

**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: \_\_\_\_\_

Marital 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.



**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...) \_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_

- |                                             |                                              |                                                  |
|---------------------------------------------|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Physical Therapy   | <input type="checkbox"/> Chiropractic Care   | <input type="checkbox"/> Acupuncture             |
| <input type="checkbox"/> Diagnostic Imaging | <input type="checkbox"/> Epidural Injections | <input type="checkbox"/> 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): \_\_\_\_\_

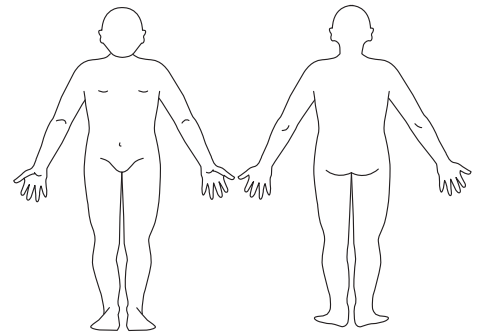
\_\_\_\_\_  
 \_\_\_\_\_

Current Medications?: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Any Radiology Testing?: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_



Pain Drawing & Scale Review



## 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 will 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



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

\_\_\_\_\_  
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):  
\_\_\_\_\_