DISC SPINE INSTITUTE

Dr. Mark Valente
Dr. Andrew Indresano
Minimally Invasive Spine Surgeons
Board Certified, Fellowship Trained
Ph 972-707-0005 Fax 888-992-6199

NEW PATIENT FORM

Name _____

Street _____ Apt _____ City _____ State ____ Zip _____

DOB _____ / _____ / _____ Driver's License _____ Social Sec # _____ / _____ / _____

Mobile Phone _____ Work Phone _____

E-mail address _____

PRIMARY INSURANCE CO _____ Insurance ID # _____ Group # _____

Name of Insured _____ DOB _____ / _____ / _____

Relationship to Insured □ Self □ Spouse □ Child □ Other Insured's Social Sec # _____ / _____ / _____

SECONDARY INSURANCE _____ Insurance ID # _____ Group # _____

Name of Insured _____ DOB _____ / _____ / _____

Relationship to Insured □ Self □ Spouse □ Child □ Other Insured's Social Sec # _____ / _____ / _____

Employer Name _____ Occupation _____

Pharmacy Name _____ City _____ Phone # _____

Emergency Contact _____ Relationship _____ Phone # _____

Do you have an attorney due to this condition being the result of an accident or injury? _____

Name of your attorney _____ **Attorney phone #** _____

LEGAL GUARDIAN / MEDICAL POWER OF ATTORNEY

Name _____ Relationship _____ Phone # _____

REFERRAL INFORMATION

How did you first hear of us?

□ Internet search (google) - what words or phrase did you use in google: _____
□ Internet advertisement
□ Facebook
□ Physician
□ Insurance
□ TV
□ Friend, co-worker, relative. Name:_____
□ Radio
□ Magazine - which one? _____
□ Billboard
□ Other _____

REFERRING PHYSICIAN

Name of Physician who referred you to us _____ What city are they in _____

Name of your Primary Care Physician (PCP) _____ What city are they in _____

CONSENT FOR TREATMENT

I understand that I have presented myself to Dr. Mark Valente and/or Dr. Andrew Indresano, Renaissance Neurodiagnostics, P.A. (d/b/a DISC Spine Institute), DISC Clinic, PLLC, and/or one of their affiliate entities for evaluation and/or treatment for my condition. I authorize and direct Dr. Valente and/or Dr. Indresano to perform quality care upon me, and understand that all options will be discussed prior to the administration of treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

_____ (Initial)

FACSIMILE AUTHORIZATION

I, the undersigned, authorize Dr. Valente and/or Dr. Indresano (DISC Spine Institute/DISC Clinic, PLLC) or one of their affiliate entities to send/receive confidential healthcare information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. I may revoke this authorization by giving Dr. Valente and/or Dr. Indresano (DISC Spine Institute/DISC Clinic) five (5) days written notice. This revocation may be by facsimile transmission, however, a written copy of the revocation must be mailed to Dr. Valente/Indresano as well.

_____ (Initial)

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Valente and/or Dr. Indresano (DISC Spine Institute/DISC Clinic, PLLC) or one of their affiliate entities and any assisting physicians, PA, NP, RNFA, or CRNA for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ (Initial)

ACKNOWLEDGEMENT OF FINANCIAL INTERESTS

I understand that Dr. Mark Valente and/or Dr. Andrew Indresano have a direct or indirect contractual relationship with or ownership interest in the following health care professional(s) or facility(ies), which may include management companies, laboratories, pharmacies, neuromonitoring companies, imaging companies, medical device distributorships/manufacturers, first assist companies, anesthesia companies, ambulatory surgery centers, and/or hospitals. I understand that Dr. Mark Valente and/or Dr. Andrew Indresano have a direct or indirect contractual relationship with or ownership interest in, but is not limited to; DISC Clinic, PLLC, Blue Star Medical Management, PLLC, Ridgeline Medical Management, PLLC, AAI Investment Holdings, LLC, Movement Orthopedics, PLLC, MEG Healthcare, Inc., Equinox Clinic, PLLC, Equinox Spine, PA, Evolution Spine, LLC, Gemini Medical Consulting, LLC, Methodist Hospital for Surgery, Montage Monitoring, PLLC, Monticello Diagnostic Imaging, LP, Nizuc Care, PLLC, Otway Medical Holdings, LLC, Parkway Surgical & Cardiovascular Hospital, Preston Surgery Center, LLC, and Surgical Safety, PLLC and may benefit by referring me to these health care professionals or health care facilities. Some of these professionals or facilities may be out of network and as a result, I understand I may receive an out of network bill. I understand that I have the right to choose the provider of my health care services, and I am welcome to seek treatment from an alternative provider or at an alternative facility at any time. I will not be treated differently by Dr. Valente, Dr. Indresano, or any other provider at DISC Spine Institute, DISC Clinic, or any of its affiliates if I choose to obtain health care services from an alternative provider or at an alternative facility.

_____ (Initial)

ACKNOWLEDGEMENT FORM

I have received and/or reviewed the Notice of Privacy Practices. I have received a copy of the financial policy for this practice and agree to adhere to the terms.

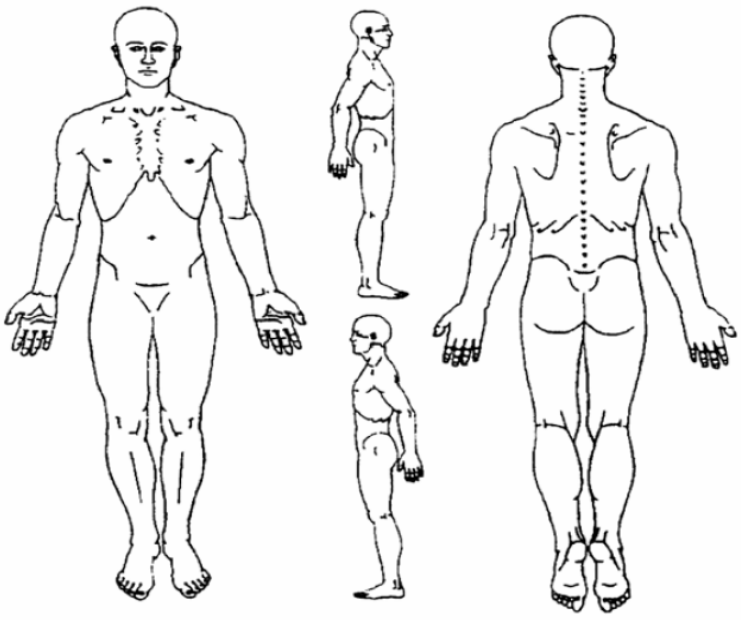
_____ (Initial)

Patient Signature _____ Date _____

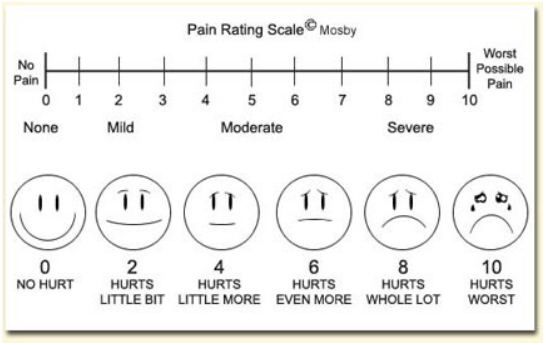
PAIN DIAGRAM

Please mark the area of discomfort on the diagram below using the appropriate symbols

Pain or burning **x x x x x**
Numbness **o o o o o**
Pins and Needles **= = = = =**



Grade your overall pain



Please place an X on the hash mark that most accurately describes your overall degree of pain *now.*

HISTORY (Check all that apply) **Your Age _____**

Chief Complaint □ Back pain Leg symptoms: □ Pain □ Numbness □ Weakness

□ Neck pain Arm symptoms: □ Pain □ Numbness □ Weakness

Is your condition the result of a: Work injury? □ YES □ NO Auto accident? □ YES □ NO

Was there a trauma or inciting incident? _____ What is the date of the injury? _____

Symptoms have been present for: How many weeks _____ How many months _____ How many years_____

Symptoms are described as: □ Sharp □ Dull □ Achy □ Burning □ Spasms

My pain is: □ Worsening □ Improving □ Same (unchanged since it started)

NECK and ARM pain

Neck Pain _____ % + Arm Pain _____% = 100%
For example 70 + 30 = 100%

If you have significant arm pain: Left Arm Pain _____ % + Right Arm Pain _____% = 100%

Do you have difficulty picking up small objects like coins or buttoning buttons? □ YES □ NO

Do you have problems with balance or frequent tripping? □ YES □ NO

Do you have abnormal bowel or bladder control (incontinence or retention)? □ YES □ NO

Have you had the following treatments **for your neck**?

□ Anti-inflammatories □ Physical Therapy □ Facet injections □ Epidural steroid injections

BACK and LEG pain

Back Pain _____ % + Leg Pain _____% = 100%
For example 70 + 30 = 100%

If you have significant leg pain: Left Leg Pain _____ % + Right Leg Pain _____% = 100%

Worst position for pain is: □ Sitting □ Standing □ Walking

How many min. can you stand/walk before you need to rest?

□ less than 5 min □ less than 30 min □ less than 60 min □ 60+

Sitting: □ Makes the pain worse □ No change in pain □ Makes the pain better

Bending forward: □ Makes the pain worse □ No change in pain □ Makes the pain better

Lying down: □ Makes the pain worse □ No change in pain □ Makes the pain better

How many days/weeks/months of work have you missed due to your condition: _____

PAST TREATMENTS

□ Anti inflammatory medication
□ Muscle relaxants
□ Narcotic pain medication
□ Acupuncture
□ Chiropractic manipulation
□ Bracing
□ Traction
□ Physical Therapy
□ Trigger point injections
□ Sacroiliac injections
□ Facet injections
□ Epidural Steroid Injections
□ Other _____

PAST MEDICAL HISTORY □ **I have no past or current medical problems**

□ Osteoarthritis
□ Rheumatoid Arthritis
□ Ankylosing Spondylitis
□ Osteoporosis
□ Bleeding disorder
□ Blood clot in leg
□ Blood clot in lung
□ High blood pressure
□ Diabetes
□ Heart disease
□ Heart failure (CHF)
□ Heart attack (MI)
□ Stroke
□ Lung disease
□ Tuberculosis
□ Asthma
□ Liver disease
□ Hepatitis
□ Kidney disease
□ Kidney stones
□ Kidney failure
□ Seizures
□ Thyroid trouble
□ Mental Illness
□ Anemia
□ Gout
□ HIV
□ Cancer
□ Stomach ulcers
□ Alcoholism
□ Substance Abuse
□ Serious injury
□ Other _____

PAST SURGICAL HISTORY

Type of Surgery	Approx. Year	Type of Surgery	Approx. Year
_____		_____	
_____		_____	
_____		_____	
_____		_____	

MEDICATIONS

Please list ALL CURRENT medications and doses □ **None**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Please list any known allergies to food or medications and their reactions □ **I have no known allergies**

_____

REVIEW OF SYSTEMS

Are you currently or have had problems with: *** Please explain and describe all YES answers below**

Hematological / Bleeding problems	□ Yes	□ No	Describe _____
Unexplained weight loss	□ Yes	□ No	Describe _____
Skin	□ Yes	□ No	Describe _____
Ear, Nose, Throat	□ Yes	□ No	Describe _____
Stomach / Digestion	□ Yes	□ No	Describe _____
Bladder / Bowel problems	□ Yes	□ No	Describe _____
Musculoskeletal	□ Yes	□ No	Describe _____
Neurological	□ Yes	□ No	Describe _____
Psychiatric problems	□ Yes	□ No	Describe _____
Fever / Chills	□ Yes	□ No	Describe _____
Night sweats	□ Yes	□ No	Describe _____
Night pain / Pain at rest	□ Yes	□ No	Describe _____

FAMILY HISTORY

Check all that apply □ **None apply**

□ Stroke □ Bleeding disorders □ Genetic disease □ Mental illness □ Spine problems

□ Heart disease □ Cancer □ Diabetes Other: _____

SOCIAL HISTORY

Height _____ Weight _____ Occupation _____

Employment: □ Homemaker □ Retired □ Disabled □ Unemployed □ Employed: □ Full time □ Part time

Marital Status □ Married □ Single □ Divorced □ Widowed Number of living children: _____

I live: □ Alone □ I live with _____

Do you smoke? □ Yes □ No I smoke ____ packs/day for_____years □ Quit How long ago? _____

Drink alcohol □ Never □ 1-2 per month □ 1-2 per week □ Daily □ Alcoholic □ Recovering alcoholic

Illicit drug use □ Never □ In the past □ Currently Which substances _____

Dr. Mark Valente
Dr. Andrew Indresano
Minimally Invasive Spine Surgeons
Board Certified, Fellowship Trained
Ph 972-707-0005 Fax 888-992-6199

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

Patient Signature: _____

I request and authorize the following doctor's office and/or medical facility to release my healthcare information

to the DISC SPINE INSTITUTE: _____

Please send the following records to the below fax number:

_____

_____

Please send the records to FAX #888-992-6199