BRUCE CHOZICK, M.D.,P.C. NEUROSURGEON
MICHELLE SAVARESE PA-C

Patient Information

Last name: First name: Middle initial:

Mailing Address:

City: State: Zip: Social Security #:

Home Phone ( ) Cell Phone ( ) DOB:

Email:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Family Physician:

Referring Provider:

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Self-employed ☐ Unemployed ☐ Other

Employer Name: Work Phone ( )

Emergency Contact ( ) Relationship: ☐ Cell ☐ Home ☐ Work

Insurance Information

Responsible Party (check one) ☐ Self ☐ Other _____

Primary Insurance: ID/Policy #:

Subscriber Name: ☐ Self ☐ Spouse ☐ Parent Subscriber Employer:

Subscriber SS # DOB: Group #:

Secondary Insurance: ID/Policy #:

Subscriber Name: ☐ Self ☐ Spouse ☐ Parent Subscriber Employer:

Subscriber SS #: DOB: Group #:

Accident Information

Workers Compensation Claims:

Workers Comp. Carrier:

Address/Phone:

Claim #: Date of Injury: Referring Medical Provider:

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Patient Name: Date:

Medical Conditions: (Check all that apply to you):

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Psychiatric Illness ☐ Stroke

☐ Skin Disorder ☐ Other _____

Surgeries:

☐ Appendectomy ☐ Cardiovascular Procedure ☐ Cervical Spine ☐ Hysterectomy ☐ Prostate

☐ Joint Replacement ☐ Lumbar Spine ☐ Thoracic Spine ☐ Gall Bladder ☐ Carpal Tunnel ☐ Brain

☐ Shoulder ☐ Knee ☐ Gastro-intestinal ☐ Uro-genital ☐ Hernia ☐ Other:_____

Allergies:

☐ Eggs ☐ Fish and Shellfish ☐ Peanuts ☐ Other:_____

Social History:

Caffeine Use: ☐ occasional ☐ often ☐ never

Drink Alcohol: ☐ occasional ☐ often ☐ never

Exercise: ☐ occasional ☐ often ☐ never

Recreational Drug Use: ☐ occasional ☐ often ☐ never

Chew Tobacco: ☐ occasional ☐ often ☐ never

Cigarettes: ☐ occasional ☐ often ☐ never

Wear Seat Belts: ☐ occasional ☐ often ☐ never

Other:_____

Family History:

Arthritis: ☐ Parent ☐ Sibling

Cancer: ☐ Parent ☐ Sibling

Diabetes: ☐ Parent ☐ Sibling

Heart Disease: ☐ Parent ☐ Sibling

Hypertension: ☐ Parent ☐ Sibling

Stroke: ☐ Parent ☐ Sibling

Thyroid: ☐ Parent ☐ Sibling

Other:_____

Please Describe Your Occupation:_____

Doctor's Signature:_____

Symptom Chart

Name: _____ **Date:** _____

What is your current weight: _____ lbs. Height: _____ Feet _____ Inches.

ABOUT YOU:

Please describe your present condition as you understand it:

_____

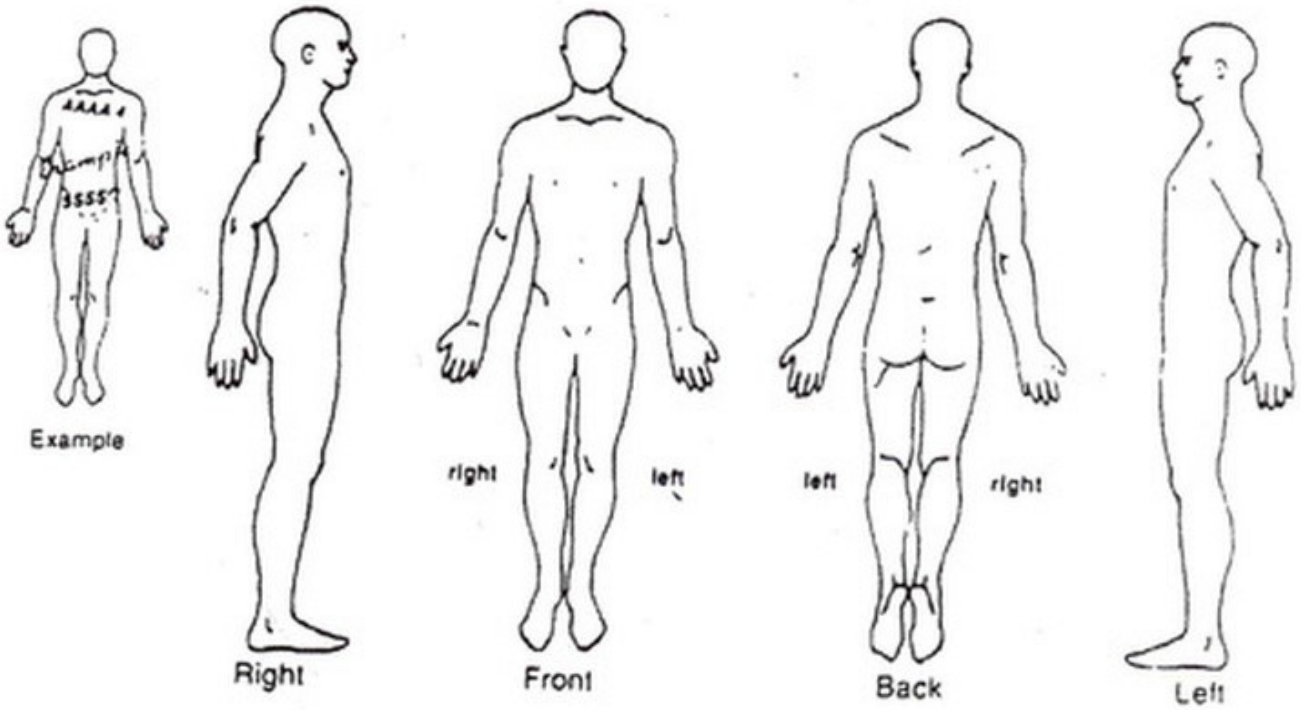
_____

Signature: _____ **Date:** _____

SHOW US WHERE IT HURTS:

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with appropriate symbols and indicate the degree of pain **using a scale from 1 (discomfort) to 10 (extreme pain)**

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	**NNNN**	**PPPP**	**BBBB**	**AAAA**	**SSSS**



Please tell us <u>when</u> and <u>how often</u> these symptoms happen:

_____

_____

How long has this been going on? _____

Describe how your movements or activities are presently affected:

_____

_____