REGISTRATION

DATE: ____________

Patient: Last Name ________________________ First Name ______________________ Initials ________________________
Home Phone ____________________ Work Phone ________________ Email ____________________________
Address: (Street, No, App.) ____
City ____ Province _______ Postal Code ____________
Sex ☐ M ☐ F Age______ Birth date____________ ☐ Without Spouse ☐ With Spouse
Health Insurance Number:________________________________ Expiration Date________________________
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Car accident ☐ Other

Insurance: Insured Name____
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

How and where did you learn about this clinic? ____

EMPLOYER	Company Name____ Occupation________________ Address__________________________________ Phone______________ ☐ Full-time ☐ Part-time City ______________________________ Province _______ Zip ____________ Years Employed_________
SPOUSE (PARENT)	Name____________________________________ Birthdate ____________ SSN:____________________ Last Name First Name Initials Employer Name____ Years Employed________________ Address ______________________ Phone______________________ Occupation______________________ City______________________________ Province ______ Zip___________ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name____ Policy/Group #:______________________________________ Effective Date:______________________ Name of Insured: ______________________________________ ID #:_____________________________
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name____ Policy/Group #:______________________________________ Effective Date:______________________ Name of Insured: ______________________________________ ID #:_____________________________
AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u>? ☐ Yes ☐ No** Your Initials:__________ Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician________________________ Person to contact in emergency (Name and Phone #)____ Attorney____ Telephone:____________________ Address____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and Provincial Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** I'm asking for medical services from Dr. Remi Nader and partners. I understand the implications of this request. I become financially responsible for all expenses that will result. A check may be made to ascertain whether the insurance policy cover my treatment (if applicable). I understand that this is not guaranteed. I acknowledge that I am personally responsible for ensuring the required funding. I give permission hereby to the offices associated with Dr. Remi Nader to be reimbursed by the insurance company for all medical and surgical services performed by Dr. Remi Nader and partners (if any). I authorize my personal insurance (if any) to pay directly the offices associated with Dr. Remi Nader for medical services provided to me or to my dependent. I agree to communicate the necessary information to make the refund of insurance for me or my dependent. The patient is responsible for paying the doctor in advance, regardless of whether the insurance policy covers the costs or not. If necessary, an extension request must be previously discussed and approved by the offices associated with Dr. Remi Nader. I understand and agree to be legally responsible for all expenses and all fees that I allowed regardless of any insurance payment or benefit applicable So, I authorize the offices associated with Dr. Remi Nader to transmit any medical information necessary for claim processing as stated by law. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the offices associated with Dr. Remi Nader, to the full extent permissible under the laws, , any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the offices associated with Dr. Remi Nader to issue any medical information to proceed to the recovery of the insurance company, a third person responsible for the payment of a financial entity, a responsible for my treatment, a local, provincial or federal representative in accordance with the law, an audit of a referral or medical coverage. I have read and fully understand this agreement. ______________________________________ ______________________ Signature of Insured / Guardian Date

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PATIENT HISTORY FORM

Patient Name:______________________________________ Birthdate:___________________ Date:___________________

Height: ____________ Weight: ___________________

Reason for Office Visit (briefly explain):_______________
____
____
____

☐ Injury/Date of Injury ____________________________

☐ Illness/Date Illness Began__________________________

☐ Symptoms/Date symptoms began ________________

☐ Second Opinion/IME ____________________________

1. Pain is:

☐ in the neck ☐in the shoulder ☐in the arm/hand

☐in the back ☐in the hip ☐in the leg/foot

☐ other________________

2. How long has pain been present?__________________

3. Pain occurs with the following frequency:

☐ occasionally ☐ on and off ☐ all the time

☐ throughout the day ☐ at night ☐ no difference

4. Each episode of pain usually lasts: ___________

☐ seconds ☐ minutes ☐ hours ☐ days ☐ weeks

5. Are you: Right Handed_____ Left Handed _____
Use both Equally______

6. Pain feels like:

☐a dull aching ☐sharp ☐stabbing ☐burning ☐cramping

Pain location: ☐ middle of low back

☐ to Left ☐ to Right

☐ across buttock / back

7. Intensity of pain (scale of 1-10: 1 –2 –3 –4 –5 –6 –7 – 8 – 9 – 10)

☐no pain (0) ☐mild pain (1-2)

☐moderate pain (3-4) ☐severe pain (5-6)

☐very severe pain (7-8) ☐worst possible pain (9-10)

8. Pain in the neck compared with arm is:

☐ worse in the neck ☐same ☐less in the neck

Pain in the back compared with leg is :

☐ worse in the back ☐ same ☐less in the back

9. Mark the body position and /or activities that make pain better or worse:

a.	Sitting	☐ better	☐ worse
b.	Standing	☐ better	☐ worse
c.	Walking	☐ better	☐ worse
d.	Laying Down	☐ better	☐ worse
e.	At night, pain is	☐ better	☐ worse
f.	Coughing, Sneezing	☐ better	☐ worse
g.	Straining only	☐ better	☐ worse
h.	Movement	☐ better	☐ worse
i.	During the day pain is	☐ better	☐ worse
j.	No activity	☐ better	☐ worse

10. Any urinary or fecal incontinence? ☐ NO ☐ YES

11. Do you have foot drop or paralysis? ☐ NO ☐ YES

12. Previous tests done: Where/ when ?

☐MRI____

☐CT Scan ____________________________________

☐Myelogram _________ ☐EMG/NCV ___________

☐Discogram ___________ ☐Bone Scan __________

13. Treatment done so far:

☐bed rest ☐pain pills ☐muscle relaxants

☐anti-inflammatory non-steroidals ☐ TENS unit

☐chiropractic ☐physical thereapy ☐epidural blocks

☐Other injections (trigger point) ☐Back/ neck brace

☐decompression of nerve ☐removal of disc

☐spinal fusion

14. Previous treatments have been:

☐unsuccessful ☐partially successful ☐very successful

15. Is current condition:

related to an accident ? ☐ yes ☐no

Covered under Workmen's Compensation? ☐ yes ☐no

related to an injury on the job? ☐yes ☐no

Under litigation? ☐yes ☐no

If yes, Name of
Attorney____________________________________
Phone#______________________________________
Date of injury or accident_______________________

PATIENT HISTORY FORM

Patient Name:____________________________________ Birthdate:___________________ Date:___________________

MEDICATIONS:
List all medication you are now taking & what they are for:
____
____
____
____
____
____
____
____
____
____

ALLERGIES:
List all medications you are allergic to and the reaction you have:_______________________________________
____
____

PAST HOSPITALIZATION / SURGICAL HISTORY:
Check any previous SPINAL surgeries and indicate the date(s) when they occured:
☐ NONE ☐ Thoracic ____________________________
☐ Lumbar ____________________________________
☐ Cervical ___________________________________
Check all OTHER surgeries: ☐ NONE ☐ appendectomy
☐ cardiac surgery ☐ tonsil / adenoidectomy
☐ wisdom teeth removal ☐ gall bladder surgery
☐ other orthopedic surgery ☐ thyroid surgery
☐ breast surgery ☐ hernia repair ☐ Cesarean section
☐ Other ____________________________________

PERSONAL MEDICAL HISTORY
Do you have a history of medical problems or surgery of the following (please explain)?

	NO	YES	
Eyes	☐	☐	__________
Ears	☐	☐	__________
Skin	☐	☐	__________
Heart	☐	☐	__________
Circulation/Blood flow	☐	☐	__________
Lungs/Asthma	☐	☐	__________
Stomach	☐	☐	__________
Bowels/Intestines	☐	☐	__________
Kidneys	☐	☐	__________
Uterus/Prostate	☐	☐	__________
Depression/Mental problems	☐	☐	__________
Arthritis/Joints	☐	☐	__________
Blood clots/other problems	☐	☐	__________
High blood pressure	☐	☐	__________
Diabetes	☐	☐	__________
Cancer	☐	☐	__________
Brain seizures/Epilepsy	☐	☐	__________
Headaches/Migraines	☐	☐	__________
Dizziness/Fainting	☐	☐	__________
Hepatitis	☐	☐	__________

Other personal medical problems:
____
____

REVIEW OF SYSTEMS:
check items that applies to you:
Musculoskeletal / Joints: ☐ Muscular disease ☐ Arthritis
Neurological: ☐ Headaches ☐ Seizures ☐ Strokes
Metabolic: ☐ Diabetes ☐ Thyroid problems
Bleeding Disorders: ☐ Anemia ☐ Clots
☐ Bleeding problems
Urinary: ☐ Blood in Urine ☐ Frequent Urination
☐ Trouble Starting Urination
☐ Trouble Stopping Urination ☐ Pain with Urination
☐ Prostate Disease ☐ Kidney Disease
Respiratory: ☐ Asthma ☐ Bronchitis ☐ COPD
☐ Emphysema ☐ Pneumonia ☐ Tuberculosis
Cardiovascular: ☐ Chest Pain ☐ Mitral Valve Prolapse
☐ Irregular Heartbeats ☐ High Blood Pressure
☐ Shortness of Breath
Reproductive: ☐ Infections ☐ Herpes
☐ Venereal Disease
Gastrointestinal: ☐ Stomach Ulcers
☐ Gallbladder Problems ☐ Pancreatitis
☐ Colitis ☐ Blood in Stool ☐ Hiatal Hernia
☐ Liver Disease ☐ Constipation ☐ Loss of Bowel Control
☐ Hepatitis ☐ Jaundice
Cancer: ☐ Lung ☐ Breast / Colon / Intestinal ☐ Stomach
☐ Prostate ☐ Skin ☐ Kidney ☐ Bone
☐ Other Malignancy ___________________________
Immunological Diseases: ☐ HIV Infection / AIDS

Women only: ☐ Endometriosis
Are you on the Pill? ☐ NO ☐ YES
Are you pregnant now? ☐ NO ☐ YES : due date: _______
How long ago was your last complete physical?
_____ yrs _____months
Were there any abnormal findings? ☐ NO ☐ Yes, describe: ________________________________

LIFESTYLE
Do you smoke NOW? ☐ No ☐ Yes:
Packs per day: __________ for __________ years
Did you smoke in the Past? ☐ No ☐ Yes:
Packs per day: __________ for __________ years
Do you drink alcoholic beverages? ☐ No ☐ Yes:
Drinks per week: ________ for __________ years
Do you have a history of drug abuse? ☐ No ☐ Yes:
Please describe: ______________________________
____

SOCIAL HISTORY:
Patient's Marital Status: ☐ Married ☐ Living common-law
☐ Widowed ☐ Divorced ☐ Separated ☐ Single
Number of children: ________
Hobbies: ____________________________________
Spouse Occupation: ___________________________

PATIENT HISTORY FORM

Patient Name:_________________________________ Birthdate:_________________ Date:_________________

FAMILY HISTORY:
Please check any of the problems immediate family have had and indicate the family member:
☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease
☐ Neck Pain ☐ Back pain ☐ Low Blood Pressure
☐ Kidney disease ☐ Depression/mental problems
☐ Alzheimer /Memory loss ☐ Vascular Disease
☐ Stroke/brain tumor/aneurysm
☐ Lung problems ☐ Parkinson's ☐ Multiple Sclerosis
☐ Cancer:___________________________________
OTHER______________________________________

Is there any reason you cannot receive blood or blood product: ☐ no ☐ yes: ________________________

OCCUPATIONAL HISTORY:
Occupation: ________________________________
Employer: __________________________________
When did this employer hire you? ________________
Presently Working? ☐ Yes ☐ No
How long off work? ____________________________

Does your job require you to perform the following activities:
☐ Lift ________ kg / lb
☐ Sit ☐ Stand
☐ Lift over head ☐ Reach over head
☐ Use a computer
☐ Bend
☐ Drive a truck or a forklift

If you are married, does your spouse work?
☐ YES ☐ NO
If no, how long has he/she been off work? ___________

ADDITIONAL PATIENT INFORMATION:
(Provide additional explanation of any response on this form in the space below)

I certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

X ____________________________________ ___________ ____________________________________
Signature of Patient or Personal Representative Date Verified by Physician/Nurse/ Medical assistant

X____________________________________ ___________ ____
Signature of Patient or Personal Representative Date Name (& Description of Personal Representative Authority if applicable)

AUTHORIZATION FOR USE & DISCLOSURE OF INFORMATION/ CONSENT TO PUBLICATION/PHOTOGRAPHY

I authorize Dr. Remi Nader, M.D., and partners to take photographs or videos of myself/ my surgery or the below named patient or to use information contained in my medical record such as history and physical, progress notes, consultations, operative reports, laboratory and pathology reports, radiological images and reports, other hospital and clinic documents for the purpose of medical publication and studies. I understand that the information mentioned above, could be used under these conditions

I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply for information that has already been released. I understand that this authorization is voluntary and I can refuse to sign this authorization. I fully and completely release Dr. Remi Nader, M.D., and partners from any claims or liabilities arising from the use of this information. I also understand that the information gathered will be the property of Dr. Remi Nader, M.D., and partners. I understand that disclosure of this information carries with it the potential of unauthorized redisclosure and the information may not be protected by federal and provincial confidentiality rules.

X____ _______________
Signature of Patient or Personal Representative Date