Ohio Neurosurgical Institute, Inc.

Miami Valley Office (MVH)
30 E. Apple Street, Suite 6253
Dayton, Ohio 45409
(937) 208-2088
(937) 208-5143 – Fax

Please note: Locations vary by physician

☐ **First Available Physician** ☐ **MVH** ☐ **Greenville** ☐ **Piqua**

☐ Cynthia Africk, M.D. ☐ Philip Minella, M.D. ☐ Hugh Moncrief, M.D.

Patient Name: ______________________________

Date of Birth: ______________ Social Security No.: ______________

Address: ______________________________
Street *City* *Zip Code*

Home phone # ______________ Work/Cell phone # ______________

Referring Physician: ______________ **Phone #:** ______________

Contact Name: ______________ **Fax #:** ______________

NPI # ______________ **UPIN #** ______________

Diagnosis: (must be surgical) ______________________________

Films/Tests Performed (MRI, CT, EMG, etc..)	**When/Where**

(We prefer all patients recent testing and bring actual films/CD's with them unless other arrangements have been made)

Primary Insurance ______________________________

Secondary Insurance ______________________________

(We are NOT Cigna, Beechstreet Providers)

Was this a work related injury? Y / N
BWC: *(Must have an approved C9 prior to scheduling appointment)*
Date of Injury: ______________ Claim Number ______________
Allowed ICD.9's ______________ POR ______________
Was this a motor vehicle accident? Y / N
Auto Accident: *(Must have letter of protection from attorney prior to visit)*
Date of Injury: ______________ Responsible Insurance Co. ______________
Name of Attorney and/or Insurance Agent: ______________

All information must be completed in order for the patient to be scheduled. Recent test results and insurance card copies MUST be included with fax.

For Office Use Only: *Appointment Date:* ______________ *Time:* ______________ *Office:* ______________

Packet Mailed: ______________ *Previous Chart Ordered:* ______________