NYSI
SPINE
NEUROSURGERY
ORTHOPEDICS
PAIN MANAGEMENT
DIAGNOSTICS

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.

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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

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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

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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): _____

_____

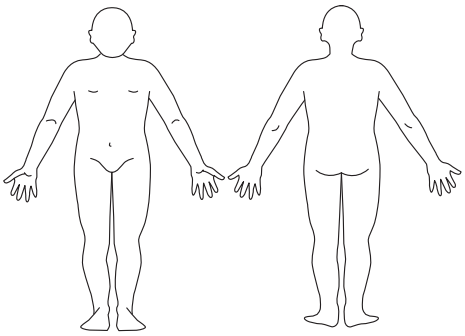
_____

Current Medications?: _____

_____

Any Radiology Testing?: _____

_____



Pain Drawing & Scale Review