New Jersey Advanced Pain Management Center

973—917- 3800 fax 973-206-2236

PATIENT INFORMATION

NAME: _____ SEX: _____ AGE: _____DOB:_____/_____/_____

ADDRESS: _____ CITY: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: M____ S_____ D____

HOME PHONE: ( ) _____ OTHER PHONE: ( ) _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____

REFERRING DOCTOR: _____

PHONE: _____ ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____

INSURANCE INFORMATION

INSURANCE CARRIER: _____ CARRIER PHONE: _____

INSURANCE ID #: _____ GROUP #: _____

NAME OF INSURED: _____ DOB: _____

INSURANCE CLAIMS ADDRESS: _____ CITY: _____ STATE: _____

MEDICARE ID # _____

SECONDARY INSURANCE CO: _____ ID#:_____

NAME OF INSURED: _____DOB: _____

INSURANCE CLAIMS ADDRESS _____ CITY: _____ STATE: _____

_____ AUTO ACCIDENT, then complete the ACCIDENT DETAIL FORM attached

_____ WORKMAN'S COMPENSATION, and then complete the ACCIDENT DETAIL FORM

_____ OTHER ACCIDENT, then complete ACCIDENT DETAIL FORM

Assignment of Benefits: I assign New Jersey Advanced Pain Management Center, all my rights and benefits under any/all insurance carrier payments t any/all services rendered. I also authorize all information regarding my benefits regarding claims submitted by New Jersey Advanced Pain Management Center to file insurance claims on my behalf for all services rendered to me. I also direct any/all my insurance carrier listed to make payment directly to New Jersey Advanced Pain Management Center. This assignment has been explained to my full satisfaction and with my signature, I will allow this assignment of benefits.

PRINT PATIENT NAME: _____ DATE: _____

SIGNATURE OF PATIENT: _____ DATE: _____

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ACCIDENT DETAIL FORM

IF YOU WERE INVOLVED IN A MOTOR VEHICLE ACCIDENT, complete this section

I was the: _____ DRIVER_____PASSENGER (did you were a seatbelt? ___ yes ____ no) _____PEDESTRIAN

MY AUTO INSURANCE CARRIER IS: _____ CLAIM: _____

ADDRESS FOR CLAIMS _____ CITY: _____ STATE: _____

POLICY NUMBER: _____ POLICY EFFECTIVE DATE: _____

ADJUSTER'S NAME: _____ PHONE: _____ EXT: _____

IF YOU WERE NOT IN A WORK OR AUTO RELATED ACCIDENT, please complete this section:

DESCRIBE YOUR ACCIDENT: _____

LOCATION OF ACCIDENT: _____ NAME OF OWNER: _____

NAME OF INSURANCE CARRIER: _____

ADJUSTER'S NAME: _____ PHONE #: _____

CLAIM # FOR THIS ACCIDENT: _____

CHIEF COMPLAINT

What is the reason for this visit? _____

Current problem is a result of (check all that applies) ___ CAR ACCIDENT ___ WORK ACCIDENT ___OTHER (explain)

REVIEW OF SYMTOMS

ARE YOU CURRENTLY HAVING OR HAVE YOU HAD PROBLEMS WITH ANYTHING LISTED BELOW?

	CIRCLE	Describe all **YES** responses, under treatment?
EYES	**YES / NO**	_____
EARS, NOSE, THROAT	**YES / NO**	_____
LUNGS, BREATHING	**YES / NO**	_____
DIGESTION	**YES/ NO**	_____
GI: Ulcer/Reflux	**YES/ NO**	_____
BOWEL MOVEMENT	**YES/ NO**	_____
BLADDER PROBLEM	**YES/ NO**	_____
DIABETES	**YES/ NO**	_____
HIGH BLOOD PRESURE	**YES/ NO**	_____
BLEEDING PROBLEMS	**YES/ NO**	_____
BALANCE PROBLEMS	**YES/ NO**	_____
NUMBNESS/ FAINTING	**YES/ NO**	_____
BLACKOUT/FAINTING	**YES/ NO**	_____
CARDIAC SYSTEM	**YES/ NO**	_____
STROKE	**YES/ NO**	_____
AIDS	**YES/ NO**	_____
CANCER	**YES/ NO**	_____
ARTHRITIS	**YES/ NO**	_____
TB	**YES/ NO**	_____
EPILEPSY	**YES/ NO**	_____
HEPATITIS	**YES/ NO**	_____
ASTHMA	**YES/ NO**	_____
FEVER/CHILLS/NIGHT SWEATS	**YES/ NO**	_____
WIGHT LOOS/ WEIGHT GAIN	**YES/ NO**	_____
APPETITES INCREASE/ DECREASE	**YES/ NO**	_____

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PAST SURGICAL HISTORY

SURGERIES / HOSPITALIZATIONS **YEAR** **COMPLICATIONS**

_____

_____

_____

HAVE YOU EVER HAD GENERAL ANESTHESIA? **YES/ NO** **COMPLICATION YES/ NO**

Work in the home _____ Employed (Occupation) _____ Student _____

If Student _____ Full Time _____ Part Time School Name _____

____Single _____ Married _____Divorced ____ Separated _____ Widowed

Do you have any children? _____Yes _____ No Number of children's _____

Do you live alone? _____ Yes _____No

Exercise ____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never

What type of exercise? _____

Smoke currently? ____ Yes _____ No Number of pack a day: _____

Drink alcohol? _____ Daily _____ 1x2 week _____ 1-2x month _____ 1-2 year _____ Never

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ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgement of Privacy Practice Notice

I have received a copy of the New Jersey Advanced Pain Management Center Notice of Privacy Practices.

Patient Name: _____ DOB _____/_____/_____

Signature of Patient, Parent Guardian: _____ Date: _____

II. Designation of Certain Relatives, Close Friend and Other Caregivers

I agree that New Jersey Advanced Pain Management Center may disclose certain of my health information to the family member, close personal friend, attorney, or other caregivers because such person is involved with my health care. In that case, New Jersey Advanced Pain Management Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I also understand that my insurance carriers are entitled to my medical record for health care operations or for payment of any/all claims.

I designate the following persons listed bellow as persons involved with my health care or payment relating to my health care for the purpose of New Jersey Advanced Pain Management Center . I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____ Relationship_____

Print Name: _____ Relationship_____

_____ _____

Signature of Patient/ Parent/ Guardian Date