# Federico P. Girardi, M.D., P.C.
## Spinal Surgery

**Patient Intake Sheet** **Date:**

| **Name:** | **Telephone Numbers:**<br>Home:<br>Cell:<br>Work |
|---|---|
| **Address:** | **Optional:**<br>Race:<br>Ethnicity:<br>Language: |
| **Sex:**<br>Male Female | **Email:** |
| **Date of Birth:** | **SS#:** |
| **Pharmacy:**<br>Name:<br>Address:<br>Zip Code:<br>Phone<br>Fax | **Marital Status:**<br>M W S D<br>Spouse name:<br>DOB:<br>SS#: |
| **Have you ever been in a motor vehicle accident? Yes No** | **Have you ever been injured at work?**<br>**Yes No** |
| **INSURANCE DATA:** | |
| **Primary:**<br>Name of Insurance:<br>ID #:<br>Group#:<br>Policy Holder's Name:<br>Policy Holder's DOB:<br>**Secondary:**<br>Name of Insurance:<br>ID#:<br>Group#:<br>Policy Holder's Name:<br>Policy Holder's DOB: | **PLEASE NOTE: It is the patient's responsibility to obtain a referral from your insurance carrier if one is required. Please check with your insurance company prior to your appointment to ensure you have proper coverage.**<br>____________________ |
| **Primary Care Physician: Name:** **Phone:**<br>**Address:**<br><br>**Emergency Contact: Name:** **Relationship:** **Phone:**<br><br>**Referred By:** | |

** **Have you ever been exposed to the Measles virus (rubeola) ? Yes _____ No _____**

** **Do you currently have the Measles virus (rubeola) ? Yes _____ No _____**

**PLEASE LIST MAIN COMPLAINTS:**

| |
|---|
| **1.** |
| **2.** |
| **3.** |
| **Do you have any of the following?** |
| Neck Pain: |
| Arm Pain:<br>☐ Left Arm ☐ Right Arm |
| Back Pain: |
| Leg Pain:<br>☐ Left Leg ☐ Right Leg |
| Weakness:<br>In Legs?<br>In Arms?<br>How long have you had it for? |
| Did you have previous spine surgery?<br>☐ Yes ☐ No<br>If yes, please list the name of procedure and the date:<br>Date: Procedure: |
| How did this problem begin? |
| How long have you had this problem? |
| Briefly describe your current condition: |

| **What Doctors have you seen for this problem?<br>Please list their names below.** | **Was surgery recommended, if so, what procedure?** |
|---|---|
| Orthopedist: | |

| Neurologist: | |
|---|---|
| Neurosurgeon: | |
| Pain Management:<br>Have you had any Injections?<br>If so, what type? | Please List: |
| Physical Therapy: | How long did you go for? |
| Are you currently taking any pain medication?<br>If so, please list ALL pain medicine: | List: |
| **Have you had any of these studies? List type below.** | **Please bring images to appointment** |
| X-rays: | Date: |
| MRI Scan: | Date: |
| CT Scan: | Date: |
| Myelogram: | Date: |
| EMG/Bone Scan: | Date: |
| **Below is for MD use only** | **Below is for MD use only** |
| **LUMBAR SPINE:**<br>□ L/S Series<br>□ Flexion & Extension<br>□ Standing AP/Lat Long cassette<br>□ Other Views: | **CERVICAL SPINE:**<br>□ C/S Series<br>□ Flexion and Extension<br>□ Other View: |
| **Scheduling Urgency:**<br>□ Urgent<br>□ ASAP | **Scheduling Urgency:**<br>□ Next Available |
| **Need to Obtain:** | |
| **Physician's Recommendation:** | |
| | |

FEDERICO P. GIRARDI, M.D.,P.C.
SPINAL SURGERY

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**Acknowledgement of Dr. Girardi's NO FAULT and Workers Comp Claim policy**

***** ALL PATIENTS MUST COMPLETE AND SIGN TO PROCEED*****

**Patient Name:**__________________________________________
**D.O.B:**____________________

If you have been in a motor vehicle accident or injured at work and have an open claim you must complete a *(BC6/AOB/NO FAULT/WCIF)* forms and send it with the intake forms to Dr. Girardi P. Federico's office.

If you have been in a motor vehicle or work accident and the claim related to the accident is currently closed you must submit the *(closed case form/letter*) from the adjuster/case manager along with the intake forms.

I am aware, If I have been involved in a motor vehicle or work accident, I must advise my insurance carrier that I was in a motor vehicle or work accident and there is no open case connected to this accident. I will be responsible for resolving any issue with my insurance related to said accident or *I will be responsible for 100% of the bill.*

I have read and understood all of the above information. (Initial here ____________)

Patient/Responsible Party signature DATE:

**X**______________________________________