

MIU Patient Information Form

appointment date/time _____ / _____

RICHARD P. ABRAMSON, M.D. _____	ALPHONSE M. SANTINO, M.D. _____	RICHARD C. SARLE, M.D. _____
RICHARD C. BENNETT, M.D. _____	JASON M. HAFRON, M.D. _____	EDWARD W. SCHERVISH, M.D. _____
JAMES J. BOUTROUS, M.D. _____	JOHN R. HARDING, M.D. _____	BRIAN D. SEIFMAN, M.D. _____
MICHAEL G. COTANT, M.D. _____	MITCHELL B. HOLLANDER, M.D. _____	BRYAN P. SHUMAKER, M.D. _____
ROBERT R. DI LORETO, M.D. _____	KENNETH M. KERNEN, M.D. _____	SCOTT I. SIRCUS, M.D. _____
ROBERT J. DIMITRIOU, M.D. _____	EARL R. KOENIG, M.D. _____	JENNIFER L. SOBOL, D.O. _____
JEAN-CLAUDE ELIE, M.D. _____	DAVID W. LAW, D.O. _____	STEPHEN A. STUPPLER, M.D. _____
J. RENE FRONTERA, M.D. _____	MICHAEL D. LUTZ, M.D. _____	JORGE R. TORRIGLIA, M.D. _____
VALAL K. GEORGE, M.D. _____	SHIVA MARALANI, M.D. _____	ROBIN J. RYE, D.N.P. _____
MARKO R. GUDZIAK, M.D. _____	LINDA L. McINTIRE, M.D. _____	HEATHER M. GULISH, C.U.N.P. _____
BRIAN V. GUZ, M.D. _____	GREGORY M. OLDFORD, M.D. _____	ANN PAZZI, R.N. _____
	CLAUDE REITELMAN, M.D. _____	RESEARCH DEPARTMENT _____
	JAMES D. RELLE, M.D. _____	

ST. CLAIR SHORES _____ UTICA _____ DEARBORN _____ TROY _____ W. BLOOMFIELD (ORCHARD LAKE) _____ TRENTON _____

W. BLOOMFIELD (LAKES) _____ PONTIAC _____ CLARKSTON _____ HURON VALLEY _____ ROCH. HILLS _____ HIGHLAND _____

PATIENT'S NAME (LAST, FIRST, M.I.) _____ BIRTHDATE _____ AGE _____

PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP) _____ SEX _____

M _____ F _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

SOCIAL SECURITY NO. _____ PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN _____

MEDICARE HIC # _____ IS INSURED RETIRED? _____ RETIREMENT DATE _____ PATIENT'S WORK PHONE/EXT. _____

YES _____ NO _____

SUBSCRIBER'S NAME (LAST, FIRST, M.I.) _____ SUBSCRIBER'S BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER'S ADDRESS (STREET, CITY, STATE, ZIP) _____

SUBSCRIBER'S EMPLOYER _____ PRIMARY INSURANCE NAME _____

PRIMARY INSURANCE ADDRESS (CITY & STATE) _____ PRIMARY INSURANCE PHONE _____

CONTRACT NUMBER _____ GROUP _____ SERVICE CODE _____

SECONDARY INSURANCE NAME _____ SECONDARY INSURANCE (CITY & STATE) _____ SECONDARY INSURANCE PHONE _____

SECONDARY INSURANCE SUBSCRIBER NAME _____ BIRTHDATE OF SECONDARY SUBSCRIBER _____ RELATIONSHIP TO INSURER _____

CONTRACT NUMBER _____ GROUP _____ SERVICE CODE _____

ALLERGIES TO MEDICATION: _____

NAME OF NEXT OF KIN OR EMERGENCY CONTACT / RELATIONSHIP TO PATIENT _____

NEXT OF KIN OR EMERGENCY CONTACT'S ADDRESS / PHONE # _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN - I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services described below but not to exceed the reasonable and customary charge for these services. "I UNDERSTAND THE PROVIDER'S CHARGE MAY EXCEED THE PRIVATE INSURANCE CARRIER PAYMENT, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT."

ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment

SIGNED (PATIENT OR PARENT IF A MINOR)