Nevada Spine Center
Nevada Medical Care

Medical Development Company of Nevada

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? ____

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Emergency Contact:
Person to Contact In Case Of Emergency____________________________________

Home # ____________________ Cell # ____________________ Other # ____________________

2nd Emergency Contact:
Person to Contact In Case Of Emergency____________________________________

Home # ____________________ Cell # ____________________ Other # ____________________

If Patient Is A Minor:
Parents' Names __________________________ Parents' Employers ______________________________

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Referral Source:

Internet: ☐Google Search
☐Facebook
☐Bing Search
☐Yahoo Search
☐Other: ______________________________
Seminar (please list location): ____________________

TV: ☐Commercial (Channel): _____________
☐Show (Channel): __________________
Radio (Station): _________________________
Newspaper (please list) __________________
Referral: Doctor (name) __________________
Patient (name) _________________
Other: (please list) _______________________

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 _______________________

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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	☐

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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)

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

NAME: **CHART:**

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: _____

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:

Showering ☐ Preparing meals ☐

Dressing ☐ Laundry ☐

Putting on shoes / socks ☐ Washing dishes ☐

Sweeping / mopping ☐ Taking out trash ☐

Comments: _____

Functional / Physical Activity:

Lifting ☐ Pushing / pulling ☐

Twisting ☐ Turning head ☐

Bending at waist ☐ Bending head forward/backward ☐

Carrying objects ☐

Comments: _____

Travel: Driving for long periods of time ☐

Comments: _____

Sleeping: Difficulty sleeping due to pain ☐

Comments: _____

Current Primary Care Physician: _____ Date of last exam: _____

Nevada Spine Center

NAME: **CHART:**

PAST MEDICAL HISTORY

Anemia ☐	CVA ☐	Hepatitis A B C ☐	Multiple Sclerosis ☐
Anxiety / depression ☐	Diabetes type I / type II ☐	HIV ☐	Myocardial Infarction ☐
Arthritis ☐	Seizure Disorder ☐	Hypercholesterolemia ☐	PUD ☐
Asthma ☐	GERD ☐	Hypertension ☐	Schizophrenia ☐
Bipolar disorder ☐	Heart Disease ☐	Kidney disorder ☐	Thyroid: Hypo / Hyper ☐
Cancer ☐	Sleep Apnea: C-Pap ☐	Migraines ☐	Tuberculosis ☐
DVT / PE ☐			

Other: _____

PAST SURGICAL HISTORY

No prior surgeries: ☐

_____

_____

_____

_____

_____

_____

PRIOR SPINE SURGERIES:

No prior spine surgeries: ☐

_____

_____

_____

_____

_____

Nevada Spine Center

NAME: **CHART:**

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: _____

ALLERGIES: [ ] NO KNOWN ALLERGIES:

REACTIONS:

_____ _____

_____ _____

_____ _____

_____ _____

Nevada Spine Center

NAME: **CHART:**

CURRENT MEDICATIONS:	**DATE STARTED:**	**DATE STOPPED:** If stopped, length of time medication was taken

Are you currently being treated with a blood thinner or anti-coagulant for previous vascular problems such as a stroke, heart attack, stent placement, DVT/Pulmonary Embolism or any other conditions?

☐ **Yes** ☐ **No** **If yes for what?** _____

Prior to your appointment here at The Bonati Spine Institute, we strongly recommend that if you are currently taking any of these types of medications that you seek clearance through the prescribing physician.

This includes when to stop and restart any blood thinners/anticoagulants. Prompt attention to this will prevent delays in your recommended treatment plan.

Please write the name and phone number for your prescribing physician in case any additional information may be needed for clearance.

Physician: _____ *Phone Number:* _____

Medical Clearance may also be needed, prior to any recommended procedures in the past 12 months for any conditions such as a stroke, heart attack, cancer, blood clots, COPD, sleep apnea, any history of bleeding disorders.

I attest that all of the information in this questionnaire is accurate to the best of my knowledge.

Print Name: _____ Date: _____

Signature: _____