Matthew T. Major, MD

**ASSOCIATES OF VASCULAR & ENDOVASCULAR SURGERY**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1555 E. South Boulevard - Beaumont Health & Wellness Building

Rochester Hills MI 48307

**TELEPHONE:** 248.267.5005 ∙ **FAX:** 248.267.5006

**Patient Questionnaire**

Name: Male Female \_ Birthdate:

Address: City: Zip:

Phone: (Home and/or Cell) SS#:

Emergency Contact:

Relationship to patient:

Patient Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name & Policy Number:

Relationship to Insured/Policy Holder: Group #:

**BRING YOUR DRIVERS LICENSE AND INSURANCE CARD(S) WITH YOU TO THE OFFICE.**

**YOUR ID AND CARD(S) WILL BE SCANNED INTO YOUR MEDICAL HEALTH RECORD.**

Referring Physician’s Name & Address:

Height: Weight: Cardiologist: Internist (PCP):

**MEDICAL HISTORY**: Check the conditions which apply to you. Write the approximate year of the occurrence or onset next to each checked condition. Answer the questions following the chart.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Ck | Year | Condition | Ck | Year | Condition |
|  |  | Anemia |  |  | Heart Attack or Disease |
|  |  | Anesthetic |  |  | Heart Failure |
|  |  | Angina/Chest Pain |  |  | Heart Murmur |
|  |  | Arthritis |  |  | Hepatitis/Jaundice |
|  |  | Asthma |  |  | Hiatal Hernia |
|  |  | Bladder Infection |  |  | High Blood Pressure |
|  |  | Bleeding Problem |  |  | High Cholesterol |
|  |  | Blood Transfusion |  |  | Hypoglycemia |
|  |  | Breathing Problem |  |  | Irregular Heartbeat |
|  |  | Bronchitis |  |  | Kidney Problem |
|  |  | Cancer (Type) |  |  | Dialysis (Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
|  |  | Circulation Problem |  |  | Chronic Kidney Disease, Stage \_\_\_\_\_\_ |
|  |  | Diabetes |  |  | Kidney Transplant (Date:\_\_\_\_\_\_\_\_\_\_) |
|  |  | Drug Dependency |  |  | Paralysis |
|  |  | Emphysema |  |  | Phlebitis |
|  |  | Glaucoma |  |  | Skin Disorder |
|  |  | Headaches |  |  | Stroke |
|  |  | Hearing Problem |  |  | Tuberculosis |
|  |  | Other |  |  | Ulcers |

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Please Check if you:

\_\_\_\_\_\_ have used any aspirin product in the last two weeks

\_\_\_\_\_\_ have ever had a problem with alcohol

\_\_\_\_\_\_ smoke – how many packs per day \_\_\_\_\_\_, number of years \_\_\_\_\_

\_\_\_\_\_\_ have quit smoking? – When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OPERATIONS/HOSPITALIAZTIONS:** List all prior surgeries. Give approximate date of occurrence.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** List all medications (prescription and non-prescription drugs you are currently taking. Please include the frequency and strength) **or Bring a list that gives this information that we can copy or keep**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** List all know **DRUG/FOOD** Allergies

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*IMPORTANT\*\*\*** DO YOU HAVE AN ALLERGY TO CONTRAST DYE USED IN SOME X-RAY, CT, CTA OR MRI PROCEDURES? \_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payment directly to Associates of Vascular & Endovascular Surgery office of Matthew T. Major, MD, for medical/surgical benefits payable to me for services as described, but not to exceed the reasonable and customary charges for the service provided. I authorize any holder of medical or other information about me to release such information as necessary to process related medical claims. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible to pay any charges that are not be covered by my insurance provider of this assignment.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If signing for minor or you are a Guardian – state relationship)

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Please let us know if you take any of the following medications on a regular basis:

Strength Dosage

COUMADIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLAVIX \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASPIRIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VITAMIN E \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEPARIN SUBQ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NONE OF THE ABOVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This will be a permanent part of your chart.

When it becomes necessary for you to have certain test or surgery, you will be instructed to discontinue or continue accordingly prior to your test or surgery date.

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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DEAR PATIENT:

On January 1, 2023, the United States of America Federal Government has mandated and enforced the use of Electronic Prescriptions for all medication to include Controlled Substances (EPC) for all drugs prescribed. Unless there is a major reversal in the proposed 2023 Medicare Physician Fee Schedule, as of January 1, 2023, Michigan prescribers will be required to electronically transmit all prescriptions for controlled and non-controlled substances.

For your convenience and safety, all prescriptions will be sent through and electronic prescription program. All prescriptions must be sent to the pharmacy of your choice, **(note: we can not select the pharmacy for you**). So, this section must be completed.

You may add an additional or alternate pharmacy of our choice (I.E. – 90-day mail order supply pharmacy)

*Please provide any/all information you may have regarding our pharmacy.*

**Main** Pharmacy:

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional** Pharmacy you would like to keep on file:

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PATIENT MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ETHINICITY AND RACE DATA COLLECTION**

Name:

Date of Birth:

Corewell Health (Formerly Beaumont Health) Systems is required by Michigan Law to collect and report data on ethnicity and race or the tracking of certain medical conditions. Included below are the definitions for ethnicity or race provided by the Michigan Department of Community Health (“MDCH”). If your have any questions regarding these definitions or the requirements to collect this data, please contact MDCH at (517) 335.8900.

The collection of this information will not affect your care at Corewell Health (Formerly Beaumont Health) Systems, in any way. We are collecting it only to meet requirements of Michigan Law.

Please choose all categories below that best describe your ethnicity or race, or the ethnicity or race of the patient your brought for care today:

○ Arab Descent: Ancestry form the Middle East or North Africa

○ Hispanic/Latino: Ancestry form South or Central America or other Spanish culture

○ African American: Having origins from Africa

○ American Indian/Alaskan Native: Having origins form North, Central or South America and who maintain tribal affiliation or community attachment

○ Asian: Having origins from Europe, the Middle East, North Africa or North America

○ Caucasian: Having origins from Europe, The Middle East, North Africa or North America

○ Native Hawaiian/Pacific Islander: Having origins from Hawaii, Guam, Samoa or Other Pacific Islands

○ Other/None of the above

○ Unknown

○ Decline to Answer

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Parent/Authorized Representative/Guardian’s Signature

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name & Relationship to Patient