THE SPINE INSTITUTE
COMPREHENSIVE SPINE CENTER

The following pages contain forms for new patients.

They are to be filled-out **COMPLETELY** and brought to your appointment along with **ANY** x-rays and/or scans pertaining to your spine.

Don't forget to bring your insurance card because it is required for our billing department.

Should you have any questions please feel free to contact our office. Our friendly staff will be more than happy to assist you.

Thank you in advance for your cooperation.

Name: ____
(Last) (First) (Middle Initial)

Address: ____
(Street) (Unit Number) (City) (State) (Zip)

Day Phone:______________________ Evening Phone: ______________________

Birth Date:________________ Age: _______ Social Security Number: ______________

Sex: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Who is your referring or primary care physician? ______________________________
(Name)

Would you like a copy of your visit sent to this doctor?
[ ] Yes [ ] No

____
(Address)

____
(Phone)

Occupation:______________________ Employer:______________________

Is this a work-related condition?: [ ] Yes [ ] No Date of injury ______________
(If Yes, then skip to the top of page two.)

Primary Insurance Company: ______________________ Phone: ______________

Name of Insured: ______________ Birth Date: ________ Soc. Sec. Number: ________

Address: ____

Policy #: ______________________ Group # ______________________

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

Secondary Insurance Company: ______________________ Phone:______________

Name of Insured: ______________________ Soc. Sec. Number: ______________

Address: ____

Policy #: ______________________ Group # ______________________

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

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Worker's Compensation Information:

Carrier:_______________________________________ Claim # _____________________________________

Claim Office Address: ____

Adjuster ____ Phone_____________________________________

Date of Injury: ___________________ Employer____

Are you represented by an attorney? ❑ Yes ❑ No

Please read the following sections carefully.
Your signatures are required prior to seeing the physician.

As a courtesy, we will bill your insurance company. In some cases, unless you are insured under worker's compensation, you may be responsible for up to the full amount of the charges incurred during your visit. If the doctor you are seeing is a contracted provider under your insurance plan, you may wish to discuss your financial responsibility with the member services department at your insurance company.

I understand that I may be responsible for paying for services rendered, including reasonable attorney's fees and costs incurred in the event of any default. The information that is provided on this form is complete and accurate to the best of my knowledge.

Signature:____ Date: ___________________________

I hereby authorize my physician at The Spine Institute to release any information obtained in the course of my examination that my insurance company may request. I also authorize assignment of my medical benefits to my physician at The Spine Institute. This assignment of benefits allows our office to collect directly from your insurance company. Without this release, you will be required to pay for your visit at the time the services are rendered.

Signature:____ Date:

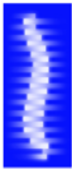
Please consider this signature as authorization to release my confidential medical records with written release on the basis of a telephone request. I understand that it is possible for someone to misrepresent themselves by telephone and that my right to privacy may be compromised.

Signature: ____ [ ] Permanent [ ] Until _________________

In case of a medical emergency, whom would you like us to notify:

Name: ____ Phone: ______________________________

Address: ____________________________________ Relationship ________________________________



SYMPTOMS AND CONDITIONS

Name:____

What is your main complaint?____

____

____

What symptoms have you been having?____

____

____

How long have you been having these symptoms?____

____

Have you been seen by another Doctor for this condition? [ ] Yes [ ] No

Please describe your past treatments:

<u>Surgery</u>:
Type ____ Date ______________________

Surgeon____

Type ____ Date ______________________

Surgeon____

<u>Physical Therapy:</u>
Therapist ____ Date ______________________

<u>Injections</u>:
Type____ Date ______________________

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Please list any medications you are currently taking for this or any other condition:

Medication _________________________ Dosage _______________________

Medication _________________________ Dosage _______________________

Medication _________________________ Dosage _______________________

Medication _________________________ Dosage _______________________

Please list any other medical conditions: ____

____

____

Please list any allergies: ____

____

____

Please list any studies you have had in the past (MRI, CAT Scans, X-Ray, etc.)

____ Date ________________

____ Date ________________

____ Date ________________

Please list any records/films you have brought with you today:

____

____

____

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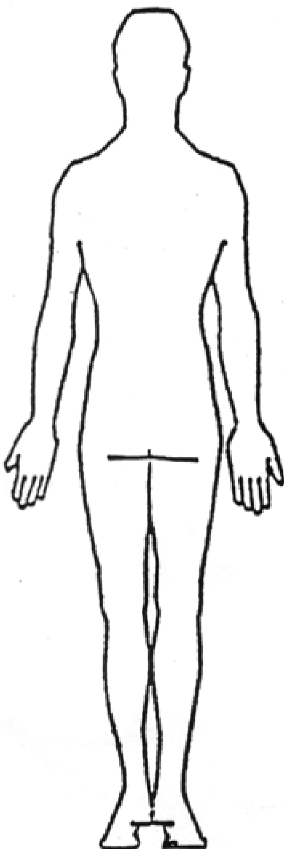
Name____ Date ________________________

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

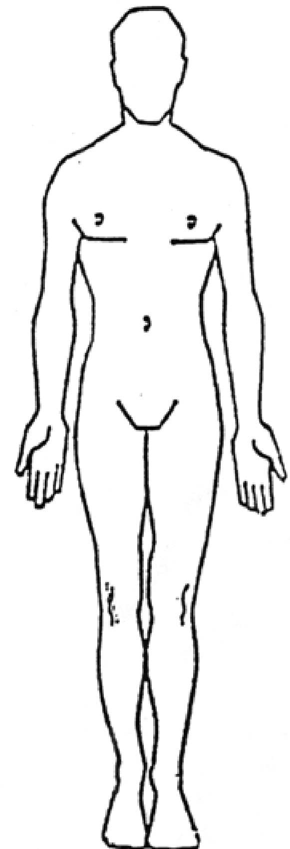
Ache ^ ^ ^	Numbness o o o	Pins & Needles = = =	Stabbing / / /
^ ^ ^	o o o	= = =	/ / /
^ ^ ^	o o o	= = =	/ / /



Back pain__________________%

Leg pain___________________%

Total______________________%



PLEASE MARK ON THE LINE: How bad is your pain now on a scale from 0 to 10?

0 ____ 10