

# Patient Information Form

First Name:	Last Name:	Middle Initial:	Suffix (Jr., Sr., Etc.):	Date:
Address:				
City:	State:	Zip Code:	Social Security #:	Date of Birth:
E-mail Address:	Cell Phone:	Home Phone:	Work Phone:	
Occupation:	Employer:	Company Address:		
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 (Relation: _____)
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 (Relation: _____)
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)

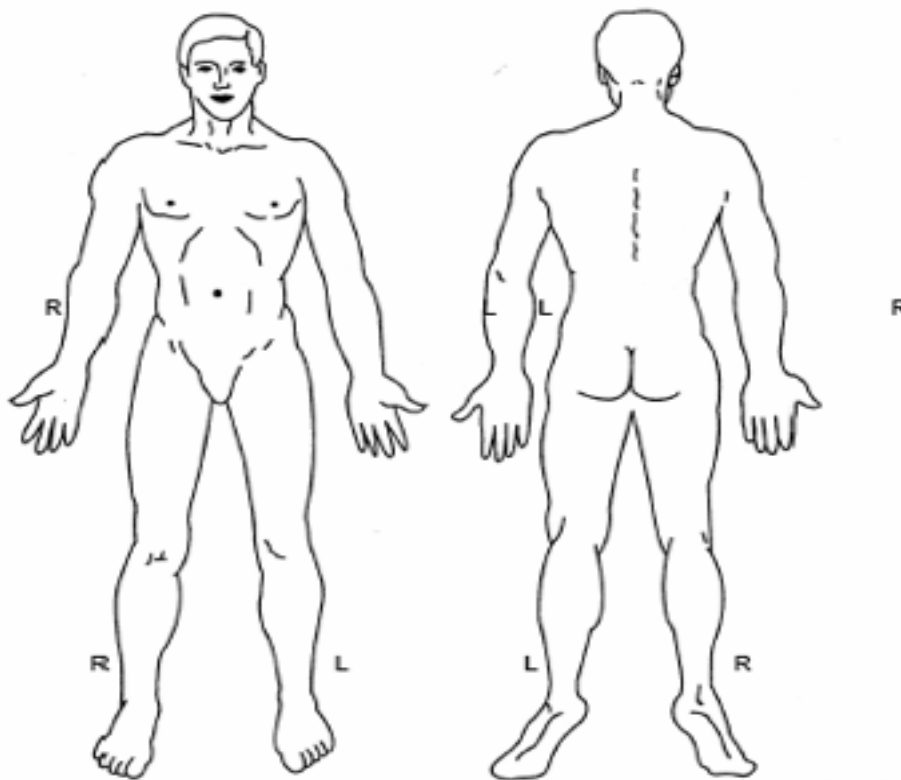
Indicate all areas of your body where you typically feel pain or numbness.

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.

<b><u>Treatment : have had this</u></b>	Check if you	<b>Did it make things</b>		
		<b><u>Better</u></b>	<b><u>Worse</u></b>	<b><u>No change</u></b>
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

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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

**GI**

Heartburn Yes/No  
Nausea/vomiting Yes/No

**Endocrine**

Thyroid disorder  
Diabetes Yes/No

Dizziness Yes/No

Diarrhea Yes/No  
Blood in stools 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 \_\_\_\_\_