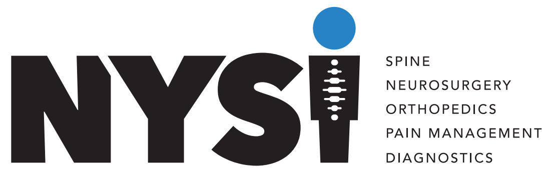
COMM OR MCR



COMM OR MCR

Alexandre B. de Moura, M.D., P.C.
Patient Demographic

Name: ______________________________ Date: ______________

Address: ______________________ City: ____________________ State: ______ Zip: ________

Please Provide Your Email Address: ______________________________

Tel.#: (Home) ______________________ (Cell) ______________________

S.S.#: ____________________ Sex: ☐ Male ☐ Female D.O.B: ______________ Age: ________

Height: __________ Weight: __________ Race: ____________ Ethnicity: ______________

Preferred Language: ______________________________

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Emergency Contact Name: ______________________ Tel.#: ______________________

Primary Care Physician's Name: ______________________ Tel.#: ______________________

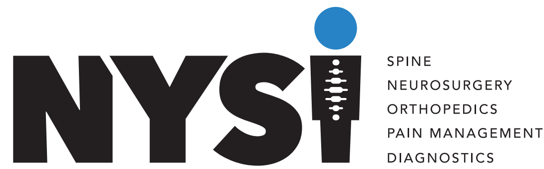
Address: ______________________ City: ____________________ State: ______ Zip: ________

Pharmacy Name: ______________________ Tel.#: ______________________

Address: ______________________ City: ____________________ State: ______ Zip: ________

Please Indicate Below How You Were Referred To Our Office:

☐ Doctor ☐ Attorney ☐ By Patient ☐ Internet/Magazine Ad/Etc.



INSURANCE INFORMATION

Please fill out in entirety

PRIMARY INSURANCE/GUARANTOR

Insurance Carrier Name: ____

Member ID #: ____

Policy Holders Name: ____________________ Relationship to Patient: ____________________

Policy Holders Occupation: ____

Policy Holders Employer: ____

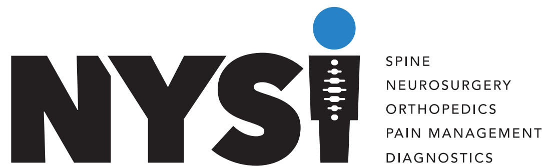
SECONDARY INSURANCE

Insurance Carrier Name: ____________________ Ins. Telephone #: ____________________

Member ID #: ____________________ Group #: ____________________

Policy Holders Name: ____________________ Policy Holders Date of Birth: ____________________

Please provide the front desk with a copy of ALL your insurance cards



I understand that "**The NEW YORK SPINE INSTITUTE**" is participating only with the following insurance:

- ☐ **MEDICARE**
- ☐ **WORKERS COMPENSATION**
- ☐ **NO FAULT**

All other **NEW YORK SPINE INSTITUTE** providers, including **MRI**, Pain Management, Physical Therapy, Chiropractic and X-ray DO NOT participate with any insurance companies other than **MEDICARE**.

I understand that if my insurance is not listed above, I will be utilizing my **OUT-OF-NETWORK** benefits for services rendered by the New York Spine Institute.

I understand it is the policy of the New York Spine Institute to accept my insurance payments as payment in full, and I will only be held responsible for my deductible, co- payment and co-insurance. **NEW YORK SPINE INSTITUTE** will accept the percentage paid by the insurance after the deductible met.

I understand that if my insurance does not provide **OUT-OF-NETWORK** benefits, I will be responsible for payment, in full unless other arrangements have been made with the billing department.

I, ____ , understand that I may receive the payment(s) directly from my insurance carrier for services rendered to me at New York Spine Institute. In such event, I will immediately forward such payment(s) to New York Spine Institute. If I fail to do so, I will remain responsible for the payment(s) in full. Payments turned over in excess of thirty (30) days of receipt of payment(s) from the insurance carrier will be subject to monthly finance charges of 1.5%. I acknowledge that New York Spine Institute may seek remedies in recovering payment(s) for services rendered.

X ____   _______ / _______ / _______

SIGNATURE   DATE

Alexandre B. de Moura, MD, PC. / New York Spine Institute 761 Merrick Avenue, Westbury, NY 11590

NYSI

SPINE
NEUROSURGERY
ORTHOPEDICS
PAIN MANAGEMENT
DIAGNOSTICS

MUST BE FILLED OUT IN ENTIRETY

History

Patient Name: ______________________________

Date Of The Accident: ________ / ________ / ________

Occupation And Employer: ______________________________

Chief Complaint: ______________________________

Where Is Pain? ☐ Neck ☐ Back ☐ Shoulder Rt/Lt ☐ Mid Back ☐ Knee Rt / Lt

How And Where Were You Injured?: ______________________________

Describe: ______________________________

Prior History Of Neck Or Back Pain? ☐ Yes ☐ No

Treatments You Have Received To Date: ______________________________

☐ Physical Therapy ☐ Chiropractic Care ☐ Acupuncture
☐ Diagnostic Imaging ☐ Epidural Injections ☐ Trigger Point Injection

Are You Currently Working? ☐ Yes ☐ No

Where Did Injury Occur: ______________________________

Work: ________________ Car Accident: ________________ Other: ________________

Are You Doing? ☐ Better ☐ Worse ☐ Same

Any Other Medical Problems?: ______________________________

Any Known Allergies?: ______________________________

Social History:

Smoke? ☐ No ☐ Yes, How Much?: ____________ Drink? ☐ No ☐ Yes, How Much?: ____________

List Any Operations And/Or Hospitalizations (With Dates): ______________________________

____

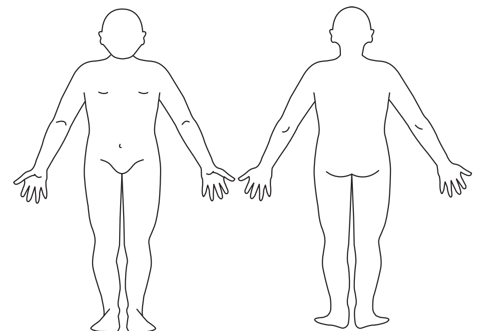
____

Current Medications?: ______________________________

____

Any Radiology Testing?: ______________________________

____



Pain Drawing & Scale Review