PLEASE BRING TO YOUR SCHEDULED APPOINTMENT

Photo ID- DRIVER'S LICENSE OR PASSPORT.

INSURANCE CARD AND REFERRAL, IF NECESSARY.

WORKERS' COMP OR AUTO-PIP CLAIM INFORMATION IF APPLICABLE INCLUDING INSURANCE COMPANY ADDRESS, CLAIM NUMBER AND DATE OF ACCIDENT, ADJUSTER/CASE MANAGERS NAME AND PHONE NUMBER AND YOUR **ATTORNEY'S NAME**, ADDRESS AND PHONE NUMBER.

MRI, CT SCAN, X-RAY CDS AND REPORTS
(EVEN IF THE FILMS ARE 2 TO 3 YEARS OLD)

A **LIST OF ALL MEDICATIONS** THAT YOU ARE CURRENTLY TAKING, INCLUDING ALL PRESCIPTION MEDICATION AND ALL OVER-THE-COUNTER MEDICATIONS THAT YOU ARE CURRENTLY TAKING, FOR EXAMPLE: ST JOHN'S WORT, VITAMINS, SUPPLEMENTS, ETC.

COMPLETED PATIENT FORMS

NAME AND ADDRESS OF YOUR **REFFERING AND PRIMARY CARE DOCTOR**

IF YOU HAVE ANY QUESTIONS REGARDING YOUR APPOINTMENT, PLEASE CALL **732-720-0247.**

PATIENT INFORMATION

Date:_____

Last Name:_____**First Name**:_____**M:**_____

Address:_____**City:** _____ **State/Zip:**_____

Primary Telephone # _____**Cell Phone #**_____

Sex: Male/Female **Date of Birth**:_____ **Social Security Number**:_____

Marital Status: Single/Married/Divorced/Widowed **E-Mail Address**:_____

Next of Kin:_____ Relationship:_____

Address:_____ Phone:_____

Referring Doctor:_____**Primary Care Doctor**:_____

Attorney Name, Address, Phone:_____

Employer/School:_____Occupation:_____

Pharmacy Name,Address,Phone:_____

Primary Insurance Information

Type: Health Insurance Workers' Comp Auto/PIP Accident None/Self-Pay

Subscriber's Name:_____**Date of Birth**:_____
Address:_____SS#_____
Insurance Company:_____**Date of Accident**:_____
Address:_____Phone#_____
Group/Claim #_____Policy/ID#_____
Case Manager:_____Phone #_____

Secondary Insurance Information

Type: Health Insurance Workers Comp Auto/PIP Accident None/Self-Pay

Subscriber's Name:_____**Date of Birth**:_____
Address:_____SS#_____
Insurance Company:_____**Date of Accident**:_____
Address:_____Phone#_____
Group/Claim #_____Policy/ID#_____
Case Manager:_____Phone #_____

INITIAL PATIENT QUESTIONNAIRE

PATIENT NAME:_____ **DOB** ___/____/____ **DATE:** _____

Chief Complaint:_____

Is Your Injury From an Auto or Workers' Compensation Accident? YES / NO Date______________

Initial Pain Level (0-10): 0 1 2 3 4 5 6 7 8 9 10 **How often is your pain present?** Occasional Frequent Constant

What makes symptoms worse?

Walking_____ Standing _____ Sitting_____ Lying Down_____ Other_____

What makes symptoms better?

Walking_____ Standing_____ Sitting_____ Lying Down_____Other_____

Medical History:

- **Patient Medical History:**

			Previous Hospitalizations/Surgeries	**When?**
Diabetes	No	Yes		
Blood Pressure	No	Yes		
Asthma/COPD	No	Yes		
Stroke	No	Yes		
Heart Problems	No	Yes		
Kidney Problems	No	Yes		
Seizure disorders	No	Yes		
Bleeding/Clotting	No	Yes		
Liver/Hepatitis	No	Yes		
Sleep Apnea	No	Yes		
Cancer	No	Yes		
Thyroid	No	Yes		

ALLERGIES

Latex Yes / No

Dye Yes / No

Other Medication Allergies

_____

_____

Current Medications: name, dose, frequency

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

7)_____ 8)_____

9)_____ 10)_____

herbals, vitamins

_____

- **Patient Social History:** **Occupation:**_____ **Full time Part time** (circle one)

Marital status: Single_____Married _____Separated_____Divorced_____Widowed_____

Use of alcohol: Never_____Rarely_____Moderate_____Daily_____(alcoholics anonymous yes or no)

Use of tobacco: Never_____Previously, but quit_____ Current packs/day_____

Use of illegal drugs Never_____Type/Frequency_____ marijuana, cocaine, heroin, cocaine, pills

Family History of Drug Abuse: No_____Yes_____ relationship_____

- **Family Medical History, if pertinent:**

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

- **Please check off if any current problems in any of the following areas**:

____General Wellness	____Lungs/Breathing	____Neurological	____Chest pain	____Reproductive/Urinary
____Headaches	____Fatigue	____Skin	____Thyroid Endocrine	____Trouble Sleeping
____Nausea	____Ears, Nose, Throat	____Blood/Lymph		
____Memory	____Ringing in Ears			
____Stomach/Digestion	____Psychiatric	____Dizziness		
____Muscles/Joints/Bones	____Eyes			

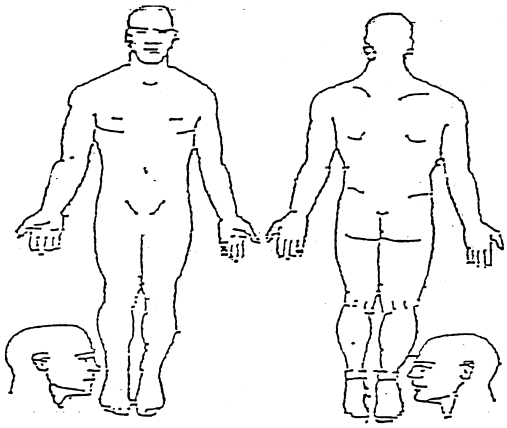
If any of above areas are checked, please explain:

_____

Previous back/neck pain history? _____

Do you experience weakness or numbness? ( ) Yes ( ) No
Do you experience pain at night? ( ) Yes ( ) No
Does cough, sneeze or strain increase pain? ( ) Yes ( ) No
Do you experience loss of bowel or bladder control? ( ) Yes ( ) No
Recent weight loss, how much? _____

Indicate the location of your pain



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Previous Treatment: **Please CIRCLE any of the following you have had:**

Physical Therapy Chiropractic Treatments Surgery

Anti-Inflammatories Medications Nerve Blocks/Injections

Previous tests:

MRI Back Yes_____ No_____ Date of Most Recent Exam______________
MRI Neck Yes_____No_____ Date of Most Recent Exam______________
X-Rays Back Yes_____No_____ Date of Most Recent Exam______________
X-Rays Neck Yes_____No_____ Date of Most Recent Exam______________
CT SCAN Back Yes _____No _____ Date of Most Recent Exam _______________
CT SCAN Neck Yes _____ No _____ Date of Most Recent Exam _______________

EMG Yes_____ No_____

Patient Signature: _____

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Patient Name_____Date of Birth____/____/_____

STANDARD AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize you to release my complete records, including intake sheet, and/or patient history form, nurse's notes, lab reports, x-ray reports, MRI reports, operative reports, pre and post operative records, etc., concerning any and all of my treatments and/or evaluations or confinements at your hospital and /or office at any time.

Purpose of the Disclosure:_____

Will this information be used for marketing? Yes_____ No_____

Has this information been previously de-indentified? Yes_____ No_____

Person(s) Authorized to Use or Disclose the Above Information: NJ PAIN CARE SPECIALISTS

Person(s) to Whom Information May be Disclosed:_____

Expiration Date of Authorization:

This authorization is effective through (check one) ☐____/_____/_____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient's representative.

Right to Terminate or Revoke Authorization:

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure:

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

X_____ **X**_____

Signature of Patient or Patient Representative (relationship) **Date**

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of **NJ PAIN CARE SPECIALISTS** Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

X_____ **X**_____

Signature of Patient or Patient Representative (relationship) **Date**

Patient Name:_____DOB____/____/_____

PAYMENT AUTHORIZATION FORM

For and in consideration of services rendered, I agree to make payment to NJ Pain Care Specialists when billed for any and all charges not covered by valid insurance benefits. I authorize payment directly to NJ Pain Care Specialists for health insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed during this period of treatment. NJ Pain Care Specialists may seek, release and verify all or part of my medical and/or financial records to any person, corporation or government agency which is or may be liable under a statute, regulation or contract to NJ Pain Care Specialists, myself, a family member or my employer for all or part of the NJ Pain Care Specialists charge.

If any of the following changes: patient's address, patient's phone number, patient's insurance information or any other information necessary for NJ Pain Care Specialists to process your medical bill, the patient must inform NJ Pain Care Specialists immediately.

In the event the provider's charges are outstanding, I hereby authorize the provider to file such claim and/or action on my behalf so that the provider may receive payment of their charges. I understand that, if the provider does not receive payment from the insurer, I remain personally responsible for payment of the provider's charges.

Medicare – Authorization to release information and payment request:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the physician or organization furnishing the services or authorize such payment or organization to submit a claim to Medicare for payment.

Please check the appropriate box: (MEDICARE CERTIFICATION)

I am entitled to benefits under Medicare Hospital Insurance, Part A. YES _____ NO _____

I am entitled to benefits under Medicare Hospital Insurance, Part B. YES _____ NO _____

_____ _____

Date **Signature**

SURGICAL CENTER NOTICE

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Accordingly, take notice that Dr. Bram has a financial interest in the following health care facilities to which patients are referred: Shrewsbury Surgical Center, Toms River Surgical Center, and Surgicare of Freehold.

In addition, take notice that these facilities may or may not participate with your health insurance company, therefore you may use your out-of-network benefits if the center does not participate. If you have any questions regarding this coverage, please contact the surgical facility directly.

_____ _____

Date **Signature**