PATIENT INFORMATION

NAME:_____ TODAY'S DATE: ____/____/____
ADDRESS:_____CITY:_____STATE:_____ZIP:_____
HOME PHONE:_____CELL:_____ (Circle preferred contact phone number)
EMAIL ADDESS:_____
SS#: _____ BIRTHDATE: __ /__ /__ (mm/dd/yy) AGE:___ SEX: MALE__/FEMALE__

RACE:
__American Indian/Alaskan Native
__Black/African American
__More than one Race
__Native Hawaiian
__Pacific Islander
__Unreported/Decline to provide
__White

ETHNICITY:
__Hispanic/Latino
__Non-Hispanic/Latino
__Unreported/Decline to provide Race and Ethnicity

REFERRING: Doctor, Attorney, Therapist, Trainer, Case Worker, Family, Friend, Advertisement, Other
NAME:_____ ADDRESS:_____PHONE:_____

FAMILY PHYSICIAN OR OTHER TREATING PHYSICIANS:
NAME:_____ ADDRESS: _____ PHONE:_____

PREFERRED PHARMACY:_____
ADDRESS :_____PHONE: _____

EMERGENCY CONTACT NAME:_____ PHONE: _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? _____yes _____no. IF YES PLEASE EXPLAIN:_____

PRIMARY INSURANCE COVERAGE

TYPE OF COVERAGE: _ HMO,_ POS,_ PPO,_ MEDICARE,_ SCHOOL,_ SELF PAY,_ OTHER

NAME OF INSURANCE PLAN:_____

CLAIM ADDRESS:_____, CITY _____STATE___ ZIP_____

INSURANCE PHONE NUMBER (Back of Card) _____

SUBSCRIBER'S NAME: _____, DATE OF BIRTH __/__/____

SUBSCRIBER'S SS# _____SEX: ___ male __ female

RELATIONSHIP TO PATIENT: _____

INSURANCE ID #: _____ GROUP # _____ EFFECTIVE DATE: ___/__/_____

SUBSCRIBER'S EMPLOYER NAME: _____

IS THE INSURANCE COVERAGE THROUGH THE SUBSCRIBER'S EMPLOYER? _____ yes, ____no

SECONDARY INSURANCE COVERAGE

TYPE OF COVERAGE: __ HMO,__ POS,__ PPO,__ MEDICARE,__ SCHOOL,_ SELF PAY,_ OTHER

NAME OF INSURANCE PLAN:_____

CLAIM ADDRESS:_____, CITY _____STATE___ ZIP_____

INSURANCE PHONE NUMBER (Back of Card) _____

SUBSCRIBER'S NAME: _____, DATE OF BIRTH __/__/____

SUBSCRIBER'S SS# _____SEX: ___ male __ female

RELATIONSHIP TO PATIENT: _____

INSURANCE ID #: _____ GROUP # _____ EFFECTIVE DATE: ___/__/_____

SUBSCRIBER'S EMPLOYER NAME: _____

IS THE INSURANCE COVERAGE THROUGH THE SUBSCRIBER'S EMPLOYER? _____ yes, ____no

IS THE INJURY MOTOR VEHICLE RELATED? __ yes __ no

If worker's comp or MVA please fill out insurance information below:

INSURANCE COMPANY: _____Date of Injury/accident_____
ADJUSTER / CASE WORKER: _____
TELEPHONE #: _____
ADDRESS: _____
CLAIM #: _____ATTORNEY:_____
EMPLOYER: _____

IF MVA. THIRD PARTY LIABILITY? __YES___ NO, THIRD PARTY INSURED?_____POLICY #_____
THIRD PARTY INSURANCE CARRIER & ADDRESS_____

REASON OF DOCTOR'S VISIT: _____

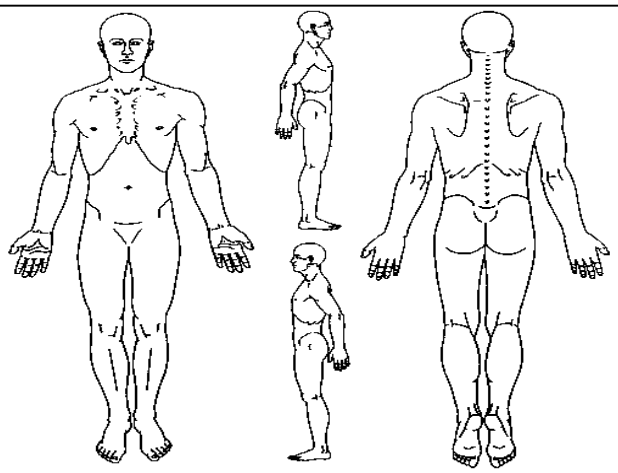
HAVE YOU BEEN SEEN FOR THIS INJURY/Condition BEFORE _____ (IF YES) FOR HOW LONG _____AND BY WHOM:_____

INJURY INFORMATION

DATE OF INJURY/ACCIDENT OR ONSET OF SYMPTOMS: _____

PART OF THE BODY BEING SEEN FOR TODAY: _____ (RIGHT / LEFT)

PLEASE GIVE A DESCRIPTION OF HOW SYMPTOM OCCURRED: _____
_____



PLEASE DESCRIBE YOUR PAIN ON THE DIAGRAM ABOVE, CIRCLE THE AREAS:
X = PAIN **O = PINS AND NEEDLES/NUMBNESS**

MEDICAL HISTORY

IF 18 YEARS OR YOUNGER, HAVE YOU RECEIVED ALL OF YOUR PEDIATRIC IMMUNIZATION / VACCINATIONS? YES NO.

FEMALE PATIENTS: IS THERE A CHANCE THAT YOU ARE CURRENTLY PREGNANT? Yes__No____

DO YOU HAVE ANY MEDICAL PROBLEMS, IF SO, PLEASE INDICATE AND LIST BELOW
Diabetes_____ History of Cancer _____ Fevers _____ Active Infections_____
Unintentional weight loss_____Recent changes in bowel or bladder function_____
Other:_____

HAVE YOU EVER HAD ANY SURGERIES? IF YES, PLEASE LIST BELOW AND PROVIDE DATES:
_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____

SOCIAL HISTORY

EMPLOYER/JOB TITLE / OCCUPATION:
_____

EMPLOYMENT STATUS: __full time, __part time, __full/part time student, __ self employed, ___disabled, __unemployed, __retired

MARITAL STATUS: __Single, __ Married, __ Divorced, __Widow(er). __# OF CHILDREN

DO YOU USE TOBACCO __yes __no IF YES how many years ___, and ___# packs per day

ALCOHOL USE: __ none, __social, __ # of drinks per day OR __ # of drinks per week

DO YOU USE RECREATIONAL DRUGS: __ yes __ no

HAVE YOU EVER BEEN TREATED FOR CHEMICAL DEPENDENCE? _____ yes, _____ no

EDUCATION ATTAINED _elementary school, _high school, _technical, _ college, _advanced degree

FAMILY MEDICAL HISTORY PLEASE LIST ANY FAMILY HISTORY OF ILLNESS
Cancer: Yes/No
Diabetes: Yes/No
Other:

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS SINCE THE ONSET OF YOUR PAIN PROBLEM(S):

__CHEST PAIN
__HEART PALPITATIONS
__IRREGULAR HEART RATE
__SHORTNESS OF BREATH
__DIFFICULTY BREATHING
__INFECTION
__DIFFICULTY HEARING
__VISUAL CHANGES
__RASHES/SKIN INFECTIONS
__ EMOTIONAL/ANXIETY DISORDERS
__JOINT DISLOCATION / SEPARATION
__UPSET STOMACH
__GI DISTRESS
__NAUSEA / VOMITTING
__BOWEL INCONTINENCE
__LOSS OF CONSCIOUSNESS
__LOSS OF CONSCIOUSNESS
__FAINTING
__DIZZINESS
__ABDOMINAL PAIN
__FRACTURE
__LOW BACK PAIN/SCOLIOSIS
__NUMBNESS/WEAKNESS
__LEG/ANKLE SWELLING
__BLEEDING PROBLEM/ BRUISING
__DIFFICULTY WITH URINATION
__JOINT PAIN/SWELLING
__JOINT SPRAIN/MUSCLE STRAIN
__DIFFICULTY WITH SWALLOWING
__OTHER

MEDICATIONS

DO YOU TAKE ANY OF THE FOLLOWING MEDICINES ON A REGULAR BASIS:

__ ASPIRIN__ BIRTH CONTROL__TYLENOL __ COUMADIN or other blood thinners____
ANTI-INFLAMMATORY__OPIATES __OTHER PAIN MEDS_____

PLEASE LIST ANY PRESCRIPTION MEDICATION WITH DOSE & FREQUENCY THAT YOU ARE TAKING: _____
_____

PLEASE READ AND SIGN

DO YOU HAVE AUTHORIZATION TO BE SEEN IN OUR OFFICE? IF NO, PLEASE BE ADVISED THAT IF YOUR INSURANCE COMPANY DOES NOT PAY YOU WILL BE RESPONSIBLE FOR YOUR BILL.

It is our office policy that all services rendered are charged directly to the patient and that you are ultimately and personally responsible for payment of all services rendered, regardless of personal insurance you may have.

1. Patients with no insurance: payment is expected at the time of service. A specific payment plan acceptable between you and billing office may be arranged.
2. Patients with insurance: deductibles and all co-payments are expected at the time of service. Your co-payment is an amount, which is not covered by your insurance and is not always an exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility.
3. If a patients account balance remains unpaid for more than 90 days, and no response has been made to our office billing department, the patient's account may be turned over to our attorney for collection.

INSURANCE POLICY

We extend to our patients the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out of pocket expenses. Please also note the following:

1. The privilege of insurance assignments begin? When your insurance is qualified and forms are received. Until that time you must pay for services rendered.
2. All deductibles must be made prior to submitting any insurance claims.
3. Since we do not own your insurance policy we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.
4. This office does not promise that an insurance company will pay the usual and customary charges of this office, nor does this office enter into any dispute with an insurance company concerning the amount of the reimbursement.
5. Lastly, it is the goal of this office to provide you with the finest quality care available. If you have any questions regarding your health care or any of our office policies, please do not hesitate to let us know.

PLEASE SIGN BELOW

I have reviewed and am aware of the payment policies of Interventional Spine and Pain Associates of New Jersey (ISPANJ), LLC.

_____ ___/____/_____ _____ ___/____/_____
Signature of responsible party Date Signature of patient Date

I authorize my insurance company to make payment for my unpaid balance directly to ISPANJ.

_____ ___/____/_____ _____ ___/____/_____
Signature of responsible party Date Signature of patient Date

I hereby authorize the release of any information relating to my care directly to my insurance company, attorney, school or any other treating specialists.

_____ ___/____/_____ _____ ___/____/_____
Signature of responsible party Date Signature of patient Date

OUT OF NETWORK

I HAVE BEEN MADE FULLY AWARE THAT IF ISPANJ AND/OR THEIR PROVIDERS DO NOT PARTICIPATE WITH MY INSURANCE. I AGREE THAT I WILL BE HELD RESPONSIBLE FOR ANY AND ALL REMAINING BALANCES THAT MY INSURANCE WILL NOT PAY.

_____ ___/____/_____ _____ ___/____/_____

Signature of responsible party Date Signature of patient Date

MEDICATION POLICY

MEDICATION PRESCRIPTIONS OR REFILLS WILL NOT BE CALLED IN ON WEEKNIGHTS, FRIDAYS, WEEKENDS OR HOLIDAYS UNDER ANY CIRCUMSTANCES. IT IS YOUR RESPONSIBILITY TO MONITOR THE AMOUNT OF MEDICATION YOU HAVE. THEREFORE, YOU CAN NOT EXPECT THE PHYSICIAN(S) TO CALL IN REFILLS ON THE SAME DAY OF YOUR REQUEST. YOU MUST ALLOW THE DOCTORS AT LEAST 2 DAYS TO CALL IN YOUR REFILL OF YOUR CURRENT MEDICATION.

_____ ___/____/_____ _____ ___/____/_____

Signature of responsible party Date Signature of patient Date

Please complete the form with signatures and fax it back to our office at your earliest convenience, prior to your scheduled appointment. Fax: 732 847-3367.

Interventional Spine & Pain Associates of New Jersey, LLC
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