

**SUPERIOR IMAGING SPECIALISTS
PATIENT INFORMATION**

Name: _____ Birth Date: _____ Age: _____

SEX: Male Female MARITAL STATUS: Married Single Widowed Divorced Separated

Address _____ Soc. Sec. #: _____

City _____ State _____ Zip Code _____ Home Phone: _____

Employer Name: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____

RESPONSIBLE PARTY
(If other than self)

Name: _____ Relationship: _____

Address _____

City _____ State _____ Zip Code _____ Phone: _____

INSURANCE INFORMATION
(Office staff will photocopy your insurance cards)

1st Insurance: _____ Policy Holder: _____ Birth Date: _____

2nd Insurance: _____ Policy Holder: _____ Birth Date: _____

INSURANCE AUTHORIZATION/MEDICARE OR MEDICAID AUTHORIZATION

I authorize Superior Imaging Specialists to furnish information to insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I CERTIFY that information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf. This assignment will continue as long as I remain eligible for such benefits. I understand I am responsible for any benefit co-pays or deductibles not covered by these plans.

X _____
Signature of patient or authorized representative Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The notice of Privacy Practices for Marquette General Health System has been made available to me for my review. I understand that I may request a copy of the notice or obtain a copy from their website at www.mgh.org at any time.

X _____
Patient/Representative Signature Date

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

Interventional & Vascular Institute of Northern Michigan Patient Questionnaire & Medical History

NAME: _____ DATE: _____ GENDER: Male Female
 DATE OF BIRTH: _____ MARITAL STATUS: Single Married Divorced Widowed
 OCCUPATION (current or prior, if not working): _____ Working Unemployed Retired
 REFERRING PHYSICIAN: _____ CITY: _____
 PRIMARY CARE PHYSICIAN: _____ CITY: _____
 HOME PH.: _____ WORK PH.: _____
 CELL PH.: _____ EMAIL: _____

How did you hear about the Interventional & Vascular Institute?

- Friend/Family Member Website/Internet Newspaper Television
 Referring Physician Yellow pages Health Fair Other: _____

FAMILY HISTORY

Family background may be related to medical conditions. Please fill in the following chart to the best of your ability. Please include your mother, father, siblings and children.

FAMILY MEMBER	DECEASED (Y/N)	CURRENT AGE OR AGE AT DEATH	CAUSE OF DEATH	ILLNESSES
Example: Mother	No	72	Not Applicable	Diabetes

GYNECOLOGICAL HISTORY (Female Patients Only):

First day of your last menstrual period (LMP): _____
 Number of Pregnancies: _____
 Number of Live Births: _____

PAST MEDICAL HISTORY:

Please check any of the following medical conditions you currently have:

- HIGH BLOOD PRESSURE THYROID DISEASE HEART DISEASE
- DIABETES LIVER DISEASE LUNG DISEASE
- CANCER- TYPE: _____ OTHER: _____

PAST SURGICAL HISTORY:

Please list all surgeries you have had.

SURGERY	YEAR SURGERY PERFORMED

- Do you have difficulties with anesthesia? Yes No
- Do you require antibiotics prior to surgical/dental procedures? Yes No
- If yes, which antibiotic do you usually take? _____

SOCIAL HISTORY:

- Do you currently use tobacco products? Yes No
- If yes, how much do you use on a daily basis? _____
- Have you used tobacco products in the past? Yes No
- If yes, how many years did you use tobacco products? _____
- Do you currently consume alcohol products? Yes No
- If yes, how often do you consume alcohol products? _____

REVIEW OF SYMPTOMS:

Indicate the symptoms that apply to you at this time.

GENERAL

- Fever
- Chills
- Weight Loss
- Change in appetite
- Dizziness
- Fatigue

HEAD/EARS/EYES/NOSE/THROAT

- Headache
- Hearing Problems
- Sore Throat
- Swollen Glands
- Eye Pain
- Blurred Vision

RESPIRATORY/LUNGS

- Shortness of Breath
- Coughing Blood
- Productive Cough
- Wheezing

CARDIOVASCULAR

- Chest Pressure
- Ankle/Foot Swelling
- Varicose Veins
- Palpitations
- Ulcers on Feet/Legs
- Leg Pain When Walking
- Fast Heart Rate
- High Blood Pressure
- Slow Heart Rate
- Low Blood Pressure

GASTROINTESTINAL/DIGESTIVE

- Nausea
- Yellow Jaundice
- Vomiting
- Constipation
- Diarrhea
- Difficulty Swallowing
- Abdominal Pain
- Can't Control Stool
- Abdominal Mass
- Bloody Stool

URINARY

- Painful Urination
- Blood in Urine
- Frequency
- Incontinence

MUSCULOSKELETAL

- Muscle Loss
- Loss of Limb Movement
- Muscle Pain
- Back Pain
- Joint Pain
- Difficulty Walking
- Joint Swelling

SKIN

- Rashes
- Bruising
- Skin Ulcers

NEUROLOGICAL

- Weakness
- Numbness
- Tingling

Patient Signature _____ Date _____

Physician Signature _____ Date _____