NEUROSURGERY **Remi Nader, MD**

CP 26038, BP Salaberry, Montréal, QC, H3M 3E8

REGISTRATION

DATE: _____

Patient: Last Name _____ First Name _____ Initials _____
Home Phone _____ Work Phone _____ Email _____
Street Address _____
City _____ Province _____ Postal Code _____
Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security # _____ Driver's License # _____
Insured Name _____ How and where did you learn about this clinic? _____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

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 requesting medical services from Dr. Remi Nader and his associates. I understand the implications of this request. I acknowledge that I am financially responsible for all expenses that will result thereof. A verification may be made to ascertain whether the insurance policy covers my treatment (if applicable). I understand that this is not guaranteed. I acknowledge that I am personally responsible for covering the required expenses of this treatment. 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 applicable). I authorize my personal insurance (if applicable) to pay directly Dr. Remi Nader and his associates for medical services provided to me or to my dependent. I agree to communicate the necessary information to make the refund from the insurance carrier for me or my dependent (if applicable). The patient is responsible for paying the doctor in advance, regardless of whether the insurance policy covers the costs of the care provided. 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 are incurred with the care provided by Dr. Remi Nader and his associates regardless of any insurance payment or benefit applicable Therefore, I authorize Dr. Remi Nader and his associates 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

Remi Nader, M.D.

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PATIENT HISTORY FORM

Patient Name:_____ Date:_____ Birthdate:_____

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_____

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PATIENT HISTORY FORM

Patient Name:_____ Date:_____ Birthdate:_____

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: _____

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PATIENT HISTORY FORM

Patient Name:_____ Date:_____ Birthdate:_____

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

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

I authorize Dr. Remi Nader, M.D., and associates 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 (**patient identifications will be kept confidential**). 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 associates. 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