Other: _____
- o Sudden without injury
- o Gradual without injury
- o Work

How often is your symptoms/problem? (check **ALL** that apply)

- o Constant
- o Better in AM
- o Better in PM
- o Intermittent
- o Worse in AM
- o Worse in PM

What is the severity of your pain?: (check **ALL** that apply)

- o Mild
- o Severe
- o Moderate

Any of the following symptoms: (check **ALL** that apply)

- o Numbness
- o Trouble walking
- o Muscle tightness
- o Weakness
- o Muscle spasms
- o Fatigue

	☺					😟					☹
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

0 is no pain and 10 is the worst pain imaginable

What makes your pain BETTER? (check **ALL** that apply)

- o Rest/sleep
- o Medications
- o Exercise/stretching
- o Social activity
- o Sexual activity
- o Meditation
- o Walking
- o Working
- o Massage

What makes our pain WORSE? (check **ALL** that apply)

- o Sitting
- o Walking
- o Standing
- o Sleeping
- o Social activity
- o Sexual activity
- o Traveling
- o chores
- o Lifting

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 for this condition

_____

_____

_____

Any improvement?

_____

Medications, Vitamins, and supplements: List ALL medications you are currently taking ☐ NONE

MEDICATION NAME	DOSAGE	FREQUENCY

Do you take any BLOOD THINNING medication(s)? Ex: Plavix, Coumadin, Xarelto, Eliquis, Pradaxa ☐ Yes ☐ No

If taking NARCOTICS/OPIODS (pain medication(s)), do they cause impairment? ☐ Yes ☐ No

Allergies:

Are you allergic to latex? ☐ NO ☐ YES

Are you allergic to penicillin? ☐ NO ☐ YES

Are you allergic to IV Contrast Dye? ☐ NO ☐ YES

Are you allergic to Sulfa? ☐ NO ☐ YES

Are you allergic to NSAIDS? ☐ NO ☐ YES

Are you allergic to ASA? ☐ NO ☐ YES

Please list any other allergies you may have:

_____

Past Surgical History: (Please list any surgeries you have had including dates) ☐ No history of surgery

_____

_____

_____

Family History: (Please check ALL that apply)

- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Autoimmune Disorder
- ☐ Bipolar
- ☐ Cancer
- ☐ Liver problems
- ☐ Substance abuse
- ☐ COPD
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Mental health disorder
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Kidney problems
- ☐ Stroke

Other family history: _____

Social History:

Advanced directives: ☐ NO ☐ YES

Work status: ☐ Employed/occupation _____ ☐ Unemployed ☐ Retired ☐ Disabled

Smoking status: ☐ Never

☐ Former smoker; quit date: _____ years smoked: _____

☐ Current smoker; packs per day: _____ Years smoking: _____

Use of e-cigarette or vape products? ☐ NO ☐ YES If other, what product? _____

Do you drink alcohol? ☐ NO ☐ YES If YES, how many drinks per week? _____

Any illegal drug use or substance abuse? ☐ NO ☐ YES If YES, what substance? _____

Living arrangements: ☐ LIVE ALONE ☐ LIVE WITH OTHERS

Do you feel safe? ☐ NO ☐ YES

Able to perform activities of daily living? ☐ NO ☐ WITH DIFFICULTY ☐ ABLE TO PERFORM

Have you had significant exposure to: Pesticides? ☐ YES ☐ NO

Toxic waste ☐ YES ☐ NO

Have you had prior treatment or exposure to radiation? ☐ YES ☐ NO

If YES, please explain: _____

Do you eat a balanced diet? ☐ YES ☐ NO

Is your weight stable? ☐ YES ☐ NO

Health Information

Past Medical History: (check ALL that apply)

- ☐ Acid Reflux (GERD)
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bladder problems
- ☐ Bleeding disorders
- ☐ Blood clot (DVT/PE)
- ☐ COPD/Emphysema
- ☐ Cancer
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ Fainting Episode
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headaches
- ☐ Heart attack (MI)
- ☐ Heart disease
- ☐ Heart Stents
- ☐ Hepatitis (B or C)
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Irregular heartbeat
- ☐ Kidney insufficiency
- ☐ Kidney stones
- ☐ Liver disease
- ☐ MRSA exposure
- ☐ Osteoporosis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Skin ulcers
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid problems
- ☐ Tuberculosis(TB)
- ☐ Ulcerative colitis

Other health problems:

_____

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

Constitutional		
Fever	Y	N
Weight loss	Y	N
Fatigue	Y	N
Night sweats	Y	N

Endocrine		
Thyroid Disease	Y	N
Diabetes	Y	N
Hormone Problems	Y	N

Ears, Nose, and Throat		
Hearing loss	Y	N
Ear pain/infections	Y	N
Ringing in ears	Y	N
Nasal drainage	Y	N
Sinus problems	Y	N
Sore throat	Y	N

Cardiovascular		
Chest pain	Y	N
High blood pressure	Y	N
Irregular pulse	Y	N
Heart murmur	Y	N
Edema/leg swelling	Y	N
High cholesterol	Y	N

Respiratory		
Asthma	Y	N
Emphysema	Y	N
COPD	Y	N
Shortness of breath	Y	N
Lung cancer	Y	N
Chronic Bronchitis	Y	N

Eyes:		
Infections	Y	N
Glaucoma	Y	N

Abdominal		
Nausea/vomiting	Y	N
Abdominal Pain	Y	N
Ulcers/Gastritis	Y	N
Reflux disease	Y	N
Liver disease	Y	N
Jaundice	Y	N
Colon cancer	Y	N

Genitourinary		
Bladder infections	Y	N
Incontinence to urine	Y	N
Prostate cancer	Y	N
Uterine cancer	Y	N
Cervical cancer	Y	N

Musculoskeletal		
Neck pain	Y	N
Arm weakness	Y	N
Back pain	Y	N
Leg weakness	y	N
Joint pain/swelling	Y	N
Arthritis	Y	N
Numbness	Y	N

Neurological		
Memory loss	Y	N
Seizures	Y	N
Dizziness	Y	N
Syncope (fainting)	Y	N
Slurred speech	Y	N
Blurred vision	Y	N
Loss of balance	Y	N
Facial weakness	Y	N
Headaches	Y	N
Brain tumor	Y	N

Hematologic		
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)

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

I acknowledge,

A copy of Michigan Minimally Invasive Neurosurgical Institute 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

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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 Michigan Neurosurgical Specialists

Patient signature: _____

Date: _____

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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 always 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