New Jersey Pain Consultants
Patient Information

Patient Name:_____ Sex: □Male □Female

Birthdate: _____

Mailing Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Is it acceptable to leave a message on your home phone or cell phone? □YES □NO

Email: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □Minor : 17 and under

Emergency Contact: _____Relationship: _____

Home Phone: _____ Work: _____ Cell: _____

Employment Information

Patient's employment status: □ No □ Yes □ Full time □ Part time □Retired – Date Retired __/__/___

Patient's employer: _____ Occupation: _____

Employer's Address: _____

Insurance Information

Primary Insurance: _____ Policy Holder's Name: _____

Policy Holder's Social Security#:_____ Policy Holder Date of Birth: ___/___/___

Policy Holder Employer:_____

Secondary Insurance: _____ Policy Holder's Name: _____

Policy Holder's Social Security#:_____ Policy Holder Date of Birth: ___/___/___

Policy Holder Employer:_____

Accident: Are you here as the result of an accident or specific injuy ? □ No □ Yes □ Auto □ Worker's Comp

Accident/ Injury Date: _____ Location of Accident: _____

Nature of Accident:_____

Patient Signature: _____ Date:_____

New Jersey Pain Consultants New Patient Questionnaire

Patient Name _____ Date of Birth _____ Age_____

Height_____ Weight_____ Allergies:_____

Primary Care Physician: _____ Phone: _____

Referring Provider: _____ Phone: _____

Other Physicians Consulted: _____Phone: _____

When did your pain start? _____

How did your pain start? ❑ I don't know ❑ Started gradually ❑Auto Accident ❑Work Related ❑ Injury

Describe the problem: _____

_____

_____

Physical therapy tried: When and how many sessions? _____

Injections tried: Type of injection and by whom? _____

Medications tried and did they help? _____

_____

Have you had any **FALLS** in the last year? ❑ NO ❑ YES #of falls:_____ Injuries:_____

Testing/Imaging Studies : PLEASE **BRING YOUR REPORTS** WITH YOU TO YOUR INITIAL APPOINTMENT

CT scan: Date_____ Facility Name/location _____

MRI: Date_____ Facility Name/location _____

Xrays: Date_____ Facility Name/location _____

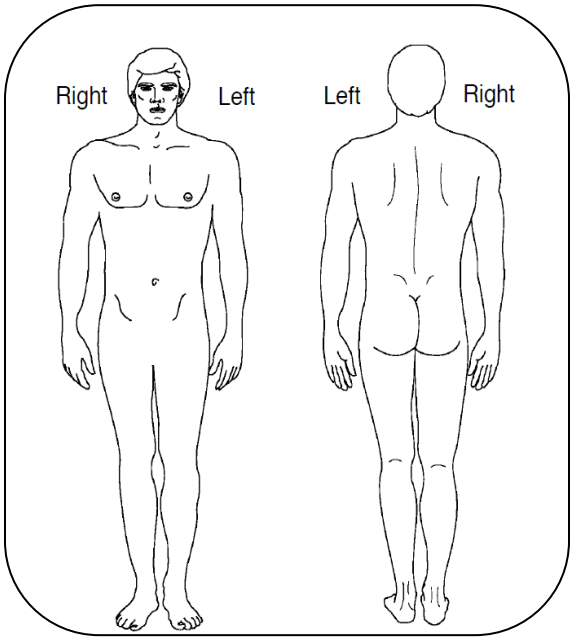
EMG: Date_____ Facility Name/location _____

Other: Date_____ Facility Name/location _____

Use the diagram to indicate the location and type of your pain.

"**N**" = numbness "**P**" = pins and needles

"**S**" = stabbing "**B**" = burning **"A**" = aching



Please indicate on a **scale of 0-10** what level your pain is.

0 = no pain, 10 = unbearable pain/ requiring emergency care

PRESENT PAIN

0 1 2 3 4 5 6 7 8 9 10

USUAL PAIN

0 1 2 3 4 5 6 7 8 9 10

WORST PAIN

0 1 2 3 4 5 6 7 8 9 10

LEAST PAIN

0 1 2 3 4 5 6 7 8 9 10

FREQUENCY OF PAIN (circle one) : Constant Intermittent

Patient Name_____

What does your pain <u>feel like</u>?

❑ Aching ❑ Shooting ❑ Cramping ❑ Spasms ❑ Dull ❑ Tingling/Pins and Needles ❑ Squeezing
❑ Burning ❑ Exhausting ❑ Numb ❑ Stabbing ❑Sharp ❑ Electrical ❑ Throbbing

What makes your pain <u>worse</u>?

❑ Sitting ❑ walking ❑ lying down ❑ standing ❑ sneezing ❑ coughing ❑ yard work ❑ weather changes
❑ house work ❑ position changes ❑working ❑ driving ❑ stairs ❑ physical recreation

What makes your pain <u>better</u>?

❑ nothing ❑ Sitting ❑ lying down ❑ standing ❑ walking ❑ heat ❑ ice ❑ medication ❑ rest ❑ TENS
❑ Acupuncture ❑ injections ❑ biofeedback ❑ relaxation exercises ❑ physical therapy ❑ physical therapy
❑ chiropractics ❑ changing position ❑ massage ❑ distraction

Do you have any numbness? ❑ NO ❑ YES: location _____

Do you have weakness? ❑ NO ❑ YES: explain _____

Does the pain interfere with your sleep at night? ❑ NO ❑ YES

Have you had any new bowel or bladder incontinence or retention? ❑ NO ❑ YES _____

Past and present medical issues:

High Blood Pressure	❑ YES ❑ NO	Cancer _____	❑ YES ❑ NO	Anxiety	❑ YES ❑ NO
High Cholesterol	❑ YES ❑ NO	Diabetes	❑ YES ❑ NO	Depression	❑ YES ❑ NO
Heart Attack	❑ YES ❑ NO	COPD/ Emphysema	❑ YES ❑ NO	Fibromyalgia	❑ YES ❑ NO
Congestive Heart Failure	❑ YES ❑ NO	Asthma	❑ YES ❑ NO	Shingles	❑ YES ❑ NO
Atrial Fibrillation	❑ YES ❑ NO	Sleep Apnea	❑ YES ❑ NO	Seizures	❑ YES ❑ NO
Stroke	❑ YES ❑ NO	Acid Reflux	❑ YES ❑ NO	Headaches	❑ YES ❑ NO
Bleeding Disorder	❑ YES ❑ NO	Stomach Ulcers	❑ YES ❑ NO	HIV/AIDS	❑ YES ❑ NO
Blood Clots	❑ YES ❑ NO	Hepatitis	❑ YES ❑ NO	Hypothyroid	❑ YES ❑ NO
Autoimmune Disease	❑ YES ❑ NO: type_____			Other _____	

Past Surgeries: Please include **ANY** surgery you have had: If extra space needed please continue on reverse side

Date	Surgery	Physician

Social History:

Do you smoke? ❑ Never ❑ Former/ Quit Date: _____ ❑ YES _____ packs per day

Do you consume alcohol? ❑ Never ❑ YES How much?_____

Have you ever felt you should cut down on your drinking? ❑ NO ❑ YES

Have people annoyed you by criticizing your drinking? ❑ NO ❑ YES

Have you ever felt bad or guilty about your drinking? ❑ NO ❑ YES

Have you had a drink in the morning to steady your nerves or get over a hangover? ❑ NO ❑ YES

Do you take prescription pain medicine? ❑ NO ❑ YES

If yes, do you ever take more than the prescribed amount? ❑ NO ❑ YES

Have you ever been treated for drug or alcohol abuse? ❑ NO ❑ YES Details: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you live alone? ❑ NO ❑ YES Are you a caregiver? ❑ NO ❑ YES Details: _____

Are you Working? ❑ NO ❑ YES Occupation: _____

If not working, Date last worked: _____ Is your pain keeping you from working? ❑ NO ❑ YES

Who released you from work? _____ When are you scheduled to return? _____

Are you on disability? ❑ NO ❑ YES What is the medical diagnosis for this disability? _____

Patient Name: _____

Family History:

Is your father alive? ❑ YES ❑ NO cause of death: _____

What health problems does/did your father have? _____

Is your mother alive? ❑ YES ❑ NO cause of death: _____

What health problems does/did your mother have? _____

Significant medical problems of blood relatives (siblings/children)? _____

Behavioral Health:

How has the pain affected your mood? Check all that apply.

❑ no effect ❑ slightly upset ❑ irritable ❑ anxious ❑ moody ❑ unmotivated ❑ severely upset

What stress has the pain caused at home or work? _____

Are you depressed now? ❑ NO ❑ YES

Do you have thoughts of suicide? ❑ NO ❑ YES

Would you like to see a mental health specialist? ❑ NO ❑ YES

Have you ever been seen by a counselor, psychologist or a psychiatrist? ❑ NO ❑ YES

Provider's name, date last seen and phone #: _____

What type of **behavioral treatment** have you tried?

❑ Therapy ❑ medication ❑ Biofeedback ❑ Shock therapy ❑ Group Therapy ❑ In-patient care

Symptoms: Check all that apply

Constitutional:❑ Weight Loss ❑ Chills ❑ Night Sweats ❑ Excessive Sweating ❑ Fatigue ❑ Fevers

Head /ENT: ❑ Glasses ❑ Contacts ❑ Visual Changes ❑ Hoarseness ❑ Earaches ❑ Hearing Loss

❑ Dry Mouth ❑ Recurrent Sore Throat ❑ Ringing in the Ears ❑ Sinus Problems

Cardiovascular: ❑ Chest Pain ❑ Fainting ❑ Lightheadedness ❑ Swelling in the Feet ❑ Palpitations

❑ Shortness of Breath with activity

Respiratory: ❑ Cough ❑ Wheezing ❑ Asthma ❑ Sleep Apnea ❑ Shortness of Breath at Rest

Gastrointestinal: ❑ Abdominal Pain ❑ Acid Reflux ❑ Constipation ❑ Nausea ❑ Diarrhea ❑ Vomiting

❑ Bloating ❑ Laxative use ❑ Loss of bowel control

Genitourinary: ❑ Loss of Urinary Control ❑ Urinary Frequency ❑ Urinary retention ❑ Erectile dysfunction

❑ Self-catheterization ❑ Painful Urination ❑ Urinary Dribbling

Musculoskeletal: ❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness ❑ Joint Swelling ❑ Muscle Spasms

❑ Muscle Stiffness ❑ Neck Pain

Neurological: ❑ Dizziness ❑ Seizures ❑ Weakness ❑ Tremors ❑ Numbness (where)_____

❑ Tingling (where)_____ ❑ Headaches

Skin: ❑ Rashes ❑ Itching ❑ Wound ❑ Infection ❑ Bed Sore/Pressure Ulcer

Endocrine: ❑ Low Sex Drive ❑ hot flashes ❑ Hair loss ❑ Always hot ❑ Always cold ❑ Always Thirsty

Blood: ❑ Easy Bleeding ❑ Anemia ❑ Easy Bruising ❑ Swollen Nodes ❑ Swollen Feet ❑ Edema

Immune System: ❑ Steroid Use ❑ Chemotherapy ❑ AIDS/HIV

Psychiatric: ❑ Depressed Mood ❑ Feeling Anxious ❑ Mood Swings ❑ Suicidal Thoughts ❑ Suicidal Planning ❑ Insomnia ❑ Nightmares

For men only: Do you have problems with erections? ❑ YES ❑ NO

For women only: Could you be pregnant now? ❑ YES ❑ NO Date of last menstrual period _____

New Jersey Pain Consultants

Medication Form

Patient Name: _____ Date of Birth:_____

Pharmacy Name and Phone #: _____

Allergies: _____

Date Started	Medication Name	Dose	How often	Reason For Taking

Medical History, Consent for Treatment and Patient Responsibility

I authorize New Jersey Pain Consultants and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for New Jersey Pain Consultants to retrieve and review my medication and medical history. I understand that this will become part of my medical record.

I understand and agree that I am financially responsible for all charges for all services rendered. This includes any medical service or visit and urine toxicology. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, prior authorization requirements or any other type of limitation for the services I receive. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have proper information for a secondary insurance, it will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

New Jersey Pain Consultants prescribes the most medically effective drug for your individual need and cannot speak with each insurance office regarding their formulary.

If I am asked to provide a urine and/or saliva sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or saliva sample as requested. I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to Aegis Labs my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to Aegis Labs. I understand that acceptance of insurance assignment does not relieve me from my responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether they are covered by my insurance. Payment in full is expected 30 days of being notified of any balance due. Please do note that if you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee accessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

ASSIGNMENT OF BENEFITS:

I hereby authorize New Jersey Pain Consultants to apply for Medicare/Medicap, and other health insurance benefits (if applicable No-Fault and Worker's Compensation) on my behalf. I request payment of all Medicare/Medicap and commercial insurance carriers be made directly to New Jersey Pain Consultants. I certify that the information I have reported regarding my insurance carrier(s) is correct. I authorize the release of medical information and records about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medicare/Medicap AND/OR commercial insurance carrier benefits be made on my behalf to New Jersey Pain Consultants. I release any holder of Medicare/Medicap information about me to my insurance carrier(s) necessary to determine benefits payable for related service(s). I hereby authorize this medical provider and its associates to provide treatment and/or examination and release any information pertinent to my case during my examination or treatment to my physician, insurance company, claims adjustor, or attorney if applicable.

Signature of Patient or Guardian: _____ Date: _____

I certify that the above information is accurate, complete and true.

New Jersey Pain Consultants

Patient Authorization for Use and Disclosure of Protected Health Information

This form establishes your consent for New Jersey Pain Consultants to release your protected health information in accordance with our Privacy Practices. Our Privacy Practices ensure New Jersey Pain Consultants provides the highest level of health care services possible in accordance with state and federal law. This consent is valid for one year, and should be renewed on an annual basis.

I acknowledge that I have had the opportunity to review New Jersey Pain Consultants Notice of Privacy Practices, which is displayed for public inspection at its facility. This notice describes how your protected health information may be used and disclosed, and how I may access your health records.

I authorize New Jersey Pain Consultants to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize New Jersey Pain Consultants to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that New Jersey Pain Consultants will not release my Protected Health Information to any other party, including family, without my completing written "Patient Authorization to Use and Disclosure of Protected Health Information" form available at its facility.

Signature:_____

Printed Name:_____

Date:_____

THIS AREA BELOW GIVES US PERMISSION TO DISCUSS YOUR CARE WITH A FAMILY MEMBER OR FRIEND. IF YOU DO NOT WANT ANY MEDICAL INFORMATION BEING GIVEN TO A FAMILY OR FRIEND THEN LEAVE THIS AREA BLANK.

"I request and authorize New Jersey Pain Consultants to disclose my protected health information in accordance with our privacy practices. I understand that if the person/organization authorized to receive and use the information is not a health plan or healthcare provider, the disclosed information may no longer be protected by federal privacy regulations."

Name of person(s):_____ Relationship:_____

Address:_____

Reason (ie: to assist medical care):_____

Date:_____

*This Consent is valid for one year from date signed

Consent to Disclose PHI Revised December 12, 2017

OFFICE RULES & POLICIES

CO-PAYMENTS

Co-payments are due at the time of your visit.

Under no circumstances are we able to waive co-payment. If you do not have your co-pay for your visit, your appointment may be rescheduled.

INSURANCE

I will keep up-to-date with any bills from the office and tell the physician, nurse practitioner or a member of the treatment team immediately if I lose my insurance or cannot pay for treatment.

BOUNCED CHECKS

A $40.00 CHARGE WILL BE ASSESSED FOR ALL RETURNED CHECKS.

NO SHOW OR CANCELLATIONS

A $100.00 (New Consult) or $50.00 (Follow-up, Procedure) charge may be assessed if you fail to keep your appointment and do not notify the office. Failure to provide 24-hour advance notification for a cancellation or rescheduled appointment may result in a fee charged.

Habitual failures to keep scheduled appointments may result in written or verbal warning, or discharge from our practice.

FORMS FEE

For any forms that need to be completed by your practitioner, there will be a fee associated with this service. If your provider has agreed to complete on your behalf, please allow 7 days for these forms to be completed, unless otherwise stated by your provider.

LANGUAGE

Rude or disrespectful language will not be tolerated.

AGREEMENT

In order to continue treatment with New Jersey Pain Consultants, I understand the rules and policies set by the Practice and agree to abide by the set office rules and policies.

Printed Name	Signature	Date