WC

NYSI
SPINE
NEUROSURGERY
ORTHOPEDICS
PAIN MANAGEMENT
DIAGNOSTICS

WC

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

Do You Have An Attorney? ☐ Yes ☐ No Attorney: _____

Attorney Tel.#: _____

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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WORKERS COMP INSURANCE INFORMATION

Please fill out in entirety

Insurance Carrier Name: _____

Carrier Address: _____

Carrier Telephone: _____

Adjusters Name: _____ Adjusters Phone: _____

Adjusters Fax: _____

WCB Claim #: _____ Carrier Case #: _____

Date of Injury: _____ Injured Body Parts: _____

List ALL Attorneys Representing You for ALL cases (Third Party/NF/WC etc...) _____

_____

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MUST BE FILLED OUT IN ENTIRETY

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 ☐ Limited Duty: _____

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): _____

_____

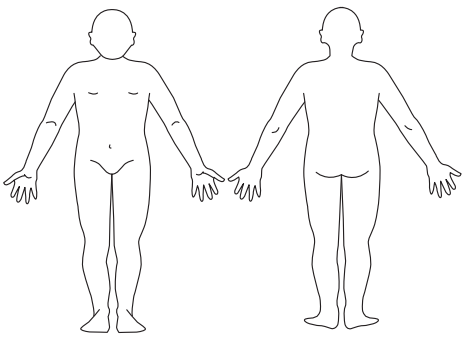
_____

Current Medications?: _____

_____

Any Radiology Testing?: _____

_____



Pain Drawing & Scale Review

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PATIENT CONSENT FORM

Patient's Name: _____

I, the undersigned, do hereby authorize **New York Spine Institute** to provide me (or the patient-minor mentioned above) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition including, but not limited to, diagnostic X-Rays or Magnetic Resonance Imaging, Physical Therapy or Chiropractic services, the administration and/or injection of medications and pharmaceutical products, including, but not limited to tripper point injections, and the drawing of blood (the "Procedure(s)"), as in the judgment of personnel and/or physicians of **New York Spine Institute** deems necessary.

I acknowledge that no guarantees or assurances have been given to me concerning the results or findings intended from the treatment or examination at **New York Spine Institute**. I understand that the Procedure(s) and any other treatment that I may receive appear indicated by the diagnostic and/or clinical observations performed by **New York Spine**. I attest that a medical staff member of **New York Spine** has explained to me the nature of the recommended Procedure(s), the purpose of and need for the recommended Procedure(s), the possible risks and complications of the recommended Procedure(s) and the alternatives, if any, to the recommended Procedure(s). I understand all explanations given to me and give this consent voluntarily. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

This consent with cover every visit made by me (or the patient-minor) as long as I (or patient-minor) remain an active patient of **New York Spine Institute.**

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Date

I declare that I have personally explained the above information to the patient or the patient representative.

_____ _____
Provider's Signature Date

FOR FEMALE PATIENTS ONLY:
I understand that in the course of my treatment I may have x-rays or other diagnostic tests. I agree to inform the health care providers if I am or may be pregnant prior to administering any diagnostic tests.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Date

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Alexandre B. Demoura, M.D., P.C d/b/a **New York Spine Institute**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

Dear Patient:

We are required to provide you with a copy of our Notice of Privacy Practices which describes your rights and the Provider's legal duties with respect to the use and/or disclosure of your protected health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of Alexandre B. De Moura, M.D., P.C. d/b/a New York Spine Institutes of Privacy Practices which discloses my rights and the Provider's legal duties with respect to the use and/or disclosure of my protected health information

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_____ _____

Patient/Designated Representative Signature | Print Name

_____ _____

If designated representative, relationship to patient | Date

FOR PROVIDER USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices. We were unable to obtain such acknowledgment, however, because:

- ☐ Treatment was rendered in an emergency treatment situation. Efforts will be made to obtain the acknowledgment as soon as reasonable practicable after the emergency.
- ☐ We were unable to effectively communicate with the patient: Reason:

  _____
- ☐ Patient refused to sign: Reason Given:

  _____
- ☐ Other (please specify):

  _____