New Jersey Pain Consultants

Patient Information

Patient Name:____ Sex: □Male □Female

Birthdate: ____________________________ Social Security #: _________________________

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 ____

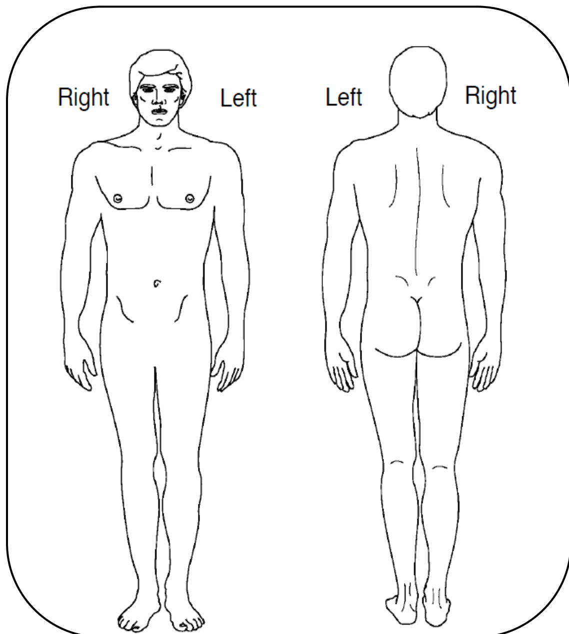
Xrays: Date_________________ Facility Name/location ____

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 feel like?

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

What makes your pain worse?

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

What makes your pain better?

❑ nothing ❑ Sitting ❑ lying down ❑ standing ❑ heat ❑ ice ❑ medication ❑ TENS ❑ Acupuncture ❑ rest
❑ 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		

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

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 and Consent for Treatment

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 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 and on its website. This notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the 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 other physician(s) I may be referred to. I also authorize New Jersey Pain Consultants to release any information required to obtain 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 a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

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

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood 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 or not they are covered by my insurance. Payment in full is expected 30 days of being notified of any balance due. Please do note that in the event that 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/Medigap, and other health insurance benefits (if applicable No-Fault and Worker's Compensation) on my behalf. I request payment of all Medicare/Medigap and commercial insurance carriers be made directly to New Jersey Pain Consultants. I certify that the information I have reported with regard to 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 any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medicare/Medigap AND/OR commercial insurance carrier benefits be made on my behalf to New Jersey Pain Consultants. I release any holder of Medicare/Medigap 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 in the course of 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:__________________

"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:______________________________

Reason (ie: to assist medical care):____

Date:_________________________

*This Consent is valid for one year from date signed

Consent to Disclose PHI Revised June 26, 2014

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