Today's Date:_____

PATIENT INFORMATION

DOB:_____
Patient Name:_____
Address:_____
_____

Cell #:_____
Work #:_____
Sex (circle one) Female Male
Occupation:_____
Employer:_____
Address:_____
Phone:_____
Marital status:_____
Spouse's Name:_____
DOB:_____
Employer:_____

In case of emergency, please contact:

Name:_____
Relationship:_____
Phone #:_____

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 release medical records
_____**referring physician**
_____**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:_____

Revised 02/21/20 *lv

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:_____Employer_____
Secondary:_____
Phone Number:_____
Insured's name:_____
Insured's DOB:_____Employer_____

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I Understand I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent.
I have had the opportunity to receive and review the Notice of Privacy Practices of NeuroSpine Surgical Consultants. **Initials**_____

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