MICHIGAN BRAIN & SPINE SURGERY CENTER

LUCIA ZAMORANO, MD, PLC

LUCIA ZAMORANO, MD LINDSAY GIETZEN, PA-C

REGISTRATION DATA & INSURANCE INFORMATION

PLEASE PRINT

DATE OF OFFICE VISIT _____

Personal Information:

Last Name	First Name	Middle Initial	Age
Street Address/Apt #	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Social Security Number	Date of Birth	Drivers License #	

Emergency Contact Information:

Contact Last Name	First Name	Middle Initial	Relationship
Home Phone	Work/Cell Phone		

Insurance Info: (Please provide a copy of your insurance card and ID to front office)

Name on Policy	Insurance Company
Contract #	Group #

MICHIGAN BRAIN & SPINE SURGERY CENTER

LUCIA ZAMORANO, MD, PLC

Physician Information:

How were you referred? If Physician please list below: ( ) Physician ( ) Self/Other

Physician's Last Name First Name Title (MD, DO, DC)

Street Address/Suite City State Zip Code

Office Phone Fax Number

Do you have a Primary Care Doctor? ( ) Yes ( ) No If yes please list below:

Physician's Last Name First Name Title (MD, DO, DC)

Street Address/Suite City State Zip Code

Office Phone Fax Number

List any other Physicians who should receive results of your consultation:

Physician's Last Name First Name Title (MD, DO, DC)

Street Address/Suite City State Zip Code

Office Phone Fax Number

Physician's Last Name First Name Title (MD, DO, DC)

Street Address/Suite City State Zip Code

Office Phone Fax Number

Medical History:

Describe (in your own words) how your illness started and what test (s) you have had done before your appointment. Please list any dates:

Family Health History:

Include blood relatives only. Do not include anyone adopted, foster, step, or those related by marriage.

Relative	Age	Alive Yes	Alive No	Cancer Yes	Cancer No	If yes- Type:	Other Medical Conditions	List Condition: (Diabetes, etc)
Mother								
Father								
Mother's Mother								
Mother's Father								
Father's Mother								
Father's Father								
Daughter 1								
Daughter 2								
Daughter 3								
Son 1								
Son 2								
Son 3								
Sister 1								
Sister 2								
Sister 3								
Brother 1								
Brother 2								
Brother 3								
Other relatives:								

Are there any illnesses that run in your family?_____

Cancer History

Have you ever had cancer surgery? If "yes" describe below_____ ( ) yes ( ) no

Month/Year of Surgery	Area of Body	Hospital	Physician

Describe any problems you experienced before/after surgery:

_____
_____
_____

Radiation Therapy:

Have you ever had radiation therapy? If "yes" describe below_____ ( ) yes ( ) no

Start-End Date	Area of Body Treated	Hospital	Physician

Describe any problems you experienced before/after surgery:

_____
_____
_____

Chemotherapy:

Have you ever had chemotherapy? If "yes" describe below_____( ) yes ( ) no

Start-End Date	Chemo Drug/Regimen	Hospital	Physician

Describe any problems you experienced before/after surgery:_____
_____
_____
_____

Medical History: Noncancer

How was your health before your diagnosis?_____( ) excellent ( ) good ( ) fair ( )poor

How do you feel right now?_____( ) excellent ( ) good ( ) fair ( )poor

Illnesses or Conditions: List all illnesses/conditions you have starting with the most recent: (diabetes, heart disease, high blood pressure, etc)

Illness/Condition	Date Diagnosed	Treatment	Physician

Hospitalizations & Operations: List all noncancerous hospitalizations/operations starting with most recent

Reason for Hospitalization	Date (s) Hospitalized	Hospital	Physician

Medications: List all medications you are currently taking (include vitamins and nonprescription drugs)

Medication	Date Prescribed	Dosage	Frequency

Allergies:

Are you allergic to the dye used in x-rays?_____ ( )yes ( ) no
Are you allergic to latex?_____ ( )yes ( ) no
Are you allergic to any medications (example: Penicillin)?__ ( )yes ( ) no

Please list all allergies below:

Allergy	**Reaction**

Social History:

Marital Status:	( ) Married	( ) Single	( ) Divorced	( ) Widowed
Education:	( ) Grade School	( ) High School	( ) College	( ) Other
Main Language:	( ) English	( ) Spanish	( ) Arabic	( ) Other

Do you:	**Yes**	**No**
Need a translator?		
Have reliable transportation?		
Have insurance for prescriptions?		
Have Advanced Directives?		
Have family/friends to help you?		
Have emotional support?		
Have someone living with you?		
Need help coping with your diagnosis?		
If "Yes" Are you receiving help?		
Are you currently being abused (physically, sexually, emotionally)?		
Would you like to speak to a cancer counselor?		

Occupation/Work History:

What is your current occupation? _____

Have you been exposed to:	**Yes**	**No**
Asbestos		
Chronic Fumes		
Chronic Dust		
Radiation		
Toxic Chemicals		

Tobacco, Alcohol, and Other Substance Abuse Use:

Do you use?	( ) Cigarettes	( ) Cigars	( ) Pipe	( ) Chewing tobacco	( ) Snuff
Did you use?	( ) Cigarettes	( ) Cigars	( ) Pipe	( ) Chewing tobacco	( ) Snuff

How much do you use per day? _____ Number of years: _____

	Yes	No
Have you been exposed to second hand smoke?		
Do you drink alcoholic beverages daily?		
Do you drink alcoholic beverages socially only?		
Has alcohol interfered with your personal life?		
Did you, do you, use marijuana?		
Have you ever used cocaine, heroin, or other illegal substances?		

Review of Systems: If you are currently experiencing any of the following, please explain of the back of this sheet

General	Yes	No
Fever		
Sweats		
Weakness		
Fatigue		
Weight loss		
Skin	**Yes**	**No**
Excess sun exposure		
Blistering/Burns		
Use sunscreen		
Dark or pigmented lesions		
Melanoma		
Bleeding skin lesion		
Skin Cancer		
Psoriasis		
Chronic rash		
Vitiligo		
Birthmark		
Eyes	**Yes**	**No**
Lost Vision		
Wear Glasses		
Wear Contacts		
Glaucoma		
Lungs	**Yes**	**No**
Cough		
Productive Cough		
Blood in your sputum		
Pneumonia		
Bronchitis		
Emphysema		
Pleurisy		
Tuberculosis		
Asthma		
Short of Breath		
Frequent Colds		

Ears	Yes	No
Lost Hearing		
Ringing in ears		
Sinuses		
Sinus trouble		
Nosebleeds		
Mouth	**Yes**	**No**
Dental Problems		
Dentures		
Sore tongue		
Laryngitis		
Hoarseness		
Swollen glands		
Breast	**Yes**	**No**
Breast Biopsy		
Breast Cancer		
Nipple Discharge		
Breast lumps		
Cystic Breast Disease		
Breast Infection		
Hormone Replacement		
Breastfed		
Heart, Blood Vessels	**Yes**	**No**
Chest pain		
Chest pressure		
Heart attack		
Short of breath at night		
Heart murmur		
Rapid heart beat		
Swollen ankles		
Leg cramps at night		
Leg cramps with walking		
Rheumatic fever		
Congenital heart disease		

Average pain most days (circle) 0 1 2 3 4 5 6 7 8 9 10 (0-lowest 10- worst)
What are you taking for it? _____
Does this help? _____

Review of Systems Continued:

Gastrointestinal	Yes	No
Lost appetite		
Recent weight change		
Excess salvia		
Swallowing problems		
Solids stick?		
Pain		
Choking		
Food comes out of nose		
Heartburn		
Ulcer		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Black bowl movements		
Bloody bowel movements		
Hepatitis		
Gallbladder problems		
Cirrhosis		
Yellow or Jaundice		
Hematologic	**Yes**	**No**
Blood transfusions		
Rejected as a blood donor		
Bruise or bleed easily		
Anemic		
Take aspirin daily		
Swollen glands		
Endocrine/Glands	**Yes**	**No**
Diabetes		
Thyroid disease		
Other endocrine diseases:		
Extremities & Back	**Yes**	**No**
Arthritis		
Back pain		
Broken bones		
Swollen joints		

Genitourinary	Yes	No
Kidney problems		
Frequent urination		
Painful urination		
Urinate at night		
Blood in urine		
Kidney stones		
Genitourinary: MEN	**Yes**	**No**
Difficult stopping urination		
Difficult starting urination		
Sexual performance problems		
Elevated PSA		
Prostate biopsy		
Swollen/Pain Testes		
Genitourinary: WOMEN	**Yes**	**No**
Age started menstruating		
Irregular or painful menstruation		
Date of last period		
Painful intercourse		
Bleeding following intercourse		
Endometriosis		
Date of last Pap Smear		
Are you pregnant now		
Number of pregnancies		
Neurological	**Yes**	**No**
Headaches		
Migraines		
Double vision		
Blurred vision		
Weakness in extremity		
Numbness		
Stroke		
Seizures		
Forgetfulness		
Confusion		
Dizziness		
Blackouts		
Other ( )		

Additional questions you have:

_____

_____

_____

_____

_____

_____

ACKOWLEDGEMENT OF RECEPIT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received Lucia Zamorano's Notice of Privacy Practices

_____ _____

Signature (Patient or Authorized Representative) Date

_____ _____

Printed (Patient or Authorized Representative) Date

_____ _____

(Witnessed) Date

Michigan Brain & Spine Surgery Center
Lucia Zamorano, MD, PLC
2004 Hazel Street, Birmingham, MI 48009
Tel: 248.723.2477 ● Fax: 248.681.3209
www.luciazamorano.com

● Neurosurgical Oncology (Gliomas, Meningiomas, Acoustic Neuromas, Pituitary Tumors)
● Stereotactic Surgery
● Computer Assisted Surgery
● Gammaknife
● Radiosurgery
● Vascular Malformations
● Epilepsy Surgery
● Trigeminal Neuralgia
● Intraoperative MRI
● Minimally Invasive Surgery
● Endoscopy/Laser Surgery
● Pain Surgery
● Robotics
● Movement Disorders
● Cervical, Lumbar Spine Surgery
● Kyphoplasty
● Traumatic Brain Injuries (TBI)
● Spinal Cord Injuries (SCI)
● WC /Auto Related Injuries

With Offices Located at:

2004 Hazel Street
Birmingham, MI 48009
248-723-2477

Harper Professional Building
4160 John R. Ste. 730
Detroit, MI 48201
248-723-2477

5107 Rochester Road
Troy, MI 48085
248-723-
Fax: 248-481-3913

Patient Payment Policy

Thank you for choosing Michigan Brain and Spine Surgery Center/ Lucia Zamorano, MD, PLC. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Our financial policy is as follows:

- You are responsible for providing accurate information pertaining to insurance coverage, including any required referrals, prior to your procedure. Please review your insurance information for accuracy with the assistant each time you come in.
- You are responsible for paying all co-pays and non-covered services within 30 days of receiving your bill.
- For insurance plans with which we participate, we will bill your insurance plan directly for all covered services. You will be billed later for any remaining balance (subject to any contractual limitations).
- HMO plans usually require a referral. Authorization from your primary care physician must be obtained by you. Our registration personnel will not obtain it for you.
- A deposit may be required for any elective or screening exams which are not covered in full by your insurance carrier.
- All patient balances are due within 30 days. Delinquent accounts may be referred to an outside collection agency. If you are experiencing finical difficulties, we will work with you to arrange a payment plan to fit your budget.

I have read, understood, and agree to the above Financial Policy. I understand that charges not covered by my insurance plan, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits to be paid directly to Michigan Brain & Spine Surgery Center/ Lucia Zamorano, MD, PLC. I authorize Michigan Brain & Spine Surgery Center/Lucia Zamorano MD, PLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____	_____	_____
Date	Printed Name	Signature
	_____	_____
	Guardians Name	Relationship to Patient

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____
(Last Name) (First Name) (Middle Initial) (Maiden Name)

____/____/____ _____ _____
(Birth Date) (Social Security Number) (MR Number)

I hereby authorize _____ _____
(Name) (Address)

_____ _____ _____
(City) (State) (Zip Code)

to release information in my medical records, including (unless otherwise note in #3 below)

- Information about communicable disease and infections, as defined by statute and Michigan Department of Public Health rules (which include venereal disease "VD", tuberculosis "TB", hepatitis B, human immunodeficiency virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDs related complex "ARC").
- Alcohol and drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2.
- Mental Health treatment records, psychological services and social services information communications made by me to a social worker or psychologist.

I authorize such disclosure to the individuals or organizations listed below in accordance with the conditions above.

1.) Person(s) or Organization(s) to whom disclosure is to be made:

Lucia Zamorano, M.D. PLC
2004 Hazel Street ● Birmingham, MI 48009
(248) 723-2477 Phone Number ● (248) 681-3209 Fax Number

2.) Specify type of information to be disclosed
_____

3.) Specify type of information not to be disclosed
_____

4.) Purpose of need for such disclosure
_____

This authorization is subject to written revocation at any time except to the extent that action has already been taken in reliance, on the authorization. If not previously revoked, this authorization will terminate six (6) months from the date of signature.

SIGNATURE OF PATIENT _____ DATE ____/____/____
(or Parent/Guardian/Authorized Representative)

Healthcare Privacy
Each time you visit a hospital, physician, or other healthcare provider, a written or electronic record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment and a pain for future care or treatment. Protecting your privacy is very important to us. All of our patients have the right to considerate and respectful care.

Privacy Practices for Protected Health Information
The provision of high-quality healthcare requires the exchange of personal, often sensitive information between an individual and a skilled practitioner. Vital to that interaction is the patient's ability to trust that the information shared will be protected and kept confidential. Yet many patients are concerned that their information is not protected.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner in the facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record
- Request to amend your health record
- Obtain an accounting of disclosures
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent action has already been taken

Consent Agreement
A "consent" allows use and disclosure of protected health information only for treatment, payment, and healthcare operations.

As part of your healthcare, we originate and maintain health records describing your health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

This information is a basis for:

- Planning treatment
- A means of communication among the health professionals who contribute to your care
- A source of information or applying your diagnosis and surgical information to your bill
- A means by which a third-party prayer can verify that services billed were actually provided
- A tool routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Confidentiality
Expect that all aspects of your care will be treated confidentially. Your medical record, both written and electronic, will not be released with out your written permission, unless in association with our healthcare operations. These operations include but are not limited for evaluation and review of healthcare professionals, quality reviews, assessments, improvement and training activities, licensing and credentialing activities, and certification and accreditation programs. Our office may use or disclose your healthcare information to a physician or other healthcare provider who is providing treatment for you. Your healthcare information will be used and disclosed by our office to obtain payment for services rendered to you.

You have the right to:

- Take part in decisions about your care. Before agreeing to any treatment, your doctor will tell you about your plan of care in terms you can understand.
- Refuse further medical care. If you make this decision, it is important that you understand the risks and how it can affect your health. If you refuse care, you become responsible for your future health outcomes. If you and your doctor cannot agree about your care which meets ethical and professional standards, you may be asked to seek treatment elsewhere.

This notice describes how medical information about you may be disclosed and how you can get access to the information. Please review it carefully. It is the right of this office to change this policy at any time as long as the changes are in accordance with applicable laws. If you receive this notice via our web-site or by e-mail, you are also entitled to receive this notice in written form from our office.