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You may print and complete these forms, or complete the forms and then print and sign..

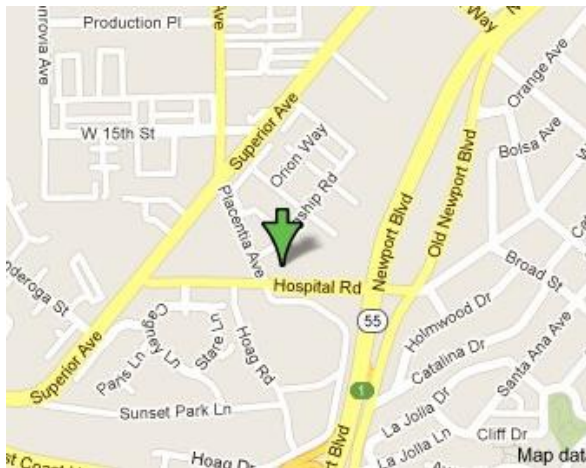
To allow a thorough review please be sure you have included:

A copy of your insurance card, front and back.

A copy of your **Imaging or Diagnostic Reports**

A copy of any other medical records you may have.

Please **BRING ALL FILMS/CDs** with you for your appointment. Thank you for your patience.



Office Location (map):  
ONE Brain & Spine Center  
361 Hospital Rd Suite 224  
Newport Beach, CA 92663  
Phone: (949) 383-4190

Please fax this document to **(949) 612-7296**  
or scan and email to [info@onebsc.com](mailto:info@onebsc.com)

Thank You.

**ONE Brain & Spine Center**  
361 Hospital Rd Suite 224, Newport Beach CA 92663  
949-383-4190 phone / 949-612-7296 fax  
[www.onebrainandspinecenter.com](http://www.onebrainandspinecenter.com)

# PRELIMINARY PATIENT APPOINTMENT/HISTORY/REGISTRATION SHEET

Physician: **Todd Peters, MD**

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
LAST FIRST

HOME ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

HOME PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_ FAX#: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
WORK PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
CELL PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_ EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_

SEX:  MALE  FEMALE

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
NAME RELATION

## PHYSICIAN INFORMATION

### REFERRING PHYSICIAN

PHYSICIAN NAME: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_  
LAST FIRST

PHYSICIAN ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_ \*FAX: (\_\_\_\_)\_\_\_\_-\_\_\_\_

### INTERNIST/PRIMARY CARE PHYSICIAN

PHYSICIAN NAME: \_\_\_\_\_  
LAST FIRST

PHYSICIAN ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_ \*FAX: (\_\_\_\_)\_\_\_\_-\_\_\_\_

### OTHER PHYSICIAN

PHYSICIAN NAME: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_  
LAST FIRST

PHYSICIAN ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_ \*FAX: (\_\_\_\_)\_\_\_\_-\_\_\_\_

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**10. PAST MEDICAL HISTORY: (PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD):**

- |                    |                            |                      |
|--------------------|----------------------------|----------------------|
| HYPTERTENSION      | HIGH CHOLESTEROL           | ASTHMA               |
| DIABETES           | DRUG/ALCOHOL ABUSE         | GOUT                 |
| HEART DISEASE      | BLEEDING/CLOTTING DISORDER | HIV                  |
| ATRIAL FIBRILATION | CANCER (TYPE: _____)       | DEMENTIA             |
| STROKE             | HEPATITIS                  | CHRONIC INFECTIONS   |
| SEIZURES           | RADIATION/CHEMOTHERAPY     | RESPIRATORY PROBLEMS |
| MULTIPLE SCLEROSIS | DEPRESSION OR              | PARKINSON'S DISEASE  |
| ULCERS             | PSYCHOLOGICAL PROBLEMS     |                      |

**11. PLEASE LIST ALL CURRENT MEDICAL PROBLEMS/CONDITIONS NOT LISTED: \_\_\_\_\_**

\_\_\_\_\_

**12. ALLERGIES: PLEASE LIST ALL DRUG OR FOOD ALLERGIES AND REACTION TO EACH: \_\_\_\_\_**

\_\_\_\_\_

**13. PLEASE LIST ANY OTHER PRIOR SURGERIES AND DATES: \_\_\_\_\_**

\_\_\_\_\_

**14. FAMILY MEDICAL HISTORY:**

a. PLEASE DESCRIBE ANY FAMILY HISTORY OF SPINE PROBLEMS: \_\_\_\_\_

b. PLEASE DESCRIBE FAMILY HISTORY OF OTHER MEDICAL PROBLEMS : \_\_\_\_\_

\_\_\_\_\_

**15. SOCIAL HISTORY:**

a. DO YOU USE TOBACCO/SMOKE? \_\_\_\_\_ IF SO, HOW MUCH OR LIST DATE YOU QUIT: \_\_\_\_\_

b. ALCOHOL INTAKE? \_\_\_\_\_ PLEASE LIST AMOUNT/FREQUENCY/TYPE: \_\_\_\_\_

c. DESCRIBE PHYSICAL ACTIVITY/EXERCISE TYPE AND FREQUENCY: \_\_\_\_\_

\_\_\_\_\_

d. VACCINES: WHICH HAVE YOU RECEIVED? INFLUENZA (YES/NO)? \_\_\_\_\_ PNEUMONIA (YEST/NO)? \_\_\_\_\_

**16. HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY):**

- |                      |                     |                      |                 |
|----------------------|---------------------|----------------------|-----------------|
| FATIGUE              | SHORTNESS OF BREATH | URINARY INCONTINENCE | DEPRESSION      |
| FEVER                | CHEST PAIN          | WEAKNESS             | ANXIETY         |
| HEADACHE             | CONSTIPATION        | RASH                 | SUBSTANCE ABUSE |
| SLEEP DISTURBANCE    | DIARRHEA            | TINGLING/NUMBNESS    | ALCOHOL ABUSE   |
| ITCHING              | NAUSEA              | MEMORY LOSS          | STRESS          |
| BLURRED VISION       | HEARTBURN           | SEIZURES             | NERVOUSNESS     |
| HOT/COLD INTOLERANCE | VOMITING            | BALANCE DIFFICULTY   | MENTAL ILLNESS  |

OTHER (PLEASE DESCRIBE): \_\_\_\_\_

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17. MEDICATIONS: PLEASE LIST ALL MEDICATIONS AND VITAMINS YOU ARE CURRENTLY TAKING AND THE DAILY DOSAGE :

MEDICATION	DOSAGE	FREQUENCY

## PATIENT CONSENT AND AUTHORIZATION

1. **Consent to Treatment.** I hereby authorize {INSERT NAME}., through its physicians and health care staff, to provide medical services to me, and I hereby consent to the performance of laboratory tests, diagnostic procedures, and other medical treatment as discussed with my health care provider. I also authorize {INSERT NAME}., to obtain outside medical and medication histories.
  
2. **Release of Information.** I hereby authorize {INSERT NAME}., to release and disclose all or any portion of my patient records to any person or entity which is or may be responsible for all or part of the charges for services rendered to me (including, but not limited to, insurers, employers and health care service plans) for the purposes of obtaining payment. I also authorize the release of patient information to other health care providers for purposes of diagnosis or treatment, and as may be required by law.
  
3. **Assignment of Benefits.** I hereby assign to {INSERT NAME}., and authorize payment directly to it of any and all health insurance or health plan benefits otherwise payable on my behalf or to me for services rendered. I understand and agree that I am financially responsible for any charges not paid by insurance benefits or otherwise not covered by this assignment and agree to pay the full cost of all such charges for services rendered.
  
4. **Health Care Service Plan Obligation.** I understand that {INSERT NAME}., participates on the panels of various health care service plans with which it contracts. If services rendered are found to be noncovered by a contracted health care service plan, or if I am not eligible to receive services by a contracted health care service plan, I agree to be individually obligated to pay the full cost of the services rendered to me by {INSERT NAME}.,
  
5. **Financial Agreement.** I hereby agree that I am individually obligated to pay all charges for services rendered to me that are not paid by insurance benefits or covered by a health care service plan (including, but not limited to, coinsurance, copayments and deductibles). I accept full financial responsibility for all such charges billed and guarantee to pay all such charges. All accounts are due and payable upon presentation of a statement. I understand that if any bill remains unpaid thirty (30) days after the statement date, interest will accrue at a rate of one percent (1%) per month on the unpaid balance. In the event that my account must be placed with an attorney or collection agency to obtain payment, I further agree to pay all reasonable fees and collection expenses. I also agree that if my insurance plan pays my benefits directly to me, I will immediately send a check in the amount of the benefits paid to {INSERT NAME}.,

I hereby certify that I have read, understand and accept the above terms and conditions.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

If patient is a minor or unable to consent

\_\_\_\_\_  
Name of Legal Representative

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

Witness: \_\_\_\_\_ Date: \_\_\_\_\_