

### Registration Information

Date \_\_\_\_\_ Chart# \_\_\_\_\_ D.O.B \_\_\_\_\_

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

Employer \_\_\_\_\_ Drivers License # \_\_\_\_\_

*Required by the State of Florida Agency for Health Care Administration*

**Ethnicity** Hispanic or Latino Non-Hispanic or Latino Unknown **Race** American Indian or Alaskan Native  
Asian Black or African American Native Hawaiian or Pacific Islander White Other Unknown

Current Home Address \_\_\_\_\_

(Street)

(City)

(State)

(Zip)

Your Local Florida Address  
(i.e. family residence, hotel) \_\_\_\_\_

Local Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Can we leave message on ans. machine? **Yes or No**

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_ Spouse D.O.B \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Primary Care Physician Phone #: \_\_\_\_\_

Primary Care Physician Address: \_\_\_\_\_ May we contact your primary care physician? \_\_\_\_\_

**Emergency Contact:**

Person to Contact In Case Of Emergency \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Other # \_\_\_\_\_

**2<sup>nd</sup> Emergency Contact:**

Person to Contact In Case Of Emergency \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Other # \_\_\_\_\_

**If Patient Is A Minor:**

Parents' Names \_\_\_\_\_ Parents' Employers \_\_\_\_\_

**Referral Source:**

Internet (Specify) \_\_\_\_\_

Radio \_\_\_\_\_

Seminar (please list location) \_\_\_\_\_

Doctor (name) \_\_\_\_\_

Newspaper (please list) \_\_\_\_\_

Patient (name) \_\_\_\_\_

Walk-In Clinic (please list) \_\_\_\_\_

TV Commercial \_\_\_\_\_

Other \_\_\_\_\_

TV Show \_\_\_\_\_

### Registration Information

**Insurance Information** *(Please specify your primary insurance)*

**Insurance #1** \_\_\_\_\_ Policy # \_\_\_\_\_  
 Group or employer name \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Insured Person's Date of Birth \_\_\_\_\_  
 Send Claims to \_\_\_\_\_ *(If Blue Cross specify State)* State \_\_\_\_\_

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**Insurance #2** \_\_\_\_\_ Policy # \_\_\_\_\_  
 Group or employer name \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Insured Person's Date of Birth \_\_\_\_\_  
 Send Claims to \_\_\_\_\_ *(If Blue Cross specify State)* State \_\_\_\_\_

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**Workman's Compensation or Auto Insurance**

Policy # \_\_\_\_\_ Date of Accident: \_\_\_\_\_  
 Send Claims to \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_  
 Employer Name/ Address at time of accident \_\_\_\_\_  
 Is condition related to Auto Accident Employment Other: \_\_\_\_\_  
 Date of first injury \_\_\_\_\_ Date symptom occurred \_\_\_\_\_  
 Was onset *Sudden* or *Gradual*? \_\_\_\_\_

Date first consulted physician \_\_\_\_\_

Is an attorney handling this case? \_\_\_\_\_ Attorney Name \_\_\_\_\_  
 Attorney address \_\_\_\_\_  
 Attorney Telephone \_\_\_\_\_

**Registration Information**  
**Authorization to Release Information**  
**And Assignment of Insurance Benefits**

I hereby authorize the medical facilities and/or practices whose name(s) appear above to furnish my insurance company(s), attorneys, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign the medical facilities and/or practices, all money to which I am entitled for medical and/or surgical expense relative the service for which I receive, but not to exceed my indebtedness to said medical facilities and/or practices. It is understood that any money received from the above named parties, over and above my indebtedness will be refunded when my bills to the above named medical facilities and/or practices are paid in full. I understand I am financially responsible to said medical facilities and/or practices for charges incurred. I further agree and understand that if extended credit, I will keep my account on a current basis. It is also understood, that even though I may have an attorney or that this may be related to an auto accident, I must still keep my account on a current basis.

As a courtesy to you, our patient, we will submit claim forms to your primary insurance company. This service shall not be construed as an act of fiduciary or agent on your behalf. You, the patient, shall remain solely responsible for payment for any medical services and the compliance with any contractual obligation between you and your insurance carrier.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. We look to you for payment, not to the insurance company.

This Consent specifically includes information concerning psychological conditions, psychiatric conditions, and/or infectious disease, including, but not limited to, blood borne diseases, such as hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

***How will you be paying for your services?***

Check \_\_\_\_\_

Cash \_\_\_\_\_

Master Card \_\_\_\_\_

Visa \_\_\_\_\_

American Express \_\_\_\_\_

Discover \_\_\_\_\_



**AUTHORIZATION TO APPEAL ON MY BEHALF**

I \_\_\_\_\_ authorize the parties whose names appear above to appeal any and all insurance claims on my behalf until such claims are paid.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Chart# \_\_\_\_\_

**Acknowledgement of Review of  
Notice of Privacy Practices**

I, \_\_\_\_\_, a patient at The Bonati Institute,  
(Please print name)

acknowledge review of the *Notice of Privacy Practices*, and that I have been provided with an opportunity to ask questions about its content. I am also aware that I may obtain a copy from Medical Records if I wish to do so.

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Date)

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In the event that the patient refuses to sign this acknowledgement, an employee of The Bonati Institute will document the reason for refusal below.

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

**Please return this document to Medical Records**

**Smoking:**

If you are smoking, we advise that it is better to stop Smoking prior to your procedures.

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

Chart# \_\_\_\_\_

### Communication of My Healthcare

I, \_\_\_\_\_, authorize my healthcare  
(Please print name)

information, including billing and collections information, written or verbal, to the below named family members, friend, Acting Power of Attorney or Healthcare Surrogate, to be disclosed for communicating results, finding, and care decisions to my family members and/or others responsible for my care or designated by me. I will provide those individuals names and/or other verification means specified by The Bonati Institute.

|                   |                |
|-------------------|----------------|
| _____             | _____          |
| (Name)            | (Relationship) |
| _____             | _____          |
| (Name)            | (Relationship) |
| _____             | _____          |
| (Name)            | (Relationship) |
| _____             | _____          |
| Patient Signature | Date           |

**I will notify this office, in writing, if this information should change. This consent will remain in effect indefinitely, unless revoked by me as described above.**

**RESTRICTIONS** on release of my healthcare information, including billing and collections information, written or verbal, to be disclosed for any purposes, to the below named.

|        |                |
|--------|----------------|
| _____  | _____          |
| (Name) | (Relationship) |
| _____  | _____          |
| (Name) | (Relationship) |

# Nevada Spine Center, LLC.

NAME: \_\_\_\_\_ CHART: \_\_\_\_\_ DATE: \_\_\_\_\_

## PATIENT HISTORY

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Right handed: \_\_\_\_\_ Left handed: \_\_\_\_\_

## CURRENT HISTORY

Motor Vehicle Accident: Date of injury: \_\_\_ / \_\_\_ / \_\_\_ Workers Comp: Date of injury: \_\_\_ / \_\_\_ / \_\_\_

Sports injury: Date of injury: \_\_\_ / \_\_\_ / \_\_\_

INTENSITY OF PAIN: **(AT ITS WORST)**      None                      Mild                      Moderate                      Severe

Pain Scale: (VAS)                      0                      1   2   3                      4   5   6                      7   8   9   10

## Social History:

Single                       Married                       Divorced                       Widowed

Children    Yes    No                      Lives alone    Yes    No

Glasses                       Contacts

Physical work: Type: \_\_\_\_\_  sedentary work: Type: \_\_\_\_\_

Homemaker                       Retired

Works:                       regular duty                       Light duty                       Out of Work

**RISK FACTORS:**                       Tobacco use:                       Current smoker: \_\_\_ packs/day                       Former smoker

Never smoked

Quit: Year quit: \_\_\_\_\_ Smoked \_\_\_\_\_ packs/day

Recreational drugs:    No    Yes: \_\_\_\_\_

Alcohol use:                      No    Yes:    Occasional    Daily: Drinks per day: \_\_\_\_\_

Exercise:                      No    Yes: \_\_\_\_\_

If you are smoking, we advise that it is better to stop smoking prior to your procedures.

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# Nevada Spine Center, LLC.

NAME: \_\_\_\_\_ CHART: \_\_\_\_\_ DATE: \_\_\_\_\_

## ACTIVITIES OF DAILY LIVING ASSESSMENT:

**Do you have any Varying degrees of losses of functional capacity with the following activities?**

### Self-care and personal hygiene:

Dressing      Putting on shoes      Preparing meals      Taking out the trash      Showering  
Bathing      Washing hair      House cleaning      Making bed      Sweeping      Vacuuming

### Physical activity:

Walking      Kneeling      Squatting      Bending      Sitting continuously  
Reaching      Twisting      Leaning

### Functional activities:

Carrying objects      Pushing      Pulling      Lifting      Twisting

### Travel:

Driving for long periods of time

### Sleeping:

Difficulty sleeping due to pain

**[ ] None of the above**

**Current Primary Care Physician:** \_\_\_\_\_

**Date of Last Exam by Primary Care Physician:** \_\_\_\_\_

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