Endoscopic Spine Questionnaire

Physician's Name: _____ Specialty: _____

Practice Locations Name and Address			
Phone			
Facility's Contact Name:			
Facilities you anticipate to operate in:			
Policies for bringing in new products:			
Credential requirements to start a new procedure from your facility			
Contacts and phone numbers at the Facility for beginning the process:			
Rep Credentialing Organization:			

elliquence Reps's name? _____

CHECK ALL THAT APPLY

Insurances and Payment ☐ Major Med's ☐ Medicare ☐ Personal Injury ☐ Cash Pay

If personal injury was selected, what is your practice percentage? ☐ Less than 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

If cash was selected, what percentage of your practice is cash? ☐ Less than 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Procedural Experience & Volume	Yes	No	Anticipated Volume After Training Per Month ↓ PLEASE FILL IN
Injections			
Discograms			
Percutaneous Discectomy			
Disc-FX			
Endoscopic Spine			
Transforaminal			
Rhizotomy			
Laminectomies			
Spine Fusions			
Microdiscectomy			

Please Fax or email completed workshop questionnaire and registration form to: Fax: (516) 277-9001 / Email: discfx@elliquence.com