MICHIGAN RHEUMATOLOGY
& WELLNESS CENTER, PLC
Tel 248.923.1300 - Fax 248.218.1071 - Email info@mirwc.com
3950 South Rochester Road, Suite 1300- Rochester Hills, Michigan, 48307

Return this form by email: info@mirwc.com

🔹 **Reason for Appointment** **Date:** .

In just a few words tell us your symptoms, diagnosis or reason for this visit so we are sure we are the right place for you. (See attached list of conditions we don't evaluate or treat).

Patient Information

- **Last Name:** _____
- **First Name:** _____
- **Home Address:** _____
- **Date of Birth:** _____
- **Phone:** _____
- **Email** _____

🔹 **Insurance Information**

- **Primary Insurance Company:** _____
- **Member ID:** _____
- **Secondary Insurance Company:** _____
- **Member ID:** _____

PCP name: **Phone** **Fax**

📌 **PLEASE SEND A COPY OF THE FRONT AND BACK OF ALL THE INSURANCE CARD(S)**

🟧 Patient Responsibilities Notice:

⚠️ It is your responsibility to check with your insurance if a referral from your Primary Care Physician is required to see a specialist. **We cannot see you without it.**

⚠️ It is your responsibility to ensure we receive **any records related to your condition you would like us to review** the day of your appointment. Previous Medical records can be submitted by you or your physician via:

- 📠 Fax: 248-218-1071
- 💻 Patient Portal: We will email you a link with your New Patient appointment.
- 📬 Hand delivery.

❌ **We are a private independent practice. We do not search for or retrieve online PRIOR medical records/information from any health system.** ❌