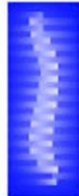


Rick B. Delamarter, M.D.
Michael A. Kropf, M.D.
Hyun W. Bae, M.D.
Alexandre Rasouli, M.D.
Timothy Davis, M.D.



THE SPINE INSTITUTE
COMPREHENSIVE SPINE CENTER - SANTA MONICA, CA

The following pages contain forms for new patients.

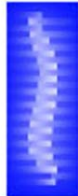
They are to be filled-out **COMPLETELY** and brought to your appointment along with **ANY** x-rays and/or scans pertaining to your spine.

Don't forget to bring your insurance card because it is required for our billing department.

Should you have any questions please feel free to contact our office. Our friendly staff will be more than happy to assist you.

Thank you in advance for your cooperation.

Rick B. Delamarter, M.D.
Michael A. Kropf, M.D.
Hyun W. Bae, M.D.
Alexandre Rasouli, M.D.
Timothy Davis, M.D.



THE SPINE INSTITUTE

COMPREHENSIVE SPINE CENTER - SANTA MONICA, CA

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (Unit Number) (City) (State)
(Zip)

Day Phone: _____ Evening Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Who is your referring or primary care physician? _____

(Name)

Would you like a copy of your visit sent to this doctor? _____

(Address)

Yes No _____

(Phone)

Occupation: _____ Employer: _____

Is this a work-related condition?: Yes No Date of injury _____

(If Yes, then skip to the top of page three.)

Primary Insurance Company: _____ Phone: _____

Name of Insured: _____ Birth Date: _____ Soc. Sec. Number: _____

Address: _____

Policy #: _____ Group # _____

Does your insurance require pre-authorization for visits to a doctor? Yes No

Secondary Insurance Company: _____ Phone: _____

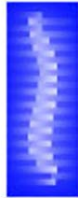
Name of Insured: _____ Soc. Sec. Number: _____

Address: _____

Policy #: _____ Group # _____

Does your insurance require pre-authorization for visits to a doctor? Yes No

Rick B. Delamarter, M.D.
Michael A. Kropf, M.D.
Hyun W. Bae, M.D.
Alexandre Rasouli, M.D.
Timothy Davis, M.D.



THE SPINE INSTITUTE
COMPREHENSIVE SPINE CENTER - SANTA MONICA, CA

Worker's Compensation Information:

Carrier: _____ Claim # _____

Claim Office Address: _____

Adjuster _____ Phone _____

Date of Injury: _____ Employer _____

Are you represented by an attorney? Yes No

Name of attorney: _____ Phone: _____

**Please read the following sections carefully.
Your signatures are required prior to seeing the physician.**

As a courtesy, we will bill your insurance company. In some cases, unless you are insured under worker's compensation, you may be responsible for up to the full amount of the charges incurred during your visit. If the doctor you are seeing is a contracted provider under your insurance plan, you may wish to discuss your financial responsibility with the member services department at your insurance company.

I understand that I may be responsible for paying for services rendered, including reasonable attorney's fees and costs incurred in the event of any default. The information that is provided on this form is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

Please consider this signature as authorization to release my confidential medical records with written release on the basis of a telephone request. I understand that it is possible for someone to misrepresent themselves by telephone and that my right to privacy may be compromised.

Signature: _____ [] Permanent [] Until _____

I hereby authorize my physician at The Spine Institute to release any information obtained in the course of my examination that my insurance company may request. I also authorize assignment of my medical benefits to my physician at The Spine Institute. This assignment of benefits allows our office to collect directly from your insurance company. Without this release, you will be required to pay for your visit at the time the services are rendered.

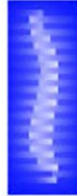
Signature: _____ Date: _____

In case of a medical emergency, whom would you like us to notify:

Name: _____ Phone: _____

444 South San Vicente, Suite 900 • Los Angeles, CA 90048 • (310) 248-7300 • Fax (310) 828-6687
2811 Wilshire Boulevard, Suite 850 • Santa Monica, CA 90403 • (310)-828-7757

Rick B. Delamarter, M.D.
Michael A. Kropf, M.D.
Hyun W. Bae, M.D.
Alexandre Rasouli, M.D.
Timothy Davis, M.D.



THE SPINE INSTITUTE
COMPREHENSIVE SPINE CENTER - SANTA MONICA, CA

Address: _____ Relationship _____

SYMPTOMS AND CONDITIONS

Name: _____

What is your main complaint? _____

What symptoms have you been having? _____

How long have you been having these symptoms? _____

Have you been seen by another Doctor for this condition? [] Yes [] No

Please describe your past treatments:

Surgery:

Type _____ Date _____

Surgeon _____

Type _____ Date _____

Surgeon _____

Physical Therapy:

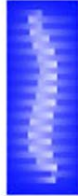
Therapist _____ Date _____

Injections:

Type _____ Date _____

444 South San Vicente, Suite 900 • Los Angeles, CA 90048 • (310) 248-7300 • Fax (310) 828-6687
2811 Wilshire Boulevard, Suite 850 • Santa Monica, CA 90403 • (310)-828-7757

Rick B. Delamarter, M.D.
Michael A. Kropf, M.D.
Hyun W. Bae, M.D.
Alexandre Rasouli, M.D.
Timothy Davis, M.D.



THE SPINE INSTITUTE

COMPREHENSIVE SPINE CENTER - SANTA MONICA, CA

Please list any medications you are currently taking for this or any other condition:

Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____

Please list any other medical conditions: _____

Please list any allergies: _____

Please list any studies you have had in the past (MRI, CAT Scans, X-Ray, etc.)

_____ Date _____
_____ Date _____
_____ Date _____

Please list any records/films you have brought with you today:

Rick B. Delamarter, M.D.
Michael A. Kropf, M.D.
Hyun W. Bae, M.D.
Alexandre Rasouli, M.D.
Timothy Davis, M.D.



THE SPINE INSTITUTE

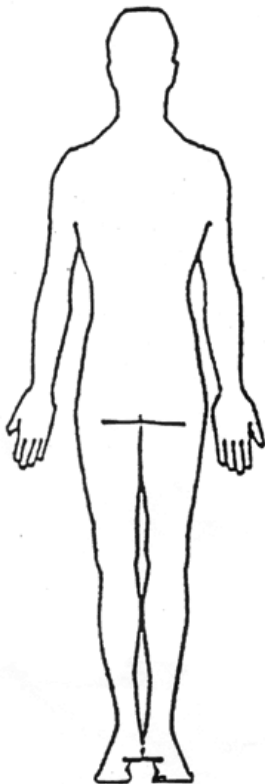
COMPREHENSIVE SPINE CENTER - SANTA MONICA, CA

Name _____ Date _____

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas.

| | | | |
|------------|----------------|----------------------|----------------|
| Ache ^ ^ ^ | Numbness o o o | Pins & Needles = = = | Stabbing / / / |
| ^ ^ ^ | o o o | = = = | / / / |
| ^ ^ ^ | o o o | = = = | / / / |



Back pain _____ %
 Neck pain _____ %
 Arm pain _____ %
 Leg pain _____ %
 Total _____ %



PLEASE MARK ON THE LINE: How bad is your pain now on a scale from 0 to 10?

0 _____ 10