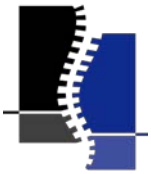
Submit by Email | Print Form



Metro Spine & Rehab, P.A.
Phone: 913.387.2800 Fax: 913.387.2970
New Patient Registration

Dr. Joseph Galate

SS#: _____ Date of Birth: _____ Marital Status: ○ S ○ M ○ D ○ W

Patients Name: _____ Referred by: _____ Phone: _____
NPI: _____

Patients Address: _____

Home Phone Number: _____ Work Phone Number: _____

Email Address: _____ Cell Phone Number: _____

Is this a work comp injury? ○ **Yes** ○ **No** **If Yes:** ○ **KS** ○ **MO** **Other:** _____
Is this a MVA? ○ **Yes** ○ **No** **MEDS:** ○ **Yes** ○ **No**

P: _____
If yes, who is the work comp adjuster/MVA lawyer? _____ **F:** _____

Is there a Nurse Case Manager assigned? If Yes, Name: _____ P: _____
F: _____

WHO DO WE CALL FOR TREATMENT AUTHORIZATION? _____

Claim#: _____ **Date of injury/accident:** _____

Work Comp Billing Company: _____

Address & Phone Number: _____

○ **Exam only** ○ **Exam and Treat** ○ **Second Opinion** ○ **IME** ○ **EMG Only**

Employer: _____ Phone: _____

Insurance: _____ Ins. Phone: _____

Insurance Address: _____

Subscriber's name: _____ DOB: _____ ID#:_____

Group Number: _____ Group Name: _____ _____

Request for Consult by: ○ Physician ○ Insurance ○ Adjustor/Case Mgr. ○ Other: _____

Name of person requesting consult: _____

Reason for Consult: ○ **Neck** ○ **Shoulder** ○ **Arm** ○ **Hand** ○ **Back** ○ **Leg** ○ **Other:** _____

How long has patient had pain? _____ Has the patient had surgery? _____

Symptoms? _____

Has patient had MRI? ○ Yes ○ No What studies have been done? _____

Appt Date: _____ Info taken on: _____ By whom: _____ Packet mailed: _____

CC: _____ CC: _____

CC: _____ CC: _____