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

New Patient Intake Request Sheet Date:

Name:	Telephone Numbers:			
	Home:			
	Cell:			
	Work			
Address:	Optional:			
	Race:			
	Ethnicity:			
	Language:			
Sex:	Email:			
Male Female	Eman.			
Date of Birth:	SS#:			
Date of Bil til.	55#.			
Pharmacy:	Marital Status:			
Name:	M W S D			
Address:	Spouse name:			
Zip Code:	DOB:			
Phone	SS#:			
Fax	Son.			
Is this visit related to:	Is this visit related to:			
Workman's Comp Yes No	No Fault Yes No			
Attach required documentation	Attach required documentation			
1	1			
INSURANCE DATA:				
Primary:				
Name of Insurance:				
ID #:	PLEASE NOTE: It is the patient's			
Group#:	responsibility to obtain a referral from your			
Policy Holder's Name:	insurance carrier if one is required.			
Policy Holder's DOB:	Please check with your insurance company			
Secondary:	prior to your appointment to ensure you have			
Name of Insurance:	proper coverage.			
ID#:	proper coverage.			
Group#:				
Policy Holder's Name:				
Policy Holder's DOB:				
Primary Care Physician: Name:	Phone:			
Address:	Phone;			
Tada ess.				
Emergency Contact: Name:	Relationship: Phone:			
Referred By:				

PLEASE LIST MAIN COMPLAINTS:	
1.	
2	
2.	
3.	
Do you have any of the following?	
Neck Pain:	
Arm Pain:	
□ Left Arm □ Right Arm	
Back Pain:	
Leg Pain:	
□ Left Leg □ Right Leg	
Weakness:	
In Legs?	
In Arms?	
How long have you had it for?	
Did you have previous spine surgery?	
□ Yes □ No	
If yes, please list the name of procedure and t	the date:
Date: Procedure:	
How did this problem begin?	
How long have you had this problem?	
Duiofly describe your assument conditions	
Briefly describe your current condition:	
What Doctors have you seen for this	Was surgery recommended, if so, what
problem?	procedure?
Please list their names below.	
Orthopedist:	
Neurologist:	
Neurosurgeon:	
Pain Management:	Please List:
Have you had any Injections?	

If so, what type?			
Physical Therapy:	How long did you go for?		
Are you currently taking any pain medication? 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:	CERVICAL SPINE:		
□ L/S Series	☐ C/S Series		
L/S Series	- C/S Series		
□ Flexion & Extension	☐ Flexion and Extension		
☐ Standing AP/Lat Long cassette	□ Other View:		
□ Other Views:			
Scheduling Urgency:	Scheduling Urgency:		
□ Urgent	□ Next Available		
	Troncer remains		
Need to Obtain:			
recu to Optain.			
Physician's Recommendation:			
Intake sent to patient by:			
Chart prepared by:			
Date chart was given to MD to review:			