



Spine and Brain Imaging Center

Neurosurgery and Endovascular Associates, S.C.

Patient: _____ Date of Birth: _____

Weight: _____ Allergies: _____

NPO Status: _____ Current Meds: _____

Reason for Exam: _____ Procedure: _____

1. Has the patient ever had any test done at SBIC? Yes No
2. Has the patient had any other tests of the same area? X-Ray CT MRI
3. Where was the prior exam performed? _____
4. Approximately when was the prior exam done? _____
5. Why did the doctor order the examination? _____
6. How long has this been going on? _____
7. Has the patient ever had any surgeries or hospitalizations? Yes No
If yes, When and Why? _____
8. Any recent accidents, injury, or surgery? Yes No
If yes, When and Why? _____
9. Does the patient have current or past history of any health problem? (Such as problems with: heart, breathing, kidneys, seizures, diabetes, gastro-intestinal, cancer). _____

10. Has the patient ever had an IV or blood drawn (for a blood test)? Yes No
11. Has the patient ever had sedation or general anesthesia in the past? Yes No
If yes, please explain _____

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Patient or Guardian) _____ Date: _____

NEUROSURGERY AND ENDOVASCULAR ASSOCIATES, S.C.

PATIENT INFORMATION

PLEASE PRINT

Name _____ Birthdate: _____ Age: _____ Sex: () M or () F
LAST FIRST MIDDLE

Home Address: _____ City: _____ State: _____ ZIP: _____

OUR BILLING OFFICE REQUIRES A STREET ADDRESS – IF THE ONLY MAILING ADDRESS IS A P.O. BOX INDICATE ABOVE.

Home Phone #: () _____ Cell/Other Phone #: () _____

Work Phone #: () _____ Patient's Social Security Number: _____

Marital Status: () M () S () Sep () D () W Name of Spouse or Parent if Minor: _____

Spouse's Date of Birth: _____

Patient's Employer: _____ Occupation: _____

Primary Physician: _____ Address: _____ Office: () _____

Referring Physician: _____ Address: _____ Office: () _____

Emergency Contact Not Living With You: _____ Work #: _____
Home #: _____ Relationship: _____

INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD(S) TO FRONT DESK FOR ACCURACY.

Primary Insurance: _____ Subscriber Name & S.S. Number: _____

ID Number: _____ Group #: _____ Subscriber's Date of Birth: _____

Subscriber's Employer Name: _____ Effective Date of Insurance: _____

Secondary Insurance: _____ Subscriber Name & S.S. Number: _____

ID Number: _____ Group #: _____ Subscriber's Date of Birth: _____

Subscriber's Employer Name: _____ Effective Date of Insurance: _____

Is today's visit due to a work-related injury or personal injury? () Yes () No If Yes, Date of Injury: _____

PROVIDE A BRIEF DESCRIPTION ON THE LINE ABOVE ON HOW INJURY OCCURRED & TO WHOM IT WAS REPORTED.

Worker's Compensation Insurance Name: _____ File #: _____

Phone: _____ Contact Name/Person: _____

Liability Insurance: _____ Where injury took place: _____

Auto Insurance: _____ Claim #: _____

Do you have a copy of the police report? () Yes - () No If yes, may we have a copy? () Yes - () No

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr. Arvind Ahuja or representative to furnish information to insurance carriers concerning my illness, treatment, and/or hospitalizations as needed to process claims. I request payment of authorized benefits be made directly to Neurosurgery and Endovascular Associates, S.C. These authorizations will remain in effect until I choose to revoke them. I understand that I am financially responsible for all charges not covered or rejected by my medical insurance or worker's compensation benefits.

Signed: _____ Date: _____