Inspired Spine 1601 Hwy 13 East, Suite 211 Burnsville, MN 55337
Office (952) 405-9760 · Fax 855.430.6952

Tristate Brain and Spine 6600 Hwy 29 S, Alexandria, MN 56308
Office (320)763-8888 · Fax 844.251.7722

NEW PATIENT REGISTRATION

PATIENT INFORMATION				
Name:		Social Security Number:		Medical Record #:
Birthdate:	Provider: Dr. Abbasi Dr. Kim			
Current Address:	CITY	STATE		ZIPCODE
Is this address a skilled nursing facility, assisted living, or group home?: ☐ YES ☐ NO				
Preferred Method of Contact (circle one): HOME CELL WORK				
Home Phone:	Cell Phone:	Work Phone:		
Email:				
Race: ☐ American Indian ☐ African American ☐ White ☐ Other: _____		Ethnicity: ☐ Hispanic ☐ Non-Hispanic		
Sex: ☐ Male ☐ Female		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		
Emergency Contact:		Phone Number:		
PRIMARY CARE PROVIDER: Clinic:		Provider:		
How did you first hear about us? ☐ Provider Referral: _____		☐ Billboard ☐ Internet (Website, Google, etc.)		☐ TV/Radio ☐ Other: _____

INSURANCE INFORMATION Copies of Insurance Card(s) and Photo ID will be obtained at check in ***COPAYS ARE DUE AT THE TIME OF CHECK IN***	
Primary Insurance:	ID:
Group #:	Effective Date:
Secondary Insurance:	ID:
Group #:	Effective Date:
Is this condition related to auto, liability or a workman's compensation case? ☐ YES ☐ NO **If yes, please complete the next section**	

AUTO/WORKERS COMP CLAIM INFORMATION		
Date of Injury:	Injured Body Part:	
Insurance Company:	Claim Number:	
Adjuster Name:	Adjuster Phone Number:	Adjuster Fax Number:
Do you have a Qualified Rehabilitation Consultant? ☐ YES ☐ NO If yes, QRC Name:		

MEDICAL HISTORY
Identify any of the following Diagnosis(es) that are relevant to you

GENERAL	LUNG	PSYCHOLOGICAL	NEUROLOGICAL	BLOOD
Cancer: _____	Asthma Pneumonia	Anxiety	Stroke	Anemia
Arthritis	Emphysema	Bipolar	Brain tumor	Blood Clots Previous
Lupus	Tuberculosis	Disorder	Headaches	Transfusion
Thyroid problem		Depression	Back injury	Bleeding problems
Diabetes		Schizophrenia	Neck injury	
Osteoporosis			Head injury	
Fibromyalgia			Seizure	
Carpal Tunnel			Epilepsy	
			Parkinson Disease	
			Multiple Sclerosis	

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GI	CARDIOVASCULAR	GU	Other:
Hepatitis GERD Heartburn Liver disease Colitis Ulcers	Heart Attack Hypertension High Cholesterol Atrial Fibrillation Pacemaker Carotid Disease Coronary Artery Disease	Kidney Problem Kidney Stones Urinary Tract Infection Bladder Problem Prostate Problem	

Do you currently smoke? ☐ YES ☐ NO	If yes, how many packs per day? How many years?
Are you a former smoker? ☐ YES ☐ NO	If yes, how many years smoke free?
Do you currently use smoke-less tobacco? ☐ YES ☐ NO	Former user? Years tobacco free?
Do you drink alcohol? ☐ YES ☐ NO	If yes, how many drinks per week?

IMAGING

Have you had any imaging (CT/MRI/Xray) completed related to your visit? ☐ YES ☐ NO

If yes, what area of the body was imaged? _____
Where was the imaging completed? _____

IF IMAGING AVAILABLE, IT IS NEEDED AT THE TIME OF VISIT
If we do not have imaging, we may not be able to complete the visit

MEDICATIONS

List any medications you are currently taking

Medication	Dose	Frequency

ALLERGIES

List any allergies to food, medications, latex, etc.

☐ NKA

Allergy	Type of Reaction	Severity (mild, moderate, severe)

PAST SURGICAL HISTORY

Have you ever had surgery before? ☐ YES ☐ NO
If yes, please list history below

Type of Surgery	Year Completed

REVIEW OF SYSTEMS

What are your main symptoms, and how long have you had these symptoms?

_____
_____
_____

Bowel or Bladder Incontinence? ☐ YES ☐ NO Specify: _____

Please rate your symptoms from 0 (no symptoms) to 10 (very severe):

PAIN	
NUMBNESS	
WEAKNESS	