

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: _____

Sex assigned at birth: Male Female Gender Identity _____ 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.

NEW YORK LOCATIONS: BRONX ■ BROOKLYN ■ LONG ISLAND ■ MANHATTAN ■ NEWBURGH ■ QUEENS ■ WHITE PLAINS

NEW JERSEY LOCATIONS: ■ ESSEX ■ PASSAIC



WORKERS COMP INSURANCE INFORMATION

Please fill out in entirety

Insurance Carrier Name: _____

Carrier Address: _____

Carrier Telephone: _____

Adjusters Name: _____ Adjusters Phone: _____

Adjusters Fax: _____ Adjusters Email: _____

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: _____

Employer Name and Address: _____

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: _____

Which State did Injury Occur: _____

Work: _____ Car Accident: _____ Other: _____

How Are You Doing? Better Worse Same

Any Other Medical Problems?: _____

Any Known Allergies?: _____

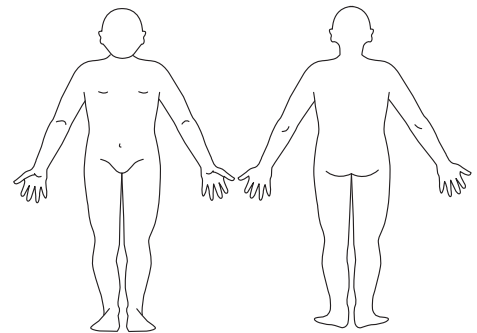
Social History:

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 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



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):
