

The Spine Institute of Southern New Jersey, PC
538 Lippincott Drive
Marlton, NJ 08053
856-797-9161
www.sjspine.com

Dear _____,

Welcome to our office! We have enclosed our registration, medical and HIPAA forms for your review and completion.

In an effort to minimize your wait time it is our office policy the enclosed forms be completed in their entirety, including all signatures, prior to your arrival.

Please bring these completed forms with you at the time of your scheduled appointment along with your

- Motor Vehicle insurance card (if applicable)
- Motor Vehicle Declaration page (if applicable)
- Drivers license / photo ID (**required for all patients**)
- Health insurance card(s) (where applicable)

In order to provide a thorough review of your medical condition it is imperative you bring the following items:

- X-Ray films and results
- EMG results
- MRI films and results

To assist you in locating our office we have included directions (below). We look forward to seeing you at our _____ location on _____ at _____

Thank you!

The Staff of The Spine Institute of Southern NJ, PC

DIRECTIONS TO OUR MARLTON LOCATION

From I-295 South:

1. Take Exit #36A to Route 73-SOUTH towards Berlin & New Jersey Turnpike.
2. Go about 4.5 miles on Route 73-S (past Route 70 interchange).
3. Turn RIGHT on Brick Road.
4. Take first RIGHT onto Lippincott Drive.
5. Immediate RIGHT into South Crossings Office Condominiums parking lot.
6. In the lot, turn left, then right. No. 538 is in Bldg. E, the next office on the right.

From I-295 North:

1. Take Exit #34A, Route 70-EAST (Marlton Pike) towards MARLTON.
2. Go about 3 miles on Route 70-E.
3. Turn RIGHT, following signs onto Route 73-SOUTH.
4. Turn RIGHT on Brick Road.
5. Take first RIGHT onto Lippincott Drive
6. Immediate RIGHT into South Crossings Office Condominiums parking lot.
7. In the lot, turn left, then right. No. 538 is in Bldg. E, the next office on the right.
- 8.

Directions to all other locations: Please visit our website at www.sjspine.com

The Spine Institute of Southern NJ, PC Health Insurance Registration Form

Date: ____ / ____ / ____

Account #

Patient Information

Last Name:		First Name:		MI:
Address: _____				
Street	City	State	Zip	
Date of Birth:	Social Security: - -	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Driver's License # & State:		
Home#:	Cell#:	Work#:	Ext:	
Your email address:		Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Retired		
Employer Name:		Employer Address:		
Family Physician Name and Phone#				
Referring Physician Name and Phone#				
Emergency Contact Name:		Relationship to Patient:		
Emergency Contact Phone#:				

Primary Health Insurance Information

Insurance Company Name and Address: _____				
Effective Date:	ID#:	Group#		
Co Pay:\$	Insured Party Last Name:	First Name:	MI:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security: - - -		
Insured's Address (if different): _____				
Street	City	State	Zip	
Home#:	Work#:	Ext:	Cell#:	
Insured's ID#:	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Employer Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer Name:			

Secondary Health Insurance Information

Insurance Company Name and Address: _____				
Effective Date:	ID#:	Group#		
Co Pay:\$	Insured Party Last Name:	First Name:	MI:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Social Security: - - -		
Insured's Address (if different): _____				
Street	City	State	Zip	
Home#:	Work#:	Ext:	Cell#:	
Insured's ID#:	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Employer Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer Name:			

Assignment of Benefits /Authorization/Notice of Collection Practices

I request payment of insurance benefits for all services rendered to me to be made on my behalf to The Spine Institute of Southern NJ, PC. I authorize The Spine Institute of Southern NJ, PC to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand I am responsible to pay certain amounts due. These amounts may include annual deductibles, co payments, co-insurances and charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). I agree this authorization shall remain valid unless/until I rescind in writing.

Print Name of Person Completing this form:	
Signature:	Date:

**** Please present your health Insurance cards to the front desk****

-OVER-

PATIENT SIGNATURE'S ON FILE

MEDICARE

We are not participating with Medicare. See separate Notice of Medicare Opt Out

COMMERCIAL ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to The Spine Institute of Southern NJ, PC for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making the assignment, I understand and agree that I am financially responsible to the above party for charges not paid under the insurance policy. I permit a copy of this authorization to be used in place of the original.

GENERAL RELEASE OF INFORMATION

The Spine Institute of Southern NJ, PC may disclose any part of my clinical record to any insurance company or companies, or, in the case of Worker's Compensation claims, to my past or present employer (s), for purposes of satisfying charges billed by The Spine Institute of Southern NJ, PC and/or its physicians. This authorization does not cover request from other parties seeking information regarding my account. If my insurance company refuses to make payment to The Spine Institute of Southern NJ, PC on my behalf I give my consent to The Spine Institute of Southern NJ, PC to appeal the denial of payment.

GUARANTEE OF ACCOUNT

For and in consideration of services rendered by The Spine Institute of Southern NJ, PC to the below and named patient, the undersigned (jointly and verbally if more than one) guarantees payment of all charges and collection fees incurred by said patient in accordance with the policy of payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS

Patient Signature

Date

Patient's Representative or Guarantor Signature

THE SPINE INSTITUTE OF SOUTHERN NEW JERSEY, PC
FINANCIAL POLICY

The Spine Institute believes that an important part of good healthcare practice is to establish and communicate our financial policy to our patients

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, Visa or MasterCard. Payment may include any unmet deductible, co-insurance, co-pay amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.
2. **INSURANCE** - We are non-participating providers with all insurance plans. We will file all of these insurance claims for surgery, a workers compensation injury or an injury which is a result of a motor vehicle accident. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.
3. **OUTSTANDING BALANCES** – Occasionally a patient will accrue a large balance for services provided by our doctors. We will work with patients to establish an appropriate payment plan and obtain a signed financial agreement.
4. **INSURANCE CHECKS**- Your health plan may send directly to you the payment (check) for the Practice's services. If you receive such payment, please call the Practice Administrator immediately and mail or bring the check in to avoid duplication of bills and a delinquent account. The Practice always receives notification from your insurance company if a payment has been made and where the check was mailed.
5. **RETURNED CHECKS** will incur a \$30 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.
6. **ACCOUNTING PRINCIPLES** – Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.
7. **COMPLETING INSURANCE FORMS AND COPYING MEDICAL RECORDS** require office staff time as well as the Doctor's time. We require \$15.00 per form prepayment when completing forms with the exception of New Jersey State disability, copying medical records fee is \$1.00 per page with a minimum of \$10.00.

If you have any questions after reviewing our policy, please contact our Practice Administrator to avoid any misunderstandings.

I understand and agree to The Spine Institute's Financial Policy.

Patient Name _____ Date of Birth _____

Signature _____ Date _____

Effective Date of this Notice: April 14, 2003

The Spine Institute of Southern NJ, PC

Notice Of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws may be complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Spine Institute of Southern NJ, PC at 538Lippincott Dr. Marlton, NJ 08053 at (856) 797-9161

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment. We may also use your IIHI to contact you to inform you of test results. We may leave the results of certain tests on your answering machine, but will do so only if your message identifies your name or telephone number.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled; notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Manager, 538 Lippincott Dr. Marlton, NJ 08053 856-797-9161** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Manager, 538 Lippincott Dr. Marlton, NJ 08053 856-797-9161**. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Manager, The Spine Institute of Southern NJ, PC 538 Lippincott Dr. Marlton, NJ 08053 856-797-9161** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Manager, The Spine Institute of Southern NJ, PC 538 Lippincott Dr. Marlton, NJ 08053 856-797-9161**.

You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our

practice is not required to be documented; for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Manager, The Spine Institute of Southern NJ, PC 538 Lippincott Dr. Marlton, NJ 08053 856-797-9161.**

All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Manager, The Spine Institute of Southern NJ, PC 538 Lippincott Dr. Marlton, NJ 08053 856-797-9161.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services.

To file a complaint with our practice, contact **Manager, The Spine Institute of Southern NJ, PC 538 Lippincott Dr. Marlton, NJ 08053 856-797-9161.** All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Manager, The Spine Institute of Southern NJ, PC 538 Lippincott Dr. Marlton, NJ 08053 856-797-9161.**

THE SPINE INSTITUTE OF SOUTHERN NJ, PC

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

Patient's Full Name

Patient's Date of Birth

I, _____, have received a copy of The Spine Institute of Southern NJ, PC Notice of Privacy Practices.

Patient Signature

Date

The Spine Institute of Southern NJ, PC

Patient Authorization for Use, Disclosure and Request of Protected Health Information

This authorization permits The Spine Institute of Southern NJ, PC to use, disclose and request the following individually identifiable health information about me

Patient's first and last name	Date of birth
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By signing this authorization, I authorize The Spine Institute of Southern NJ, PC to use, disclose or request certain protected health information (PHI) about me to: **Please LIST NAMES OF DOCTOR'S, ATTORNEY, ETC YOU APPROVE to receive medical information**

The information will be used or disclosed for the following purposes: Medical care, and reimbursement.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will remain in place until otherwise rescinded in writing by me the patient.

The Spine Institute of Southern NJ, PC will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from The Spine Institute of Southern NJ, PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re - disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

The Spine Institute of Southern NJ, PC
538 Lippincott Drive
Marlton, NJ 08053
Attn: Privacy Officer
(856) 797-9161

Signed by: _____
Patient Signature

Date

PATIENT TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION UPON REQUEST

The Spine Institute of Southern NJ, PC Patient Information Form

Patient name _____ **Age** _____ **Date of Birth** ____ - ____ - ____

Reason for Visit/What is bothering you _____

- Neck pain Arm pain (left or right) Back pain Leg pain (left or right)
 Headache Tumor _____ Fracture Scoliosis Other _____

How long have you had this problem? _____

Is this a work-related injury? yes no **Date of injury** _____

Is this the result of an automobile accident? yes no **Date of accident** _____

Have you had any treatment for this problem in the past? yes no

Medications Physical therapy __cervical__ lumbar; When/How long? _____

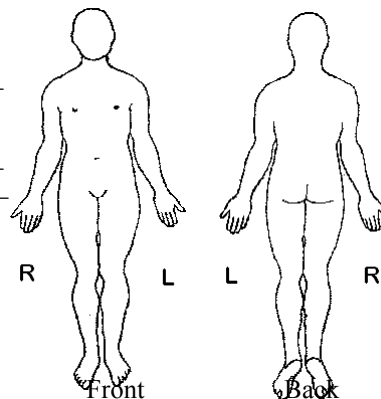
Acupuncture Chiropractic treatment __cervical__ lumbar When/How long? _____

Epidural injections/Steroids __cervical__ lumbar When/How many? _____

Surgery _____

What makes this problem worse? _____

What makes this problem better? _____



Please shade the area of your pain

Do you experience :

- Neck pain Arm pain Headaches Back pain Leg pain (left or right)
 Weakness of extremity Numbness in extremities Feeling of pins and needles in extremities
 Bowel or bladder incontinence Blackouts Memory difficulties Vision changes
 Speech difficulties Difficulty walking Other _____

Do you have a history of:

- Heart disease/heart attack Heart murmur Asthma Pulmonary disease Sleep apnea
 High blood pressure Diabetes Stomach Problems Reflux Thyroid problems Kidney problems
 Osteoporosis Arthritis Back problems Stroke Stress test in the past Depression
 Psychiatric problems Hepatitis Cancer _____ Other _____

Do you have problems with your:

- Ears, eyes, nose, throat Lungs Shortness of Breath Heart Circulation
 Heart Palpitations Recent unexplained weight loss Stomach or Intestines

Please list all medications and dosages _____

Are you allergic to any medications or food? yes no
 If yes, please list. _____

Please list all surgeries (Type of surgery and date)

- | | |
|---------|---------|
| 1 _____ | 5 _____ |
| 2 _____ | 6 _____ |
| 3 _____ | 7 _____ |
| 4 _____ | 8 _____ |

Does anyone in your family have?

- Diabetes Asthma Seizures Stroke Heart disease Cancer _____
 High blood pressure Aneurysm Back Problems Arthritis

Place of employment _____ **Job Title** _____

Are you collecting any Disability? yes no **If yes, what type of disability** _____

Do you smoke? yes no **How much do you smoke per day** _____

Have you ever smoked in the past? yes no **When did you stop smoking** _____

How often do you drink Alcohol _____

Do you use recreational drugs (marijuana, cocaine, IV drugs) yes no **If so how much** _____

Are you: Married Divorced Single Widowed

Do you have any children? _____ **Who do you live with?** _____

PHARMACY NAME AND PHONE# _____