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 Address:		Insurance Phone:	
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:

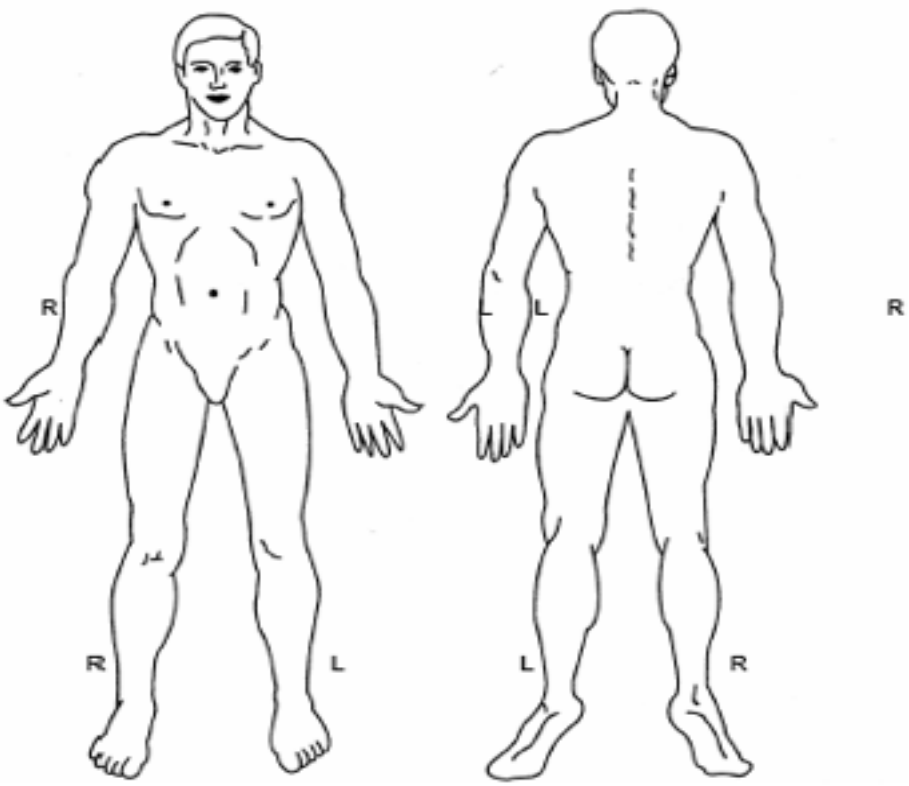
(0) is no pain (10) is the most severe

(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	□	□	□
Standing	□	□	□
Walking	□	□	□
Bending forward	□	□	□
Lying on your back	□	□	□
Rising from sitting	□	□	□
Coughing/sneezing	□	□	□
Driving	□	□	□

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.

Treatment : have had this	Check if you	Did it make things Better	Worse	No change
Antiinflammatory	□	□	□	□
Muscle relaxants	□	□	□	□
Narcotic pain meds	□	□	□	□
Physical therapy	□	□	□	□
Pool therapy	□	□	□	□
Acupuncture	□	□	□	□
Chiropractic Adjustments	□	□	□	□
Trigger point Injections	□	□	□	□
Epidural Injections	□	□	□	□
Facet joint injections	□	□	□	□
SI joint injections	□	□	□	□
Spine surgery	□	□	□	□

MEDICAL HISTORY:

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

□ Seizures	□ AIDS or HIV	□ Migraine
□ High Blood Pressure	□ Kidney Failure	□ Arthritis
□ Diabetes	□ Thyroid trouble	□ Asthma
□ Cancer	□ Liver problem	□ Stomach Ulcer
□ Radiation/Chemotherapy	□ Heart Attack	□ Tuberculosis
□ Stroke	□ Are you on Coumadin	□ Hepatitis
□ Heart Attack	□ Fibromyalgia / Chronic Fatigue	□ 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 swilling 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

Diarrhea Yes/No
Blood in stools Yes/No

Endocrine
Thyroid disorder

Diabetes Yes/No

Skin/integumentary
Rash Yes/No
Ulcer Yes/No
EczemaYes/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 _____