# JASON M. GALLINA, M.D., P.C.

ORTHOPEDIC SPINE SURGERY

154 WEST 14TH STREET, 4TH FLOOR
NEW YORK, NY 10011
TEL (212) 616-4130 • FAX (212) 691-6370

Date: ____________

Patient Name: ________________________________________________________________
Last First Middle Marital Status

Home Address: ________________________________________________________________
Street City State Zip

Home Tel. ________________ Work Tel. _______________ Cell Tel. ________________

Social Security__________________ Driver's License ______________________ State ____

**Emergency Contact (Name/Tel)** ______________________Sex (M/F) ____ Date of Birth ________ Age _____

**Responsible Party** ________________________________________________________________
(If other than patient) Last First Middle Marital Status

Home Address: ________________________________________________________________
Street City State Zip

Home Tel. ________________ Work Tel. _______________Sex (M/F) ____ Date of Birth ________ Age _____

Social Security__________________ Driver's License ______________________ State ____

Condition Related to: Illness ____ Auto Accident ____ Employment ____ Other ____ Date of Injury ____

Who Referred You: Physician ____ Friend ____ Ins. Co. ___ Attorney ____; Other _________

Referrer Name ________________________________________________________________
Name Address Telephone

Employer ________________________________________________________________
Company Name Occupation Telephone

Address: ________________________________________________________________
Street City State Zip

Insured's Name ________________________________________________________________
Last First Middle

Home Address: ________________________________________________________________
Street City State Zip

Relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

Insurance Information: ________________________________________________________________
Insurance Company Telephone

Address: ________________________________________________________________
Street City State Zip

I.D. # ________________ Group # ______________ Claim # ________________

Primary Care Physician ________________________________________________________________
Last First Middle

Address: ________________________________________________________________
Street City State Zip

Patient Medical History

Please note the reason for today's visit: ______________________________________________________

________________________________________________________________________________

________________________________________________________________________________

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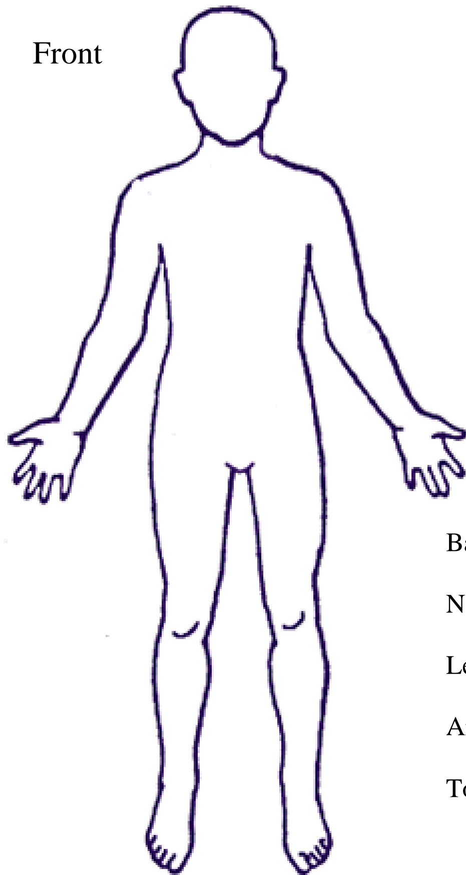
Name ____________________________________________________ Date _________________

**WHERE IS YOUR PAIN NOW?**

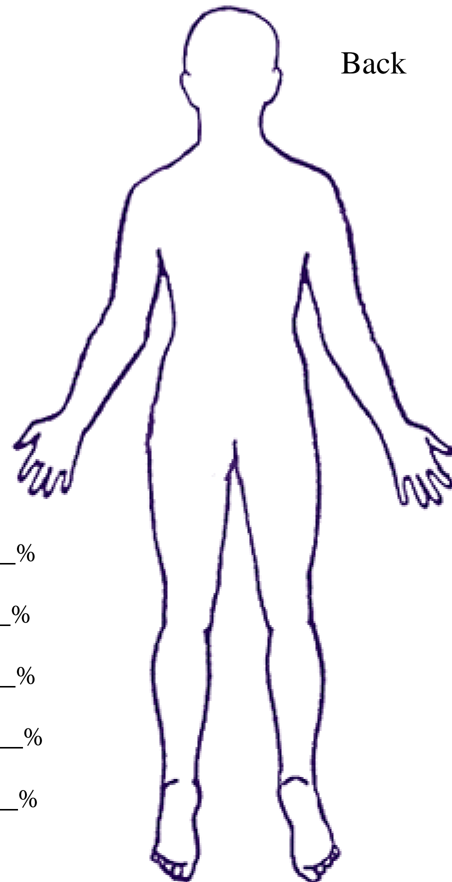
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

| | | | | | |
|---|---|---|---|---|---|
| Ache | ^ ^ ^<br>^ ^ ^<br>^ ^ ^ | Numbness | o o o<br>o o o<br>o o o | Pins & Needles | = = =<br>= = =<br>= = = |
| Stabbing | / / /<br>/ / /<br>/ / / | Spasm | x x x<br>x x x<br>x x x | Tender | z z z<br>z z z<br>z z z |

Front



Back



Back pain________________%

Neck pain ________________%

Leg pain__________________%

Arm pain__________________%

Total_____________________%

PLEASE MARK ON THE LINE: How bad is your pain now on a scale from 0 to 10?

0________________________________________________________________________ 10

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Name ______________________________________________________________________

What is your main complaint? ____________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Date of Injury/Problem Began: _______________ Side of body affected: Right ____ Left ____ Both ____

I am right handed ____ left handed ____

What symptoms have your been having? _____________________________________________

______________________________________________________________________________

______________________________________________________________________________

How long have you been having these symptoms? _______________________________________

______________________________________________________________________________

Have you been seen by another Doctor for this condition? [ ] Yes [ ] No

Please describe your past treatments:

<u>Surgery:</u>

Type _______________________________________________________ Date _________________

Surgeon ____________________________________________________

Type _______________________________________________________ Date _________________

Surgeon ____________________________________________________

<u>Physical Therapy:</u>

Therapist ___________________________________________________ Date _________________

<u>Injections:</u>

Type _______________________________________________________ Date _________________

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Please list any medications/studies you have had in the past (MRI, CAT Scans, X-Ray, etc.)

________________________________________ Date ____________________

________________________________________ Date ____________________

________________________________________ Date ____________________

________________________________________ Date ____________________

Please list any records/films you have brought with you today:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Please provide any additional medical information relevant to your current problem: ____________________

______________________________________________________________________

______________________________________________________________________

Please describe, with date, any other serious injuries: ________________________________________

______________________________________________________________________

______________________________________________________________________

## Patient Authorization

**Claims Authorization** – I hereby authorize any treating physician to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(‘s) including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon my dependent’s, and our heirs, executor’s, administrators and me.

**Assignment of Benefits – Private and Federal (Medicare)** – I authorize payments of medical and surgical benefits, including Medicare benefits, to be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it s agents any information needed to determine these benefits payable for related services. I understand that any service deemed “Non-Covered” by my carrier are my sole financial responsibility, as outlined in my coverage manual. Prompt and complete payment of said services is also my sole responsibility.

**Credit Card Authorization** – I authorize, when requested by me over the phone, the use of my credit card for outstanding charges.

**Litigation Disclaimer** – It is understood and agreed that I am requesting examination and treatment for medical purposes.

Patient Name (print) ______________________________________

Patient Signature ________________________________________ Date ____________________