SURGICAL SPINE ASSOCIATES REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

Other family members seen here:

INSURANCE INFORMATION-PLEASE PRESENT YOUR INSURANCE CARD

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

❑ Highmark	❑ UPMC	❑ Medicare	❑ Medicaid	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

ACCIDENT INFORMATION-COMPLETE ONLY IF VISIT IS DUE TO AN ACCIDENT

Workers Comp/Auto Insurance ________________________ Address ____________________________________ City__________State____Zip_________Phone ___________	Date of Accident _______________	Claim No. _______________	Type of Accident: ❑ Auto ❑ Other ❑ Work Related

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I request that payment of authorized Medicare/other insurance benefits be made on my behalf to Surgical Spine Associates for any services furnished me by physician or supplier. I authorize the release of my medical information to the Centers for Medicare & Medicaid Services and/or my insurance company and its agents, and any information needed to determine this benefit or benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as copayments and deductibles.

Patient/Guardian signature _______________________________ Date _______________

Rev 9/1/19 EAB

Eugene A. Bonaroti MD Board Certified Neurosurgeon

www.surgical-spine-associates.com

Telephone: 412.275.0227 Fax: 412.291.2111

Office Locations:

Greensburg
One Aesthetic Way
Greensburg, PA 15601

Scheduling Soon!
Cranberry
One Adams Place
310 Seven Fields Blvd
Seven Fields, PA 16046

Procedure Locations:

Greensburg
One Aesthetic Way
Greensburg, PA 15601

Fox Chapel
107 Gamma Drive
Pittsburgh, PA 15238

South Hills
100 Trich Drive
Washington, PA 15301

New Patient Packet

Welcome to Surgical Spine Associates. We are pleased that you have entrusted us with your health care needs. Please carefully review the packet and answer **all** questions to the best of your knowledge. We appreciate your compliance with completing all forms **prior** to your office visit so that we can develop the best plan of care for you.

How to Best Prepare for Your Appointment:

1. Please arrive **15 minutes** prior to your scheduled appointment time.
2. You must present with a photo I.D. (driver's license, passport, government issued I.D. card) and medical insurance card in order to be seen.
3. Complete all forms included in your New Patient packet **before** your appointment.
4. Bring all imaging studies (MRI, CT scan, X-rays, Nerve Studies EMG/NCV) and radiology reports that pertain to your problem. Please be aware that Surgical Spine Associates is a private practice and cannot access your records from outside facilities without a record request.
5. Wear comfortable clothing. You will be asked to remove your shoes for a Neurologic examination.

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. It will be entered into our electronic health record to ensure the best possible care for you.

Patient's Last Name ___________________________ **First** _________________________ **MI** __________

Sex ☐ Male ☐ Female **Date of Birth:** ____

Name of Primary Care Physician: _____________________________ **Phone # of PCP:** ________________

Name of Referring Physician: __________________________________ **Phone # of referring:** ____________

Name of Emergency Contact: __________________________________ **Phone #** _______________________

Pharmacy Preference (include location): ________________________ **Phone #** ________________________

REASON FOR TODAY'S VISIT: ____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____**Yes** ____ **No.** If yes, please list below:

Name of Medication	Type of Reaction*

Latex Allergy: ☐Yes ☐No IV Contrast Allergy: ☐Yes ☐No

SURGERIES, HOSPITALIZATIONS AND MEDICAL CONDITIONS. If yes, please list:

SURGERIES:____

____

____

____

HOSPITALIZATIONS:____

____

MEDICAL CONDITIONS:____

____

RECENT DIAGNOSTIC TESTS, MRI'S, X-RAY'S, EMG'S (Please indicate when/where these were performed):

____

____

____

Have you ever had any problems with **anesthesia** (being numbed or put to sleep)? ☐Yes ☐No

Have you ever been hospitalized for **non-surgical** reasons? ☐Yes ☐No

If yes, list reasons for hospitalizations ____

____

Surgical Spine Associates

One Aesthetic Way, Greensburg, PA, 15601
Phone: (412) 275-0227 Fax: (412) 291-2111

1. Name: ____
   First Middle Initial Last

2. Social Security #: ______________________ 3. Date of Birth: ______________

Characteristics of Pain

1. What is the main complaint for which you are seeking treatment at Surgical Spine Associates?

2. On the diagram, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.

RIGHT LEFT

LEFT RIGHT

3. How long have you had the pain problem you are currently experiencing (in months and years)?

4. What caused your current pain?

5. Describe the characteristics of your pain (circle each that describes your pain).

Piercing	Throbbing	Numbing
Stabbing	Cramping	Itching
Shooting	Aching	Tingling
Burning	Stinging	None
Grinding	Squeezing	

6. Please circle all associated symptoms of your pain:

Numbness	Incontinence of bowel	Cool, pale skin
Weakness	Tenderness of affected area	Swelling
Urinary Incontinence	Pain with only a light touch	Redness

Other:____

Rate your pain by placing an "X" on the line to best describe your pain at its WORST in the past month.

No Pain ____ Pain as bad as it could be

7. Rate your pain by placing an "X" on the line to best describe your pain at its LEAST in the past month.

No Pain ____ Pain as bad as it could be

8. How often do you have pain?
   a. ☐ Constantly (80-100% of the time)
   b. ☐ Nearly constantly (50-80% of the time)
   c. ☐ Intermittently (25-50% of the time)
   d. ☐ Occasionally (less then 25% of the time)

9. What kinds of things make your pain feel better? (example: sitting, sleeping, etc.)

10. What kinds of things make your pain feel worse? (example: standing, lifting, etc.)

SECTION MUST BE COMPLETED.

1. Please indicate which treatments you have tried in the past. Choose the corresponding number indicating the relieving effect on your pain: **PLEASE INCLUDE THE DATE AND DURATION.**

1 – Worsened Pain 2 – No Relief 3 – Partial Relief 4 – Complete Relief

	DATE		DATE		DATE
___Acupuncture	________	___Hospital Bed Rest	________	___SI joint injection	________
___Biofeedback	________	___Hypnosis	________	___Spinal Cord Stimulator	________
___Chiropractor	________	___Nerve Block	________	___TENS (Elect Stim)	________
___Epidural Steroid Inj.	________	___Physical Therapy	________	___Traction	________
___Exercise	________	___Psychotherapy	________	___Facet Rhizotomy	________
___Hot/Cold Tmts	________	___Surgery	________	___Pain Pump	________

If you have had prior neck or back surgery, please indicate the surgery performed:

____

____

2. Have any other health care professionals and/or specialists been involved in the evaluation and treatment of your current pain? **If so, please state their name, specialty, and/or their practice name if known.**

____

____

____

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____

____

____

____

Past Medical History

1. Aside from your pain problem, how is your general health? (please check one item)

☐Excellent ☐Minor Health Problems ☐Major Health Problems

2. Have you had any of the following health problems? (please circle all that apply)

Headaches/Migraines
Neurologic Disorder
Seizures or Epilepsy
Transient Ischemic Attack/Stroke
Chest Pain
High Blood Pressure
Heart Attack
Heart Rhythm Disorder
Valvular Heart Disease
Pacemaker/AICD
Lung Disease

Obstructive Sleep Apnea
Asthma or Wheezing
Chronic Cough
Stomach Ulcer
History of Polyps
Liver Disease/Hepatitis/Cirrhosis
Diabetes or High Blood Sugar
Thyroid Disease
Kidney Disease
Muscle Disease
Arthritis

Fractures
Blood Disorder
Anemia
Blood Clots: Pulmonary/DVT
Cancer
Depression
Mania
Suicidal Tendency
Other:

Review of Symptoms

Please **circle the symptoms** listed below that you have experienced in the past few months. If you are not having any of these difficulties, please check "No Problems."

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, prior diagnosis of cancer.
Other:____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, dental problems, ear pain, nosebleeds, sore throat, facial pain or numbness. Other:
____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____________________________________

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other:
____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:
____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: ____________________________________

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ____

Integumentary (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ____________________________

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ______________________

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ______________________

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____________________________________

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: ____

Family Medical History

1. Please list any medical conditions that are present in your family: ______________________________

2. Is there any family history of anesthesia or surgical problems? ☐Yes ☐No

If yes, please describe: ______________________________

Social History

1. Current or previous occupation: ______________________________
2. Present employment status:

   ☐Full Time ☐Unemployed ☐Leave of Absence ☐Student

   ☐Part Time ☐Retired ☐Homemaker
3. Substance intake per day: (Please indicate how often you use or consume the following)
   a. Caffeine (coffee, tea, cola, etc.) ______________________________
   b. Nicotine (Cigarettes, cigar, pipe, smokeless tobacco, etc) ______________________________
4. Your present use of alcoholic beverages is (choose one):

   ☐None ☐Occasionally (less than 1 drink per week) ☐Daily

   ☐Rarely(less than one drink per month) ☐Regularly (drink 2-3 times per week)

   Have you ever made a conscious effort to decrease your drinking? ☐Yes ☐No

   Has anyone ever irritated you by suggesting that you decrease your drinking? ☐Yes ☐No

   Have you ever felt bad about your drinking? ☐Yes ☐No
5. Have you ever used any of the following drugs? Choose all that apply.

   PLEASE INDICATE WHEN LAST USED in the space provided.

   ☐Marijuana ___________ ☐Cocaine __________ ☐Other Street Drugs ___________

   ☐Amphetamines __________ ☐Heroin ___________ ☐ None of these
6. Marital Status (choose one):

   ☐Single ☐Divorced ☐Widowed

   ☐Married ☐Separated ☐Remarried
7. Number of children: _________________
8. Present living situation:

   ☐Alone ☐With Children ☐With friend

   ☐With Spouse ☐With Parents ☐With other family members
9. Education (check the highest grade/degree completed):

   ☐Less than 8th grade ☐Some high school ☐Some college ☐Advanced degree

   ☐Completed 8th grade ☐High school graduate ☐College graduate

Signature of Patient: ____ Date Completed: ________________

If form has been completed by someone *__other__* than the patient, please print and sign name below:

Name: ____

Signature:____

Relationship to Patient:_____________________________________

Signature of Reviewer: __________________________________ M.D. / NP-C / PA-C

Surgical Spine Associates
Privacy Practices Notice Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached copy of the Surgical Spine Associates Notice of Privacy Practices. I also acknowledge that a copy of the Privacy Practices is available on the internet at www.surgical-spine-associates.com

______________________________ ________________

Patient or Personal Representative Signature | Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

SURGICAL SPINE
ASSOCIATES

www.Surgical-Spine-Associates.com

CONSENT TO COMMUNICATE

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	OK to leave voicemail	Ok to leave message with another person	Preferred contact method(s)	Best time to call
Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Send Email				
Email Appt Reminders	☐ Yes ☐ No			
Email Appt Confirmations	☐ Yes ☐ No			
Email Marketing Info	☐ Yes ☐ No			
Send Regular Mail	☐ Yes ☐ No			
Mail to which address: Home Other (please list):				
Send Text Page	☐ Yes ☐ No			
Text Appt Reminders – if so, list cell carrier:				
Text Marketing Info – if so, list cell carrier:				

If its ok to message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Signature: ______________________________ Date: ________________

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PATIENT FINANCIAL POLICY

Surgical Spine Associates (SSA) is committed to providing you with the best possible care and will be happy to discuss questions regarding our policies, fees or your responsibilities at any time. A clear understanding of the "Patient Financial Policy" is important for the entire scope of your care.

All patients must complete our "Patient Information Form" **before** seeing a provider. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance, phone changes etc....)

INSURANCE: As a courtesy we will file your insurance claims. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges. We will supply factual information as necessary. We do provide expert opinions in workers compensation cases as a separate service.

REGARDING HMO'S, PPO'S AND MANAGED CARE PROGRAMS: It is your responsibility to obtain referral forms required by your particular insurance company. We will do our best to remind you when a referral is due, but ultimately you are required to keep track of the referrals on hand. If you present to the office without a current referral you may be rescheduled. If you are seen without the referral you will be responsible for the bill.

COPAYS: You are expected to pay your co pay prior to seeing your provider. If you are unable to pay, you may be required to reschedule your appointment.

REGARDING PATIENTS WITH NO INSURANCE: We will set up payment arrangements for office visits and and for surgical procedures. Therefore if you do not have coverage you will be required to pay for your service in full on the date of the appointment unless prior arrangements have been made. We accept credit cards, money orders and cash payments for your initial evaluation. We will not accept PERSONAL CHECKS for the initial evaluation.

REGARDING MEDICARE: Our providers participate with Medicare. We will file all claims with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance you will be responsible for the co-insurance and/or deductible amount following the processing of your claim.

MEDICAL RECORDS/FORM COMPLETION: A charge of $20.00 is due before the forms will be completed. (Disability, FMLA, Physician statements, etc.).

WORKERS COMPENSATION: Our office requires verification of your claim prior to the initial visit. You are also to provide us with any other health insurance coverage in case your workers compensation denies the services. If you do not have health insurance coverage you will be asked to self pay for claims denied by your workers compensation claim.

AUTO LIABILITY: Our office requires verification of the claim prior to the initial visit. You are also required to provide your health insurance coverage. If you do not have health insurance coverage, we will not be able to schedule an appt. In the case that your do have health insurance coverage and it terms you will be responsible to self pay for claims not covered by your auto claim.

COPAYS/DEDUCTIBLES/GUARANTOR RESPONSIBILITY: Our office requires payment in full for any balance not paid by insurance within three months from the date of service. If you are unable to pay our balance in full it is the patient's responsibility to make arrangements with our billing office.

RETURNED CHECKS: There is a $30.00 returned check fee payable in cash or money order.

NO SHOW APPOINTMENTS: You are expected to show for the appointments made for you to adequately provide care. Failure to provide notice (of 24hrs for office visits) that you will not be keeping your appointment may result in a delay

By signing this from I acknowledge that I have read this policy and understand the terms outlined above.

____

Patient Name (Please print) Patient Signature Date