

Spine and Joint Pain Center

PATIENT INFORMATION FORM

First Name:	Last Name:	Middle Initial:	Suffix (Jr., Sr.)	Date:
Address:				
City:	State:	Zip Code:	Social Security #:	Date of Birth:
E-mail:	Cell Phone:	Home Phone:	Work Phone:	
Occupation:	Employer:	Company Name:		
Emergency Contact (First/Last Name):		Emergency Contact Phone:	Emergency Contact Relationship:	
Referring Physician:	Referring Physician Phone:	Referring Physician Address:		

INSURANCE INFORMATION

Guarantor Name:	Date of Birth:	Social Security#:	Self _____ Other (relationship) _____
Insurance Name:		Insurance Phone:	
Insurance Address:			
Insurance Policy #:		Insurance Group #:	
Signature of Insured:			Date:

SECONDARY INSURANCE INFORMATION

Guarantor Name:	Date of Birth:	Social Security#:	Self _____ Other (relationship) _____
Insurance Name:		Insurance Phone:	
Insurance Address:			
Insurance Policy #:		Insurance Group #:	
Signature of Insured:			Date:

NEW PATIENT QUESTIONNAIRE

(PLEASE BRING THIS QUESTIONNAIRE WITH YOU TO YOUR APPOINTMENT. DO NOT MAIL)

Major issue for your visit today:

- Neck Pain Lower Back Pain Shoulder Pain Hand/Wrist Pain
 Knee Pain Hip Pain Elbow Pain
 Other : _____

Tingling / Numbness : Area affected , Please indicate

Any other complaints:

How long have you had these symptoms? _____ (Months/Years)

Did your symptoms follow an injury? _____ If yes Date of accident : ___/___/___

The injury is due to : Auto Accident _____ Slip and fall _____ Work Related _____

Describe the accident in detail:

When is your pain worse (Only check one)

At night _____ In the mornings _____ At the end of the shift/day _____

No difference between day and night _____ On a wet/cloudy day _____

PAIN CHART

Circle your least and greatest pain levels over the past 2 weeks:

(0) is no pain (10) is the most severe

(None) 0--1--2--3--4--5--6--7--8--9--10 (Severe)

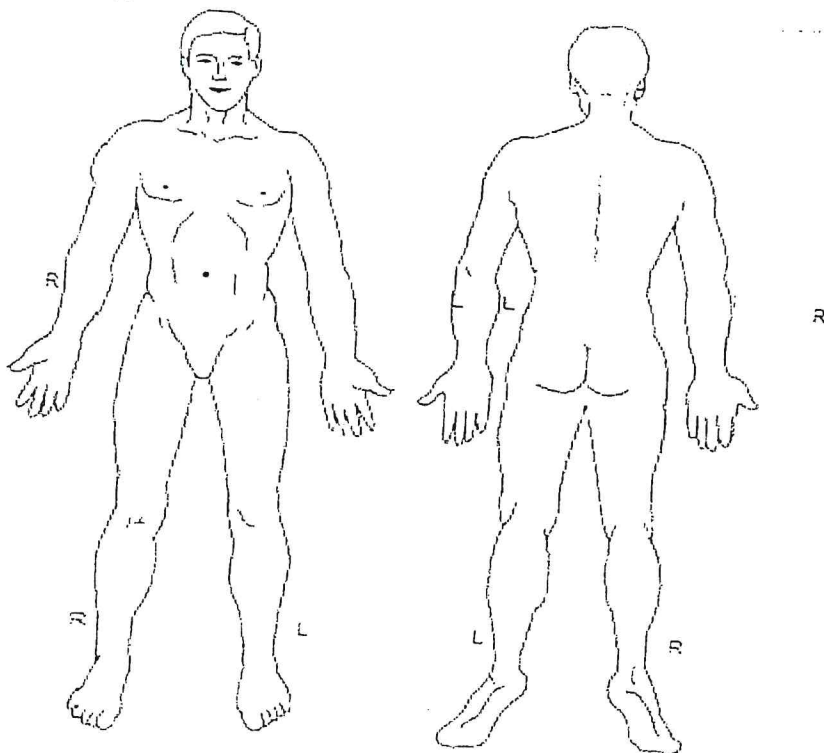
Indicate all areas of your body where you typically feel pain or numbness.

Include all affected areas. Use the appropriate symbols indicated below

PAIN = XXXXXX

NUMBNESS = OOOOOO

BURNING = ++++++



Describe your pain (check any that apply): Sharp Burning Shooting Achy Knife-like

Pressure Toothache Throbbing Dull Pulsating Numbness Tingling

Which of the following activities change the nature of your pain?

(CIRCLE the box to indicate the most aggravating and most relieving activities)

	Aggravates pain	Relieves pain	Neither
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If the symptoms of your present pain have changed, please indicate the most appropriate statement (circle one)

- a) My symptoms have remained the same since the time of onset.
- b) My symptoms are more severe since the time of onset.
- c) My symptoms are less severe since the time of onset.

PREVIOUS TREATMENT:

Put a check next to each type of treatment you have had for you back/neck in the past. Then check the column that best describes the effect of the treatment.

<u>Treatment : have had this</u>	Check if you	Did it make things		
		<u>Better</u>	<u>Worse</u>	<u>No change</u>
Antiinflammatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic pain meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pool therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Adjustments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigger point Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facet joint injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SI joint injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spine surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY:

Have you ever had (Only Mark those that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver problem | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Are you on Coumadin | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Fibromyalgia / Chronic Fatigue | <input type="checkbox"/> Phlebitis or blood clots |

If other Please specify

Have you ever had previous back or neck surgery? Y___ N___

PAST SURGICAL HISTORY; (List all Spine and Non-Spinal Surgery)

Year	Operation	Place Hospitalized

Medication : List all medication that you have taken recently.

1. _____
5. _____
2. _____
6. _____
3. _____
7. _____
4. _____
8. _____

How many months / years on pain medication:

ALLERGIES: (Check box if No Known Drug Allergies): None If Yes please indicate

Name of medicine/substance	Type of reaction	Date

FAMILY HISTORY: Circle the problems that run in your family
 (1) Spinal Problems (2) Bleeding Disorders (3) Heart Disease (4) Cancer
 (2)(5) Other _____

Family member affected : Father - Mother - Brother - Sister - Other: _____

SOCIAL HISTORY:

Who lives with you at home? _____ Are you currently Working? _____
 Your occupation: _____

Not Working? ___ Student? ___ Disabled? ___ Retired? _____

Smoking: Yes / No Amount: __ Packs per day # Years: _____ If quit, when? _____

Alcohol : Yes / No Illicit Drug Use: Yes / No Marijuana Cocaine Heroin

REVIEW OF SYSTEMS: Circle all that apply.

Constitutional
 Fever: Yes/No
 Chills: Yes/No
 Night sweats: Yes/No
 Weight loss: Yes/No
 Loss of appetite: Yes/No

Allergy/immune
 Drug allergy Yes/No
 Seasonal allergy Yes/No
 Food allergy Yes/No

Hemo-lymphatic
 Anemia Yes/No
 Excessive bleeding Yes/No
 Easy bruising Yes/No

Neurologic
 Paralysis Yes/No
 Tremors Yes/No
 Spasticity Yes/No
 Double Vision Yes/No

Musculoskeletal
 Joint stiffness/pain Yes/No
 Joint swelling Yes/No
 Muscle pain Yes/No
 Fatigue Yes/No

CV/respiratory
 Shortness of breath Yes/No
 Chest pains Yes/No
 Leg swelling Yes/No
 Palpitations Yes/No

HENT
 Loss of vision Yes/No
 Eye Redness Yes/No
 Yes/No
 Headaches Yes/No
 Dizziness Yes/No

GI
 Heartburn Yes/No
 Nausea/vomiting Yes/No

Endocrine
 Thyroid disorder
 Diabetes Yes/No

Skin/integumentary
 Rash Yes/No
 Ulcer Yes/No
 Eczema Yes/No

GU
 Pain urinating Yes/No
 Incontinence Yes/No
 Blood in urine Yes/No

Psychiatric
 Poor sleep Yes/No
 Depression Yes/No
 Anxiety Yes/No

RADIOLOGY STUDIES: (Please List and bring films with you)

	Date	Location
Spinal or Brain MRI	_____	_____
Spinal or Brain CT Scan	_____	_____
Myelogram	_____	_____
Bone Scan	_____	_____
EMG& Nerve Conduction Study	_____	_____

ASSIGNMENT OF BENEFITS

Signing this form helps ensure payment and acknowledges notification of your rights and coverage. Your healthcare services are provided by Spine and Joint Pain Center , LLC. The healthcare provider are licensed in the State of New Jersey.

I hereby assign to Spine and Joint Pain Center , LLC my right to receive reimbursement for medically necessary health care services and all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier.

I hereby authorize and direct my insurance carrier to make all such payments directly to Spine and Joint Pain Center LLC for all claims. Such payments should be forwarded by my insurance carrier directly to Spine and Joint Pain Center, LLC, at the address below, in the form of a check payable to Spine and Joint Pain Center LLC or, in alternative, a check payable to Spine and Joint Pain Center LLC and me, as joint payee.

I understand and agree that, if the check from the insurance company is made payable to Spine and Joint Pain Center, LLC and me as joint payees, that I promptly will endorse and deliver the check to Spine and Joint Pain Center LLC or will write a personal check for the full payment that is due within (1) one week of receiving payment.

I am aware that my health care provider will accept my insurance plan's out of network benefits as assigned since the provider does not participate in the plan. I will provide the entire Explanation of Benefits from my insurance carrier relating to the services provided to

Spine and Joint Pain Center, LLC
1814 E2nd street, Scotch Plains , New jersey, 07076.

My signature, below, acknowledges my accepted information above and confirms my voluntary choice to obtain services from this provider at Spine and Joint Pain Center , LLC

Name: _____

Signature: _____

Date: _____

ACKNOWLEDGEMENT FORM
NOTICE OF PRIVACY PRACTICES
THE NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used or disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information (paper and an electronic format – all forms of information);
2. The right to request corrections to your information;
3. The right to request that your information be restricted including the right to restrict the disclosure of Protected Health Information to a health plan where a patient has paid out of pocket in full for a health care item or service.
4. The right that requires the patient to specifically authorize the use of their information in a practice's third-party marketing communication in instances where the practice receives remuneration.
5. The right to request confidential communication;
6. The right to control whether they receive fundraising communications from their health care providers.
7. The right to a report of disclosures of your information; and
8. The right to a paper copy of the Notice.

We want to assure you that your Medical/Protected Health Information is secure with us. The Notice contains information about how we will insure that your information remains private.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I may request a copy of this clinic's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above on this NOTICE OF PRIVACY PRACTICES form, I further understand that the practice will offer me updated to the NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way

I _____ have received a copy of this notice.
Print your name

Date: ____/____/____

Signature _____