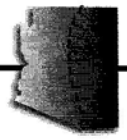
ARIZONA SPINE CENTER



ZORAN MARIC, M.D.

PATIENT REGISTRATION INFORMATION

PLEASE PRINT DATE: _____

PATIENT INFORMATION - PRINT FIRMLY AND CLEARLY ITEMS BELOW

Last Name	First	Middle	M-F

Present Address	Street	City	State	Zip	Home Phone

Permanent Address	Street	City	State	Zip

Date of Birth	Age	Soc. Sec. No.	Marital Status	Email Address

Patient's Employer	Patient's Occupation

Employer Address	Street	City	State	Zip	Emp. Phone

IF PATIENT IS MARRIED OR IS A DEPENDANT CHILD, COMPLETE ITEMS BELOW

Full Name of Spouse or Parent	Relationship	Soc. Sec. No.

Spouse or Parent's Employer	Address	City	State	Phone

Nearest Relative or Friend	Address	City	State	Phone

PATIENT PLEASE FILL IN BELOW

Referred By	Address	City	State	Phone

Date of Illness or Injury	Family Doctor	Phone

Reason for Seeing Doctor

How sustained

INSURANCE INFORMATION

Primary Insurance Co.	Address	Phone	Group/Policy No.

Name of Insured	Date of Birth	Insured's Employer	Insured's Soc. Sec. No.

Secondary Insurance Co.	Address	Phone	Group/Policy No.

Name of Insured	Date of Birth	Insured's Employer	Insured's Soc. Sec. No.

Industrial Carrier	Phone	Contact Person

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Zoran Maric, MD to release my medical information required for my treatment and for the processing of my insurance claims.
AUTHORIZATION TO PAY: I hereby authorize payment directly to Zoran Maric, MD for medical and surgical benefits to which I am entitled. I understand that I am financially responsible for the charges not covered by this authorization.

_____
Signed Insured Person

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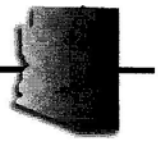

ZORAN MARIC, M.D.

(Please complete all items and print)

Date _____

Name _____ Sex _____ Age _____ Date of Birth _____

How were you referred here (physician, friend, tel, etc.) _____ Name _____

DESCRIBE WHAT BRINGS YOU HERE Include symptoms, dates, and duration if relevant.

Lawyer, if any: _____

Address _____

PAST MEDICAL HISTORY

Height _____ Weight _____ Any weight loss? Yes ☐ No ☐ How much? _____

Over what period of time have you lost weight? _____ Have you been trying to lose weight? Yes ☐ No ☐

PREVIOUS SURGERY (Please list)

Operation	Year	Complications, If any

Have you had anesthesia previously? Yes ☐ No ☐ If yes, any problems? Yes ☐ No ☐

If yes, What? _____

MEDICAL ILLNESSES

Type	Treatment, If any

PREVIOUS INJURIES (Please list)

Date	Injuries Sustained	Treatment

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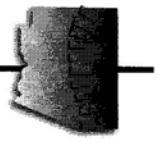

ZORAN MARIC, M.D.

Have you ever had Hepatitis? Yes ☐ No ☐ If yes, when? _____

HABITS

Do you smoke cigarettes? _____ How many per day? _____ Pipe or Cigar? _____

Do you drink alcohol? _____ How much? _____

Do you use recreational drugs? Yes ☐ No ☐ If yes, frequency _____

List all medications and dosages. Include pain relievers, aspirin, birth control pills, hormones and steroids.

_____

_____

_____

_____

_____

_____

Allergies to medications. Yes ☐ No ☐ If yes, list.

Name Type of Reaction

_____

_____

_____

_____

_____

_____

_____

SYSTEM REVIEW

Have **you** had problems with any of the following? (check, if yes)

☐ Headaches	☐ Cough	☐ Diarrhea
☐ Dizziness	☐ Chest Pain	☐ Constipation
☐ Seizures	☐ Palpitations	☐ Blood Bowel Movements
☐ Blurred/Double Vision	☐ High Blood Pressure	☐ Numbness/Tingling in Hands
☐ Glaucoma	☐ Bleeding Problems	☐ Arthritis
☐ Burning Eyes	☐ Stomach Pain	☐ Leg Pains or Cramps
☐ Nose Bleeds	☐ Stomach/Duodenal Ulcer	☐ Abnormal Scars or Keloids
☐ Sinus Problems	☐ Vomiting	☐ Skin Growths
☐ Sore Throat	☐ Liver Problems	☐ Skin Sores
☐ Hoarseness	☐ Yellow Skin	☐ Diabetes
☐ Shortness of Breath	☐ Burning when Urinating	☐ Emotional Problems/Psychiatric Care
☐ Asthma	☐ Blood in Urine	

MATERNAL HISTORY

Have you ever been pregnant? Yes ☐ No ☐ How many times? _____ Number of Children _____

Are you pregnant now? Yes ☐ No ☐ Are you planning on more children? Yes ☐ No ☐

FAMILY HISTORY

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Skin Cancer ☐ Breast Cancer

☐ Problems with anesthesia ☐ Bleeding Problems

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Name _____ Date _____

Mark the appropriate areas on your body where you feel the described sensation. Use the correct symbol.

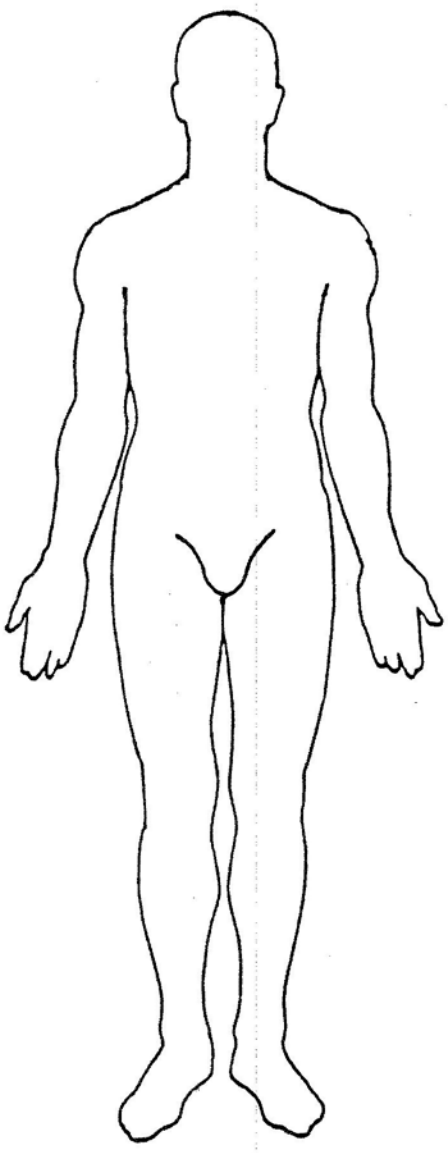
NUMBNESS: ////////
////////

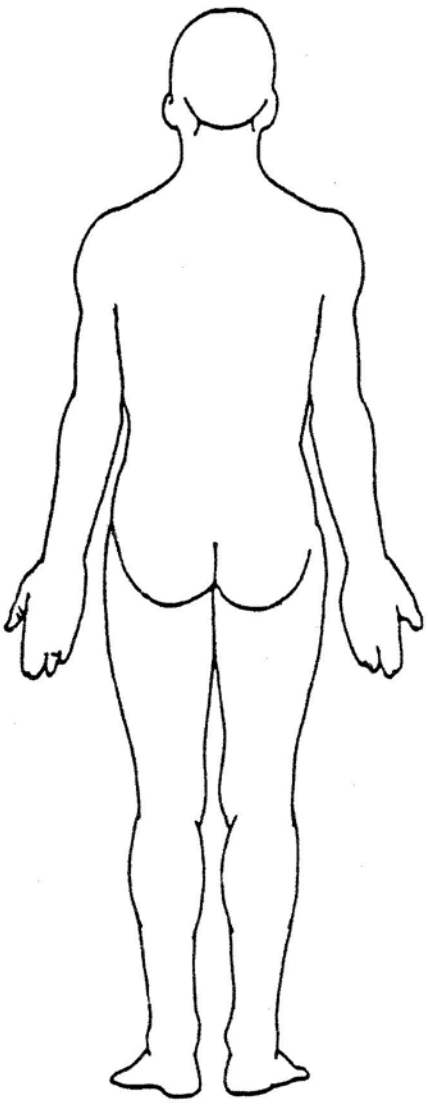
ACHE: ^ ^
^ ^

BURNING SENSATION: xxxxx
xxxxx

PINS & NEEDLES: ooooo
ooooo

STABBING SENSATION: _ _ _ _ _
_ _ _ _ _
_ _ _ _ _





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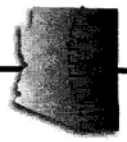

ZORAN MARIC, M.D.

FINANCIAL POLICY

PATIENT NAME: _____

We are committed to providing you with the best possible care, and we will be pleased to discuss our professional fees with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our Financial Policy or your responsibilty.

All patients must complete our patient information form before seeing the doctor for the first time. In addition to furnishing your insurance information, we will need copies of your insurance card(s) and driver's license. It is important you understand that your insurance coverage is a contract between you and your insurance company and that we are not a party to this contract. You are, therefore, ultimately responsible for the timely payment of your account, although we will help as much as possible.

As a courtesy to our patients, we will bill your primary insurance company one time; however, you are financially responsible regardless of insurance coverage. We file claims with over two-hundred insurance companies, most of which are slightly different than any other. We, therefore, depending on your insurance plan, may not bill you until after we receive payment from your insurance.

Unless you belong to a plan that has no deductible and a fixed per-visit co-pay, full payment is due at time of service for your initial office visit.

Once your coverage has been verified, normally after your first visit, you will only be required to pay the amount not being paid by your insurance. This amount will be due at the time of each visit.

If you prefer to file your own insurance, or in the few cases where your insurance company will not make payment directly to the provider, we require full payment at the time of each visit.

MEDICARE

We are a participating Medicare provider and accept assignment of Medicare's fee schedule. You are only responsible for your annual deductible plus 20% of your daily charges due at the time of service unless you have a supplemental Medicare policy. Please understand that federal law requires us to collect these payments, ignoring the laws jeopardizes Medicare benefits for all of us.

MEDICARE SUPPLEMENTS

Supplemental Medicare policies are a good way of complying with the Medicare laws. We are able to file most supplements for you and that makes everything easy, however, some companies will not pay us directly. In those cases, we appreciate your payment at the time of service.

WORKERS COMPENSATION

If you are covered under Worker's Compensation, please provide us with your employer information and the insurance information necessary for us to file for you. If your claim has been denied or closed you will be responsible for payment until your claim is accepted or reopened.

PPO / HMO PLANS

If your insurance plan is one of our contracted insurance companies (PPO or HMO), you are required, per your insurance plan, to **pay your co-payments prior to being seen** by your doctor. Once the insurance payment has been received, you will be sent a statement for any remaining balance that us your responsiblity.

AHCCCS

If you are on AHCCCS, it is your responsibility to make sure you are eligible for coverage. If at the time of your appointment you are still not elible it will be your responsibility to pay for services at the time they are rendered.

PERSONAL INJURY CLAIMS

These include auto accidents and liability claims. The patient is responsible for payment at the time of the office visit. As a courtesy we will bill your private medical insurance. We do not bill auto insurance. Under the laws of the state of Arizona, it is possible that your combined insurance policies ie; medical, auto, and liability, may reimburse you for your medical care. In litigation cases it may take several years for your case to settle, therefore, we DO NOT accept liens. If we bill your private insurance and it is one of our contracted plans, (PPO/ HMO) there may be a difference between what we bill and what the insurance company allows. When there is third party claim, most contracted plans allow us to balance bill the patient for the difference of their allowable and our charges. In these cases we will balance bill you once your insurance has paid. Payment of the balance is due and payable within 30 days.

LAB / X-RAY

If it is necessary for us to order outside laboratory tests or x-rays, you will be billed directly by the lab or x-ray facility and you are responsible for payment of that bill. If your insurance company requires that you go to a particular facility for these tests please let us know.

WE FIND THAT COMMUNICATION WITH OUR PATIENTS REGARDING OUR FINANCIAL POLICY ASSISTS US IN PROVIDING THE BEST OF SERVICE TO YOU. IF YOU HAVE SPECIAL NEEDS, PLEASE BRING THEM TO OUR ATTENTION EARLY. WE ARE HERE TO HELP YOU.

PLEASE ADVISE US IF YOUR INSURANCE COMPANY REQUIRES PRECERTIFICATION/ AUTHORIZATION FOR TESTS, X-RAYS, SURGERIES ETC.

For our mutual benefit, a copy of this form will be retained in your record.

PATIENT NAME: _____

DATE: _____

SIGNATURE OF RESPONSIBLE PARTY:

_____

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