Today's Date:____________________

Revised 02/06/2012/tlb

PATIENT INFORMATION

Social Security #:______________________________

DOB:______________________

Patient Name:______________________________

Address:______________________________

____

Home phone#:______________________________

Work #:______________________________

Cell #:______________________________

Sex (circle one) Female Male

Occupation:______________________________

Employer:______________________________

Address:______________________________

Phone:__________________________

Marital status:_____________________

Spouse's Name:______________________________

DOB:_______________SS#_____________________

Employer:______________________________

In case of emergency, please contact:

Name:______________________________

Relationship:______________________________

Home #:______________________________

Other #:______________________________

Referral Information

Referring Physician:__________________________

Address:______________________________

____

Phone #:______________________________

Family Physician:__________________________

Address:______________________________

____

Phone #:______________________________

Certain situations require us to release records to the referring/treating physician. Would you like us to forward our physician's notes to your _____referring physician and/or your _____family physician? Initials:_______

MEDICAL SUMMARY

Medical Allergies:__________________________

____

Major Illnesses:__________________________

____

CONSENT TO TREAT

I understand that I have presented myself to NeuroSpine Surgical Consultants for evaluation and/or treatment of my Neurological or Spinal condition. I am aware that I may require necessary treatment during my episode of care. I further understand that all options will be discussed prior to the administration of such treatments.

Patient's signature:__________________________

INSURANCE INFORMATION

Were you injured while working?

_____Yes _____No Date of Injury:____________

Is your visit related to an automobile accident?

_____Yes _____No Date of accident:__________

Medical insurance Carrier

Primary:______________________________

Phone Number:__________________________

Insured's name:__________________________

Insured's DOB:_________SSN:______________

Secondary:______________________________

Phone Number:__________________________

Insured's name:__________________________

Insured's DOB:_________SSN:______________

*We will need to make copies of all insurance card(s) and a photo ID.

I authorize the release of any and all medical information necessary for my medical care and to process medical claims. I understand that all fees incurred in the course of my treatment by NeuroSpine Surgical Consultants and/or it's authorized agents are my responsibility. I hereby authorize the insurance companies to make payment directly to NeuroSpine Surgical Consultants for those fees I have not previously paid. Additionally, I agree to all charges not paid by my medical insurance companies are ultimately my responsibility. I authorize the use of my signature on insurance submissions.

Responsible party name:____________________

Signature:______________________________

Date:________________

I give authorization for NeuroSpine Surgical Consultants' staff to contact the following person(s) and leave messages regarding appointments or test/surgery scheduling in the event I am unable to be reached at the number(s) I have provided.

Name and phone numbers:

Notice: Any diagnostic films/CD's left behind in this office, will be disposed of after a year.

Initials________

Luis A. Mignucci, MD
Omar Colon, MD

NEUROSPINE
SURGICAL CONSULTANTS