



Patient Registration Form

Make sure you have the following information to complete your forms:

- Insurance card
- Medication names and doses
- Medical records
- Doctor information

Your accurate and complete medical history must be received before your visit to The Bonati Spine Institute to avoid appointment cancellation or delays.

If you have any questions, call or email your Patient Advocate.

Personal Information

Date: _____

First name: _____ Middle name: _____ Last name: _____

Date of birth: _____ Age: _____ Social security #: _____

Driver's license #: _____ Employer: _____

Current home address: _____ City: _____ State: _____

Zip code: _____ Email: _____

Home phone #: _____ Cell phone #: _____

Can we leave message on your answering machine/voice-mail system? Yes No

Your local Florida address: (i.e. family residence, hotel): _____

Sex: Female Male Prefer not to say

Marital status: Single Married Partnered Divorced Widowed

If you are married, what's the name of your spouse? _____

Spouse's DOB: _____ Spouse's employer: _____

Race: American Indian/Alaskan Native Native Hawaiian/Pacific Islander
Asian White
Black/African American Unknown
Hispanic/Latino Other: _____

Ethnicity: Hispanic/Latino Non Hispanic/Latino Unknown

Emergency contact information

I authorize The Bonati Spine Institute to verbally discuss my information with the following people, including translation from/to another language:

Contact name 1: _____ Relationship: _____

Home phone #: _____ Cellphone #: _____

Address: _____ City: _____ State: _____ Zip code: _____

Contact name 2: _____ Relationship: _____

Home phone #: _____ Cellphone #: _____

Address: _____ City: _____ State: _____ Zip code: _____

If patient is a minor: Parent's name: _____ Parent's employer: _____

Signature needed

Patient/guardian signature: _____

Patient name: _____ Date: _____

Referral Information

Name: _____

Please specify how you heard about The Bonati Spine Institute:

Internet: Google
Facebook
Bing Search
Yahoo Search
Other: _____

TV: Commercial (Channel): _____
Show (Channel): _____

Radio: Station: _____

Newspaper: Please list: _____

Referral: Doctor (name) _____
Patient (name) _____

Seminar: Please list location: _____

Other: Please list: _____

Which social networking platforms do you use:



Insurance Information

Name: _____

Primary insurance: _____ Insurance company's phone #: _____
Policyholder's name: _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____
Group or employer name: _____
Policyholder's employer address: _____

Secondary insurance: _____ Insurance company's phone #: _____
Policyholder's name: _____ Policyholder's relationship: _____
Insurance claims address: _____
Policyholder's DOB: _____ Policyholder's SSN: _____
Member ID/policy #: _____ Group #: _____

Attorney information

If your condition is the result of an accident or other injury for which you are represented by an attorney, please provide the following information about your attorney:

Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ ZIP code: _____

Auto insurance

If your condition or injury is the result of an automobile accident, please provide the following information about the automobile insurance involved:

Company name: _____ Claim #: _____
Phone #: _____ Date of accident: _____
Policyholder's name: _____ Relationship: _____
State accident occurred in: _____ Adjuster name: _____

Have auto benefits been exhausted? Yes No
If yes, enter date benefits exhausted: _____

Workers' compensation

Company name: _____ Claim # _____
Phone #: _____ Date of accident: _____
Adjuster name: _____

Registration Information

Name: _____

Authorization to release information & 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).

Signature needed

Patient/guardian signature: _____

Patient name: _____ 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.

Signature needed

Patient/guardian signature: _____ Date: _____

Acknowledgment of Review of Notice of Privacy Practices

I _____ a patient at The Bonati Spine Institute, 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.

Signature needed

Patient/guardian signature: _____ Date: _____

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

Communication of my healthcare

I _____ authorize my healthcare 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 Spine Institute.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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.

Signature needed

Patient/guardian signature: _____ Date: _____

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: _____

Patient History - Main Complaint

Name: _____

Age: Right handed Left handed

What is your primary concern?

How long have you had neck/back pain? _____

How did you hurt your neck/back?

Pain management care:

Are you currently taking prescription pain medications? Yes No

Who prescribes your pain medication? Primary care physician Pain management physician Other

Physician name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____

Zip code: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Do you have a pain management contract with your prescribing physician? Yes No

Is your prescribing physician aware that you're having surgery at The Bonati Spine Institute? Yes No

Have you scheduled a follow-up appointment with your prescribing physician after surgery? Yes No

Patient History - Conservative care

Name: _____

Physical therapy

Provider name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip code: _____

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

If unable to do or discontinued therapy before 6 to 12 weeks explain why: (e.g. cost, increase pain, etc.)

Pain management care

Provider name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip code: _____

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Injection/procedure

Provider name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip code: _____

Date of injection (MM/YY): _____ Percentage of relief: _____

Date of injection (MM/YY): _____ Percentage of relief: _____

Date of injection (MM/YY): _____ Percentage of relief: _____

Chiropractic care

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Massage

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Home therapy- hot/ice-TENS unit

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Acupuncture

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Home exercise program

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Over-the-counter pain medication

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Prescription pain medication

Percentage of relief: _____ Start date (MM/YY): _____ End date (MM/YY): _____

Patient History - Continued

Does your pain interfere with the following daily activities? (check all that apply)

Showering	Dressing	Putting on shoes/socks	Sweeping/mopping
Preparing meals	Laundry	Washing dishes	Taking out trash

Other: _____

Are you able to stand for long periods of time? Yes No

Are you able to sit for long periods of time? Yes No

Does your pain interfere with your daily job functions? Yes No If yes, please explain:

Check the activities you have difficulty doing: Lifting Twisting Pushing/Pulling Turning head
Bending Carrying objects Bending head forward/backward Driving Sleeping

Have you been diagnosed previously with a spine condition such as spinal stenosis, arthritis, scoliosis, herniated disc or fracture? Yes No If yes, please explain:

Physician information

Primary care physician name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip code: _____

Specialist name 1: _____ Type: _____ Phone #: _____

Specialist name 2: _____ Type: _____ Phone #: _____

Specialist name 3: _____ Type: _____ Phone #: _____

By providing this information, you authorize The Bonati Spine Institute to send a summary of your care and medical records to the providers listed above.

Signature needed

Patient/guardian signature: _____ Date: _____

Patient History - Medical/Surgical

Medical history

Name: _____

Please indicate if you have any of the following and explain below:

- | | | |
|--------------------------|------------------------------------|--------------------------------------|
| Sleep apnea | Asthma | Seizures |
| C-Pap | Pulmonary disease | Cancer |
| CVA/stroke | Tuberculosis | MRSA |
| Heart attack | Acid reflux (GERD) | Hepatitis A/B/C |
| Arrhythmia | Peptic ulcer disease (PUD) | Liver disease |
| Congestive heart failure | Benign prostatic hyperplasia (BPH) | HIV/AIDS |
| Pacemaker | Kidney/bladder disease | DVT / PE |
| Defibrillator | Urinary incontinence | Bleeding disorders |
| High cholesterol | Anxiety | Osteoarthritis |
| High blood pressure | Depression | Rheumatoid Arthritis |
| Angina | Bipolar disorder | Anemia |
| Coronary Artery Disease | Schizophrenia | Diabetes I /II |
| Stents | Migraines/headaches | Thyroid disease |
| COPD | Multiple sclerosis | Smoking history (See social history) |
| | | Other: _____ |

Are you pregnant? Yes No

When was your last menstrual period? _____

If any of the above was checked, please explain:

Patient History - Medical/Surgical

Surgical history

Please indicate if you had any of the following procedures, conditions or surgery on any of these areas:

- | | | |
|--------------------------|----------------------------|-------------------|
| Abdominal | Gallbladder | Spine (back/neck) |
| Anesthesia complications | Hernia | Thyroid |
| Angioplasty/stents | History of dura leak | Tonsil |
| Appendix | Nerve stimulator/pain pump | Tubal Ligation |
| Breast | Orthopedic surgeries | Hysterectomy |
| Chest/lung | Pacemaker/defibrillator | Varicose veins |
| Coronary artery bypass | Prostate | Other: _____ |

Please explain your surgical history:

No previous surgery

Previous spinal surgical procedures

Procedure 1: Surgeon name: _____ Phone #: _____

Address: _____ State: _____ Surgery performed: _____

Level: _____ Side: _____ Date (MM/YY): _____ Outcome: _____

Procedure 2: Surgeon name: _____ Phone #: _____

Address: _____ State: _____ Surgery performed: _____

Level: _____ Side: _____ Date (MM/YY): _____ Outcome: _____

Procedure 3: Surgeon name: _____ Phone #: _____

Address: _____ State: _____ Surgery performed: _____

Level: _____ Side: _____ Date (MM/YY): _____ Outcome: _____

List any additional spine surgery:

Patient History - Family/Social

Name: _____

Family history

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important).

Condition	Which family member
Arthritis	
Bleeding disorder	
Cancer	
Heart disease	
Diabetes	
Kidney/bladder disease	
Liver disease	
Neuromuscular disease	
Osteoporosis	
Pulmonary disease	
Stroke	
Thyroid disease	

Social history

Marital status: Single Married Divorced Widowed **Children:** Yes No

Lives alone: Yes No **Wears:** Glasses Contacts

Type of work: Physical: Type: _____ Sedentary: Type: _____
Homemaker Retired

Works: Regular duty Light duty Out of work

Have you ever used any form of nicotine or tobacco? Yes No

If so, have you received counseling to stop tobacco use? Yes No

Type of tobacco	Daily amount	Years used	Age started	Date ended
Cigarettes				
Cigar				
Pipe				
E-cigarette				
Chewing/smokeless/snuff				
Nicotine patch				
Recreational drugs				

If you are a smoker, we advise that you stop smoking prior to your procedures.

Do you drink coffee, tea or soda? Yes No If yes, how many cups per week? _____
 Do you drink alcohol? Yes No If yes, how many drinks per week? _____
 Do you exercise? Yes No If yes how often? _____

Signature needed

Patient/guardian signature: _____

Patient name: _____ Date: _____

Patient History - Medications/Allergies

Name: _____

Height: _____

Weight: _____

Current medication: Please list below any prescription medications, over-the counter and pain medications.

Name and dose	Daily dosage	Last date taken	Reason for taking
Ex: Med name 20mg	Twice a day	3-3-2019	Blood pressure

Supplements: Please list below any herbs, vitamins or supplements.

Name and dose	Daily dosage	Last date taken	Reason for taking

Allergies: Please list below any allergies, medical, non-medical.

Medication Hold List

Name: _____

(Please keep a copy for your reference)

Please review and sign to acknowledge that you understand the following medication hold list. If you are taking an over-the-counter medication not listed here and you are unsure of its actions, please consult your pharmacist or physician, or call The Bonati Spine Institute.

The following medications MUST BE STOPPED five days prior to your surgery.

Prescription anti-inflammatory drugs such as:

- Anodynos Tablets
- Celecoxib (Celebrex)
- Diclofenac (Voltaren, Zorvolex)
- Diclofenac potassium (Cambia, Cataflam)
- Diflunisal (Dolobid)
- Etodolac (Lodine)
- Fenoprofen (Nalfon)
- Flufenamic acid
- Flurbiprofen (Ansaid)
- Indomethacin (Indocin)
- Ketoprofen (Orudis, Ketoprofen ER, Oruvail, Actron)
- Ketorolac (Toradol)
- Meclofenamate
- Mefenamic acid (Ponstel)
- Meloxicam
- Meloxicam (Mobic Vivlodex)
- Nabumetone (Relafen)
- Naproxen (Naprelan, Naprosyn)
- Naproxen sodium (Anaprox)
- Naproxen/esomeprazole (Vimovo)
- Oxaprozin (Daypro)
- Piroxicam (Feldene)
- Salsalate (Disalcid)
- Sulindac (Clinoril)
- Tolmetin (Tolmetin Sodium, Tolectin)
- ViroMed (Acyclovir)

Injectable anti-inflammatory drugs such as:

- Enoxaparin sodium (Lovenox)
- Heparin
- Ketorolac (Toradol)
- Nalfon (Fenoprofen)
- Naprosyn
- Synkavite (Menadiol Sodium Diphosphate) Vitamin K
- Warfarin and Similar (Coumadin)

Over-the-counter anti-inflammatory drugs such as:

- Alka-Seltzer Effervescent Tablets
- Alka-Seltzer Plus Cold Medicine Tablets
- Anacin Tablets & Capsules Maximum Strength
- Arthritis Pain Formula Tablets
- Arthritis Strength Bufferin Tablets
- Aspirin (in many versions)
- BC Powders
- Goody's Powder
- Ibuprofen (Advil, Motrin, Midol, Nuprin)
- Naproxen (Aleve)
- Non-steroidal anti-inflammatory (in many versions)
- Pabirin Buffered Tablets
- Panalgesic
- Pepto-Bismol Tablets
- S.A.C Tablets
- Salocol Tablets
- Supac Tablets
- Suradyne Tablets
- Synalgos Capsules
- Tri-buffered Aspirin
- Triaminicin Tablets
- Trigestic
- YSP Aspirin
- Zorporin (Aspirin)

We recommend you stop taking the following supplements at least five days prior to your scheduled surgery: St. John's wort, garlic, ginger, ginkgo biloba, fish oil, ginseng, flaxseed, vitamin E and vitamin K.

By signing, I agree that I must not take any of these over-the-counter medications for the time frame specified. I understand that failure to follow these instructions might result in the postponement of my surgery.

Signature needed

Patient/guardian signature: _____

Patient name: _____ Date: _____

Medication Alert List

Name: _____

Continue these prescribed blood-thinning medications unless The Bonati spine Institute has been provided with a written approval/permission from your doctor that you can stop the medication. If you are on any of these prescribed medications, let our nurse practitioners know.

If you are diabetic consult with the doctor who treats your diabetes about your insulin dosage or other diabetic medication. You may experience an elevation in your blood sugar before, during and/or after surgery due to the stress of surgery and the steroid medications used during the surgery. Please have a plan to address this with your local doctor who treats your diabetes so you are ready to handle elevations in your blood sugar while you are at The Bonati spine Institute. This could include additional checking on your blood sugar and additional insulin as needed. Our providers will check and treat your blood sugar before, during and after surgery. For your safety, we ask that you follow your regular doctor's instructions after you are released from The Bonati Spine Institute. Please closely monitor your dietary intake to prevent blood sugar fluctuations.

Please take time to review & to acknowledge that you understand the following medication alert list.

The following medications can only be stopped with approval of your prescribing physician.

- Aggrenox (Aspirin/Dipyridamole)
- Arixtra (Fondaparinux)
- Aspirin (when prescribed by your physician)
- Brilinta (Ticagrelor)
- Coumadin (warfarin)
- Celebrex
- Edoxaban (Savaysa)
- Eliquis (Apixaban)
- Fragmin (Dalteparin)
- Heparin
- Innohep (Tinzaparin)
- Lovenox (Enoxaparin)
- Meloxicam
- Persantine
- Plavix (Clopidogrel)
- Pletal (Cilostazol)
- Pradaxa (Dabigatran etexilate)
- Xarelto (Rivaroxaban)

By signing, I understand that approval must be obtained from my prescribing physician before stopping any of these medications prior to my surgery date. **I understand that failure to follow the exact instructions regarding what day to take the last dose of these medications might result in postponement of my surgery.**

Signature needed

Patient/guardian signature: _____

Patient name: _____ Date: _____

Signature:

Email:

Signature:

Email:

Signature:

Email:

Signature:

Email: