

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Social Security #: \_\_\_\_\_

DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone#: \_\_\_\_\_

Work #: \_\_\_\_\_

Cell #: \_\_\_\_\_

Sex (circle one) Female Male

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Marital status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_

**In case of emergency, please contact:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_

Other #: \_\_\_\_\_

**Referral Information**

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Certain situations require us to release records to the referring/treating physician. Would you like us to forward our physician's notes to your \_\_\_\_\_ referring physician and/or your \_\_\_\_\_ family physician? Initials: \_\_\_\_\_**

**MEDICAL SUMMARY**

**Medical Allergies:** \_\_\_\_\_

Major Illnesses: \_\_\_\_\_

**CONSENT TO TREAT**

I understand that I have presented myself to NeuroSpine Surgical Consultants for evaluation and/or treatment of my Neurological or Spinal condition. I am aware that I may require necessary treatment during my episode of care. I further understand that all options will be discussed prior to the administration of such treatments.

Patient's signature: \_\_\_\_\_

**INSURANCE INFORMATION**

Were you injured while working?

\_\_\_\_ Yes \_\_\_\_ No Date of Injury: \_\_\_\_\_

Is your visit related to an automobile accident?

\_\_\_\_ Yes \_\_\_\_ No Date of accident: \_\_\_\_\_

**Medical insurance Carrier**

Primary: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Insured's name: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Secondary: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Insured's name: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

\*We will need to make copies of all insurance card(s) and a photo ID.

I authorize the release of any and all medical information necessary for my medical care and to process medical claims. I understand that all fees incurred in the course of my treatment by NeuroSpine Surgical Consultants and/or it's authorized agents are my responsibility. I hereby authorize the insurance companies to make payment directly to NeuroSpine Surgical Consultants for those fees I have not previously paid. Additionally, I agree to all charges not paid by my medical insurance companies are ultimately my responsibility. I authorize the use of my signature on insurance submissions.

Responsible party name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I give authorization for NeuroSpine Surgical Consultants' staff to contact the following person(s) and leave messages regarding appointments or test/surgery scheduling in the event I am unable to be reached at the number(s) I have provided.

Name and phone numbers: \_\_\_\_\_

**Notice: Any diagnostic films/CD's left behind in this office, will be disposed of after a year.**

Initials \_\_\_\_\_

Luis A. Mignucci, MD  
Omar Colon, MD  
Samir Parikh, MD



**NEUROSPINE**  
SURGICAL CONSULTANTS