Neurosurgical Associates, L.L.C.,
5171 Cottonwood Street, Suite 950, Murray, UT 84107
Phone: 801-507-9555 Toll Free: 866-804-2193 Fax: 801-507-9550
Email: forms@nsamd.com

Date: _____

Choose the physician you want to review: **Mark V. Reichman, MD** ☐ **Charles C. Rich, MD** ☐ **Peter H. Maughan, MD** ☐
Paul A. House, MD ☐ **Nam K. Yoon, MD** ☐ **Christopher G. Wilkerson, MD** ☐ **Next Available** ☐

Patient Name: _____ Date of Birth: _____ Age: ___
First Last

Male ☐ Female ☐ Home #: _____ Mobile or Other #: _____

Home Address: _____ City: _____ State: ___ Zip: _____

Please indicate who referred you to our office: Doctor ☐ Insurance Carrier ☐ Friend/Family ☐ Self ☐ Other ☐

Referring or Current Treating Provider: _____ Phone: _____

Primary Ins: _____ Plan: _____ ID #: _____ Group #: _____

Secondary Ins: _____ Plan: _____ ID #: _____ Group #: _____

Is this accident related? Yes ☐ No ☐ If yes, please indicate type: Auto ☐ Workers Comp ☐ Other ☐

Please provide the date of onset and current symptoms (i.e., pain, tingling, numbness?): _____

_____

_____
(If you need more room, please use back of form)

Are symptoms getting worse? Y ☐ N ☐ If Yes, how long: _____

What type of scan(s) have you had: ☐ MRI ☐ CT ☐ EMG/NCV ☐ Other

Where was your scan(s) done? _____ When: _____

Have you had prior surgery on this area? Y ☐ N ☐ If yes, who was the treating surgeon? _____

Date of surgery? _____ Type of surgery? _____

Where was it performed? _____

Why are you not returning to that surgeon for further care? _____

Patient Name:

Spine Only

Have you done formal spinal physical therapy in the last 6 -12 months? Y ☐ N ☐

Have you seen a physiatrist or pain management provider in the last 6-12 months? Y ☐ N ☐

Have you had steroid/pain injection(s) in the last 6-12 months? Y ☐ N ☐

Average of 3 months of conservative treatment tried and failed will be required for all spine related consultations. This information is required by most health insurance plans prior to scheduling surgery. Please be aware you will need to contact your current treating providers and have them fax your records to us at 801-507-9550 or you may bring them to your scheduled consultation appointment. Please do not have your records faxed until we schedule a consultation with you.

For Office Use Only: ☐ Films ☐ CD ☐ Online MRI ☐ Mailed ☐ Dropped off by: ☐ Patient ☐ Provider ☐ Other

☐ NP ☐ EP ☐ Chart # _____ Facility Network: ☐ IMC ☐ St. Mark's ☐ Park City

Patient advised out of network/check benefits? ☐ Yes ☐ No Patient advised of Referral/Authorization (if needed)? ☐ Yes ☐ No

Date Called: _____ Caller: _____

Comments: _____

_____

_____

_____

☐ I.R. ☐ S. ☐ M.R.T. ☐ P.I. ☐ C. T. Staff Name: _____