SPINE CENTER
OF MIAMI
JOHN C. NORDT, III, M.D.
4720 LeJeune Road • Coral Gables, FL 33146
Tel: (305) 662-2851 • Fax: (305) 662-2532

PT NUMBER ______________
DATE ______________

PATIENT REGISTRATION

LAST NAME: ______________ FIRST: ______________ M.I. ______

**IF PATIENT IS A MINOR, RESPONSIBLE PARTY IS: ______________

D.O.B.: ___/___/___ SEX (M/F): ___ SSN: __________ *RACE: __________ ETHNICITY: __________

STREET ADDRESS: ______________ CITY: ______________ STATE: ____ ZIP: ______

HOME PHONE: __________ CELL: __________ WORK: __________ EMAIL: __________

NAME OF EMPLOYER/SCHOOL: ______________

PRIMARY CARE PHYSICIAN: ______________ ADDRESS: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE: (NAME) ______________ ID#: ______________

SUBSCRIBER: Y☐ / N☐ **IF NO — PLEASE PROVIDE INFORMATION BELOW:

NAME OF POLICY HOLDER: ______________ D.O.B.: ___/___/___ SEX (M/F): ______

ADDRESS: ______________

SSN: ______________ RELATIONSHIP TO POLICY HOLDER: ______________

SECONDARY INSURANCE: (NAME) ______________ ID#: ______________

SUBSCRIBER: Y☐ / N☐ **IF NO — PLEASE PROVIDE INFORMATION BELOW:

NAME OF POLICY HOLDER: ______________ D.O.B.: ___/___/___ SEX (M/F): ______

ADDRESS: ______________

SSN: ______________ RELATIONSHIP TO POLICY HOLDER: ______________

IS THIS RELATED TO: WORKERS' COMP? Y☐ / N☐ AUTO? Y☐ / N☐

IF ACCIDENT RELATED – PLEASE PROVIDE INFORMATION BELOW

☐ WORKERS' COMP ☐ AUTO — INJURY TO WHAT BODY PART? ______________

DATE OF INJURY: ___/___/___ WORKERS' COMP/AUTO CLAIM NUMBER: ______________

ADJUSTER: ______________ PHONE: ______________ FAX: ______________

WORKERS COMP /AUTO/OTHER INSURANCE CARRIER: ______________

BILLING ADDRESS: ______________ CITY, STATE, ZIP ______________

ATTORNEY INFORMATION

NAME OF ATTORNEY: ______________

ADDRESS: ______________ PHONE #: ______________

CITY, STATE, ZIP ______________

***This information is now a federal mandate.**

(continued on back ...)

SPINE CENTER OF MIAMI

JOHN C. NORDT, III, M.D.

4720 LeJeune Road • Coral Gables, FL 33146
Tel: (305) 662-2851 • Fax: (305) 662-2532

HISTORY AND PHYSICAL EXAMINATION

Date ______________________ Acct # ______________________
Patient's Name ______________________ Date of Birth ____/____/____
Primary Care Doctor ______________________ Referral Doctor (if different) ______________________
Reason for Visit *(Chief Complaint)* ______________________

Date of first symptoms ____/____/____ ☐ MVA ☐ Work related ______________________
Date of Injury

PAST MEDICAL HISTORY:

SURGICAL PROCEDURES: *(Include dates)*

REVIEW OF SYSTEMS: *(Check all that apply)*

Yes	No		Yes	No		Yes	No	
☐	☐	Headaches ____	☐	☐	Stomach, ulcer, intestinal problems ____	☐	☐	Anemia ____
☐	☐	Seizures ____	☐	☐	Cholesterol ____	☐	☐	Cancer ____
☐	☐	Strokes ____	☐	☐	Breathing or lung disorders ____	☐	☐	Hepatitis ____
☐	☐	Arthritis ____	☐	☐	Sleep Apnea ____	☐	☐	Phlebitis or blood clots ____
☐	☐	Nerve disorders ____	☐	☐	Use a CPAP machine ____	☐	☐	Ease of bruising ____
☐	☐	Circulation problems ____	☐	☐	Kidney/Bladder problems ____	☐	☐	Bleeding disorder ____
☐	☐	Heart trouble ____	☐	☐	Thyroid problems ____	☐	☐	Factor V Leiden ____
☐	☐	High blood pressure ____	☐	☐	Diabetes ____	☐	☐	Emotional or psychiatric difficulties ____
☐	☐	Inflammatory joint disease ____	☐	☐	Lyme Disease ____	☐	☐	Other medical problems ____
			☐	☐	HIV/Aids ____			

MEDICATION USAGE:

Med	Dose	Times/day	Med	Dose	Times/day	Med	Dose	Times/day

ALLERGIES: ☐ Latex ☐ Food *(Specify)* ______________________
☐ Iodine ☐ Drugs *(Specify)* ______________________ Reaction: ______________________

VITAL SIGNS: 1. Height ________ ft. ________ in. 2. Weight: ________ lbs.

SOCIAL HISTORY: *(Please Circle)* Single☐ Married☐ Children Yes☐ No☐
Habits: Alcohol consumption: ________ Tobacco: ________ Street drugs: ________

PERTINENT FAMILY HISTORY:
Parents/siblings/children ages and medical conditions. *(If deceased, age and cause of death)*

❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ **THANK YOU FOR COMPLETING – PLEASE STOP HERE** ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖ ❖

Temp: ____	Temp: ____	Temp: ____	Temp: ____	Temp: ____	Temp: ____
Pulse: ____	Pulse: ____	Pulse: ____	Pulse: ____	Pulse: ____	Pulse: ____
Pain Score: ____	Pain Score: ____	Pain Score: ____	Pain Score: ____	Pain Score: ____	Pain Score: ____
Resp: ____	Resp: ____	Resp: ____	Resp: ____	Resp: ____	Resp: ____
Init./date: ____	Init./date: ____	Init./date: ____	Init./date: ____	Init./date: ____	Init./date: ____
Init./date: ____	Init./date: ____	Init./date: ____	Init./date: ____	Init./date: ____	Init./date: ____

Assignment of Benefits

Patient Name: ______________________________

Insurer: ___________________________________

Claim: ____________________________________

Date of accident: ___________________________

I, the undersigned patient, by my signature below, for good and valuable consideration, including credit extended to me, hereby IRREVOCABLY ASSIGN, transfer and convey to **John C Nordt, III., M.D. AND Associates DBA Spine Center of Miami (hereinafter John C Nordt III. MD and/or assignee)**, all of my rights, title and interest in my medical benefit payer available to me to pay for medical expenses I incur in my treatment with **John C Nordt III, MD**. This Assignment of Benefits (AOB) shall include any personal injury protection (PIP), coverage related to my current situation, as well as any other Automobile Liability, **Medical Payment Insurance**, or other health Insurance benefit or Indemnification and/or agreement otherwise payable to me.

The payment to the above insured's name or any insurance covering any injuries I sustained in the above date of accident shall be directly sent to assignee or their named representative.

I further authorize John C Nordt III, MD to negotiate or demand payment, collect, bring suit and settle any claim against any insurance carrier or other third party payer with regard to these services. This AOB includes authority to request and receive from my insurer or any other party payer, and all documentation and record that I could obtain regarding the above noted accident claim, including without limitation and party's Medical Examination reports, any other records or review and reports on such records, and any information regarding to PIP payment sheets (full disclosure update) or payment log, without regard to whether such documentation has already been provided to me.

I hereby instruct said insurer that in the event the subject medical benefits are disputed or unpaid for any reason, including but not limited to any issue regarding medically reasonable treatment or medically necessary treatment, that the amount of benefits claimed by John C Nordt III, M.D. are set aside and not disbursed for any reason, including my direction to sent aside funds for any other claims, such as lost wages, until the assignee's dispute is resolved. As part od this AOB, I further instruct the insurance carrier to notify John C Nordt, III.MD immediately of any dispute as to payment so that they may exercise their legal rights. I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony third degree.

I have read this information herein and which is true to the best of my knowledge and belief. This is a direct and irrevocable assignment of my rights and benefits under my policy of insurance which shall become effective upon acceptance of John C Nordt, III.MD and by my signature below.

______________________	______________________	__________
Print Name Printed	Patient Signature	Date

I hereby accept assignment: ____

John C Nordt III, M.D. and Associates DBA Spine Center of Miami

SPINE CENTER OF MIAMI
John C. Nordt III, M.D.
And Associates, P.A.
Diplomate, American Board of Orthopedic Surgery

Surgery of the Spine
Aviation Medical Examiner

4720 LeJeune Road
Coral Gables, FL 33146
Telephone: (305)662-2851
Fax: (305)662-2532

Patient Release and Assignment

I fully understand that I am directly and fully responsible to **Dr John Nordt, III, M.D**. for all medical services rendered to me, I understand that such charges may be filed to my Insurance as a courtesy to me, and that payment is not contingent on any settlement, judgement or insurance payment which I may eventually recover said fee.

Entiendo que soy directamente responsible al **Dr John Nordt, III, MD** por todos gastos medicos servidos a mi. Entiendo que tales cargos pueden ser cobrados a mi Seguro medico.

Date: ________________ Patient Signature: ____________________________

I authorize **Dr John C Nordt, M.D**. to obtain any medical information, and I request that all copies get forwarded directly to this office.

Yo autorizo al **Dr John C Nordt, MD** a que obtenga todo mi historial medico, y pido que estos le sean enviados directamente a su oficina.

Date: ______________ Patient Signature: ____________________________

I authorize **Dr John C Nordt, MD** to release any and all information pertaining to my treatment to my insurance company or where applicable.

Yo autorizo at **Dr John C Nordt, MD** que provea informacion sobre mi tratamiento a mi compania de Seguro donde sea aplicable.

Date: _________________ Patient Signature: ____________________________

I fully understand that under Florida Law, physicians are generally required to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims. Certain part-time physicians who meet state requirements are exempt from the responsibility law. **Dr John C Nordt, MD** meets these requirements and has decided Not to Carry Medical Malpractice Insurance. This notice is provided pursuant to Florida Law.

Date: ______________________ Patient Signature: ____________________________

SPINE CENTER OF MIAMI
John C Nordt, III. M.D.
And Associates, P.A.
Diplomate, American Board of Orthopedic Surgery

OFFICE POLICIES

1. Patient agrees to provide a photo ID at the time of your initial visit. .
2. Patient agrees to inform us of any changes to your insurance, address, and or contact information at the time of check in.
3. We are not Medicaid providers. If patient's secondary insurance is Medicaid, patient will be responsible for 20% coins payment and possibly annual deductible.
4. For any questions regarding insurance benefits, contact the member services department (information located on the back of your insurance card.)
5. Patient agrees to supply proof of motor vehicle insurance, if being seen regarding to a MVA.
6. Results for tests performed outside our office (blood, X-Ray, MRI, CT scans, etc) may take up to 2 weeks. Please schedule a follow up appointment to go over your test results. Results **Will Not be discussed by telephone.**
7. If patient requires a prescription re-fill have the Pharmacy send us the request at least 72 hours in advance via fax to 305-662-2532. **DO NOT WAIT UNTIL THE LAST MINUTE OR FRIDAY AFTERNOON TO REQUEST REFILLS. Prescriptions will not be filled on weekends or holidays.**
8. There is a **$25.00 charge** and one week notice required for physician to complete forms such as: Disability, Work, Leave of Absence etc. Payment is required at the time of request.
9. The patient is responsible for bringing any test results and or films (MRI, X-rays, CTScans, Bone Scans) to the appointment. Please bring in CD's.
10. Co Payments and Deductibles are due at the time of service.
11. There is a $50.00 fee for any returned check or credit charge disputed.
12. Patient is directly and fully responsible for all medical services rendered. Charges may be filed to patient's insurance as a courtesy. Payment owed is not contingent on any settlement, judgement, or insurance payment recovered.
13. Patient will be charged **$30.00** for missed appointments. Missed appointments are those not cancelled 24 hours prior to scheduled appointments. Appointment cancellations must be called in during regular business hours (Monday-Friday 9:00 am to 5:00 pm.)

I have read and agree to the above listed Office Policies:

____________________________ __________________

Patient Signature Date

SPINE CENTER OF MIAMI
John C. Nordt III, M.D.
And Associates, P.A.
Diplomate, American Board of Orthopedic Surgery

Surgery of the Spine
Aviation Medical Examiner

4720 LeJeune Road
Coral Gables, FL 33146
Telephone: (305)662-2851
Fax: (305)662-2532

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I acknowledge that I was provided with a copy of **Dr John C Nordt III** Notice of Privacy Practices, describing how my health information may be used or disclosed under the Federal Law. Provided that **Dr John C Nordt III**, continues in its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purpose and the activities permitted under the federal privacy law, which are described in the Notice of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling **305-662-2851**, by accessing the office's website, or by requesting one at the office.

______________________	______________________
Patient Name	Date
______________________	______________________
Signature of Patient or Personal Rep	If personal Representative/ State relationship