



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

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