

ATLAS SPINE, LLC
201 Creek Crossing Blvd
Hainesport, NJ 08036
Ph. (609) 261-5800 Fx. (609) 261-5801

Date _____

Patient's Name: _____ Age: _____ Date of Birth: _____ Sex: M ___ F ___

Address: _____ City: _____ State: _____ Zip Code: _____

S.S.#: _____ Marital Status: _____ Home Phone# _____ Cell Phone# _____

Race: _____ Ethnicity: _____ Language(s): _____

Employer: _____ Phone#: _____ Retired: Yes ___ No ___

Occupation: _____ Full-time or Part-time(circle one) Full Time Student: Yes ___ No ___

Address: _____ City: _____ State: _____ ZipCode: _____

Spouse's Name: _____ Date of Birth: _____ S.S.# _____

Employer: _____ Phone# _____

Employer Address: _____ City: _____ State: _____ ZipCode: _____

In case of an emergency contact (other than spouse): _____

Relationship: _____ Phone#: _____

INSURANCE

Please list insurance companies you have coverage through below in order of coverage, and provide your card to be copied. Also, you must notify us if this is an accident or work related visit.

1) _____

2) _____

3) _____

AUTHORIZATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

I HERBY AUTHORIZE ATLAS SPINE, LLC TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO CHARLESTON DIABETES & ENDOCRINE CONSULTANTS, PLLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature of Patient or ResponsibleParty: _____ Date: _____

HIPAA ACKNOWLEDGEMENT: I have been given ATLAS SPINE, LLC's HIPAA Policy.

Signature of Patient or ResponsibleParty: _____ Date: _____

I would like _____ to be my Authorized Representative if I am not available.

***Please give receptionist a current copy of your insurance card(s) along with photo ID

**Atlas Spine, LLC
Orin K. Atlas, M.D.
201 Creek Crossing Blvd.
Hainesport, NJ 08036**

Primary Insurance

Insurance Policy Holder's Name _____

Relationship to Patient _____

Carrier _____ **Phone** _____

Address _____

Policy ID _____ **Group** _____

Subscriber's Birth Date _____

Subscriber's SS# (if other than patient) _____

Does your insurance require pre-authorization for office visits or testing?

Yes _____ **No** _____ **Uncertain** _____

Secondary Insurance

Insurance Policy Holder's Name _____

Relationship to Patient _____

Carrier _____ **Phone** _____

Address _____

Policy ID _____ **Group** _____

Subscriber's Birth Date _____

Subscriber's SS# (if other than patient) _____

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Worker Compensation or Motor Vehicle Information

If your injury is Workers Compensation or Motor Vehicle related, please specify by circling below and completing this page. If not, please circle Not Applicable and go to the next page.

Worker Compensation

Motor Vehicle

Not Applicable

Carrier _____ Claim # _____

Claims Office Address _____

Adjuster/Case Manager Name _____

Adjuster's Phone/Fax # _____

Date of Injury _____

Employer Name _____

Are you represented by an attorney? Yes or No (circle one)

Please provide attorney name/address/phone/fax below:

Are you presently working? Yes or No (circle one)

If not, when was your last day of work? _____

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Symptoms and Conditions

What is your main complaint? _____

What symptoms have you been having? _____

How long have you been having these symptoms? _____

Have you been seen by another doctor for this condition? Yes or No (circle one)

Please describe your past treatment for this condition:

Please List Previous Spine Surgeries

Type _____

Date _____ **Surgeon** _____

Type _____

Date _____ **Surgeon** _____

Type _____

Date _____ **Surgeon** _____

Physical Therapy

Place & Therapist _____

Name _____ **Date** _____

Pain Management/Injections

Doctor _____

Type of Injection _____ **Number of Injections** _____

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Medical Conditions, Medications, Allergies and Studies

Please list all your medical conditions: _____

Please list all the medications your are currently taking:

Medication _____ **Dosage** _____ **Duration** _____

Medication _____ **Dosage** _____ **Duration** _____

Medication _____ **Dosage** _____ **Duration** _____

Medication _____ **Dosage** _____ **Duration** _____

Pharmacy Name & Phone _____

Known Allergies _____

Please list any tests/studies you have had in the past pertaining to this visit such as MRI, CT scans, or X-rays:

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

_____ **Date** _____

Please list what test/studies you have with you today for doctor to review:

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Review of Symptoms

Please check below all that you are currently experiencing:

General

- Recent Weight Change
- Fever
- Fatigue
- Memory Loss/Confusion
- Depression
- Night Sweats
- HIV infection or AIDS
- Arthritis

Head and Neck

- Eye Disease or Injury
- Wear Glasses/Contacts
- Blurred or Double Vision
- Glaucoma
- Hearing Loss
- Ringing in Ears
- Earaches or Drainage
- Sinus Problems
- Nose Bleeds
- Mouth Sores
- Bleeding Gums
- Bad Breath or Taste
- Sore Throat/Voice Change
- Swollen Glands in Neck
- Snoring
- Facial Pain
- Allergies

Heart and Cardiovascular

- Heart disease
- Chest pains
- Hypertension
- Angina
- Anemia
- Pacemaker
- Swelling of ankles, hands

Musculoskeletal

- Joint Pain
- Joint Stiffness/Swelling
- Muscle Weakness
- Back Pain
- Difficulty walking

Neurological

- Headaches
- Head Injury
- Numbness
- Black-Outs
- Paralysis
- Tremors
- Seizures
- Strokes

Respiratory System

- Hoarseness
- Chronic Cough
- Throat Clearing
- Heart Burn
- Spitting up blood
- Shortness of Breath
- Asthma/Wheezing
- Bronchitis
- Emphysema
- Tuberculosis
- Lung Cancer

Endocrine

- Diabetes
- Thyroid Imbalance
- Glandular/Hormone
- Menstrual disorders
- Heat/Cold intolerance
- Excessive thirst

Hematological/Lymphatic

- Anemia
- Phlebitis
- Transfusion
- Swollen glands
- Slow to heal after cuts
- Easily bruised

Gastrointestinal

- Difficulty/Pain Swallowing
- Constipation
- Jaundice
- Hepatitis
- Liver disease
- Kidney disease
- Diverticulosis
- Gallbladder disease
- Diarrhea

Urologic

- Difficulty on urination
- Frequent urination
- Blood in urine
- Prostate problems

Skin and Breath

- Rash or itching
- Change in skin color
- Change in hair or nails
- Varicose Veins
- Breast pain
- Breast lump
- Breast Discharge

Patient Name _____ **Date** _____