INSTRUCTION: When all forms are complete, save the document to your computer, open your email and forward it as an attachment to **appointments@njspinecenter.com** or *fax it to* ***973-635-3137***.
Future changes can be made through our patient portal. Watch your email for your invitation!

Name: ______________________________ Date of Birth: ________________ Gender: ☐ Male ☐ Female

Address: ______________________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

______________________________ Social Security #: ______________________________

Email: ______________________________ Driver's License #: ______________________________

Home Phone: ______________________________ Primary Physician: ______________________________

Business Phone: ______________________________ Address: ______________________________

Mobile Phone: ______________________________ Referring Physician ______________________________

Emergency phone: ______________________________ Address: ______________________________

IF UNDER 18 YEARS OF AGE PLEASE PROVIDE GUARANTOR INFORMATION

Name______________________________ Relationship to Patient: ______________________________

Address: ______________________________ Social Security #: ______________________________

Phone: ______________________________ Date of Birth: ________________

PATIENT'S EMPLOYMENT

☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer: ______________________________

Address: ______________________________

Phone: ______________________________

Are you currently working: ☐ Yes ☐ No

INJURY RELATED TO: ☐ **Employment** ☐ **Auto Accident**

Insurance Carrier: ______________________________

Claim #: ______________________________

Date of Injury: ______________________________

Nurse Case Manager: ______________________________

Phone: ______________________________

Do you have an attorney representing you: ☐ Yes ☐ No

PRIMARY INSURANCE

☐ Same as patient ☐ Same as Guarantor ☐ Other

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Policy Holder: ______________________________

Date of Birth______________________________

Social Security #: ______________________________

Insurance Company: ______________________________

Insured ID: ______________________________

SECONDARY INSURANCE

☐ Same as patient ☐ Same as Guarantor ☐ Other

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Policy Holder: ______________________________

Date of Birth______________________________

Social Security #: ______________________________

Insurance Company: ______________________________

Insured ID: ______________________________

Name: ______________________________ Date of Birth: ______________________

RACE: □ American Indian or Alaskan Native □ Asian □ Black or African American □ More Than One Race □ Native Hawaiian
□ Other Pacific Islander □ White □ Unreported

ETHNICITY: □ Hispanic or Latino □ Non-Hispanic or Latino □ Unreported

LANGUAGE: □ English □ Spanish □ Other ______________

PREFERRED LOCAL PHARMACY:

Name: ______________________________ Tel # ______________________________

Address/City: ______________________________

Do you use a mail order pharmacy? □ Yes □ No

If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.

PREFERRED MAIL ORDER PHARMACY:

PREFERRED NOTIFICATION: □ postal mail □ telephone

Reason(s) for coming to see our physicians today: ______________________________

When did your symptoms first occur? ______________________ Frequency: ______________________

How would you describe the character or severity of your symptom(s): □ Sharp □ Dull □ Shooting □ Focal □ Non-Focal

Are there any other symptom(s) associated with your problem: □ Fever □ Chills □ Fatigue □ Nausea □ Vomiting □ Difficulty Sleeping □ Night Sweats

Do any of these make your condition worse: □ Sitting □ Standing □ Bending □ Twisting □ Overhead lifting

Do any of these make your condition better: □ Sitting □ Standing □ Bending □ Twisting □ Overhead lifting

PAST MEDICAL HISTORY:

Hospitalizations: Reason: ______________________________ **Date:** ______________

□ Anxiety	□ Deep Vein Thrombosis	□ Hypertension	□ Schizophrenia
□ Arthritis	□ Degenerative disc disease	□ Hyperthyroidism	□ Seizure Disorder
□ Asthma	□ Dependence on Renal Dialysis	□ Hypothyroidism	□ Stroke
□ Atrial fibrillation	□ Depression	□ Irritable bowel syndrome (IBS)	□ Thrombocytopenia
□ Auto Immune Disease	□ Diabetes Mellitus □ Type I □ Type II	□ Kidney Disease	□ Thrombosis/Thrombophlebitis
□ Bipolar Disorder	□ Sleep Disorder	□ Low Back Pain	□ Tuberculosis
□ Cancer, Breast	□ Emphysema Lung	□ Mitral Valve Prolapse	□ Upper respiratory tract infection
□ Cancer , Ovarian	□ Fibromyalgia	□ Multiple Sclerosis (MS)	
	□ Gastritis	□ Obesity	
□ Cancer, Skin	□ Gastric ulcer	□ Osteopenia	
□ Carpal tunnel syndrome	□ GERD	□ Osteoporosis	
		□ Parkinson's Disease	
□ Cervical Pain (Neck)	□ Hepatitis □ A □ B □ C	□ Peripheral Neuropathy	
□ Colitis, Ulcerative	□ Heart Attack	□ Renal Failure	
□ COPD	□ HIV/AIDS	□ Rheumatoid Arthritis	
□ Coronary Artery Disease	□ Herniated Disc □ Lumbar □ Cervical		
□ Crohn's Disease	□ Hypercholesterolemia		

NEW JERSEY SPINE CENTER

PLEASE LIST ANY OTHER IMPORTANT MEDICAL CONDITION(S) YOU HAVE HAD. INCLUDE DATE OF INITIAL DIAGNOSIS IF POSSIBLE.
(Do not include common colds or flu)

____

PAST SURGICAL HISTORY: List any surgery(s) or injury(s) which you have had, Please provide dates:

____

ALLERGY HISTORY: Are you allergic to any of the following? : □ Latex □ Iodine □ Contrast Dye □ Shellfish □ No known drug allergies
□ Other: ____

MEDICATION: Please list any and all medications, vitamins, minerals or herbal supplements/ Dose & Frequency or provide a list at time of service:

Name: ______________ Dosage: ______________ Frequency: ________ **Name**: ______________ Dosage: ______________ Frequency: __________
Name: ______________ Dosage: ______________ Frequency: ________ **Name**: ______________ Dosage: ______________ Frequency: __________
Name: ______________ Dosage: ______________ Frequency: ________ **Name**: ______________ Dosage: ______________ Frequency: __________

SOCIAL HISTORY: Please check:

Smoking: □ Yes □ No If yes indicate: (how much) ___________ (frequency) ________________ Quit: __________ (How long ago) ___________

Alcohol: □ Yes □ No If yes indicate: (how much) ___________ (frequency) ________________

Illicit Drugs: □ Yes □ No if yes, please indicate what type of drug (s): ___________________________(how often) ___________________

Occupation: ______________________________________ Exercise: □ Yes □ No (frequency) _____________________________________

FAMILY HISTORY:
Please check if any family members have been diagnosed with the following, please specify family member: **Example**: mother/ father / sister / brother

□ Alcohol abuse _________
□ Bleeding disorder _________
□ Cerebrovascular accident _________
□ Cerebrovascular disease _________
□ Coronary artery disease _________
□ Cancer _________
□ Depression ________
□ Diabetes Mellitus ________
□ Heart Disease ________
□ HIV ________
□ Hypertension ________
□ Hypothyroidism ________
□ Obesity __________
□ Other __________

REVIEW OF SYSTEMS: Please check if you have recently experienced the following: Are there any other symptom(s) associated with your problem:
GENERAL: □ Fever □ Chills □ Fatigue □ Nausea □ Vomiting □ Difficulty sleeping □ Night sweats

Height: __________ Weight:__________lbs.

Skin	Respiratory	Gastrointestinal	FemaleGenitourinary	Neurological	Endocrine
□ Rash □ Bruising □ Non-Healing Wound □ Skin color Changes	□ Chronic Cough □ Shortness of Breath □ Difficulty Breathing □ Wheezing	□ Heartburn □ Abdominal Pain □ Trouble Swallowing □ Change in Bowel Habits	□ Flank Pain □ Urinary Urgency □ Urinary Incontinence □ Urinary Retention □ Difficulty Urinating □ Urinary Leakage □ Pelvic pain	□ Loss of Bowel Control □ Dizziness □ Numbness □ Tingling □ Trouble Walking □ Unsteadiness □ Seizures	□ Weight Loss/Gain (Unintentional) □ Hot or Cold Intolerance □ Hair or Nail Changes
HEENT:	**Cardiovascular**	**MaleGenitourinary**	**Musculoskeletal**	**Psychiatric**	**Hematological**
□ Headaches □ Double Vision □ Hearing Loss □ Hoarseness	□ Chest Pain □ Palpitations □ Swelling of the extremities	□ Flank Pain □ Urinary Urgency □ Urinary Incontinence □ Urinary Retention □ Difficulty Urinating □ Retrograde Ejaculation □ Decreased Libido □ Impotence	□ Joint Stiffness □ Joint Swelling □ Joint Redness □ Leg Cramps □ Muscle Pain □ Muscle Cramps □ Muscle weakness □ Decreased Range of Motion	□ Anxiety □ Depression □ Suicidal Thoughts □ Alcohol/Drug Dependency □ Memory Loss	□ Abnormal Bleeding □ Enlarged Lymph Nodes □ Anemia □ Deep Vein Thrombosis/DVT

I certify that the above is accurate, complete and without fabrication or suppression

Name (Print) ________________________________ Signature__________________________________ Date of Birth________________

Reviewed by:__________________

Important Notice: Effective January 1, 2015 all prescription renewal requests must come through our patient portal. Be sure to register

PRESCRIPTION RENEWAL POLICY

New Jersey Spine Center accepts calls for prescription renewals during normal business hours only. We cannot renew medications during the evening or on weekends when your chart is unavailable.

- All medication requests, including opiates, must be made two (2) days in advance.
- Call before 10:00 a.m. to ensure that your request is addressed within 48 hours.
- Messages left after 10:00 a.m. are recovered and addressed the next business day.
- Call your pharmacy to confirm that your renewal is ready for pick-up.
- All opiate prescriptions must be picked up in person at our office.
- We do not mail prescriptions.
- There is a $15.00 fee for all prescriptions that require authorization

Please do not call more than once to inquire about your prescription as this will delay the renewal process.

Patients are required to have regularly scheduled follow up visits with their physician. We will not address any medication renewal requests or approve any renewals if you are not seen by your physician on a regular basis.

We have a phone line dedicated to prescription renewals. Call our main phone number (973) 635-0800. When the auto-attendant answers, you should dial extension #199. Follow the instructions carefully. Be assured that all messages are addressed.

PLEASE BE ADVISED:

Any single violation of our prescription policy may result in dismissal from our practice.

Signature: ______________________________ Date: _________

Thank you for your cooperation

CONSENT TO TREAT

I hereby authorize the physicians of New Jersey Spine Center to diagnose and make treatment recommendations for my care.

HIPAA CONSENT

I hereby consent to the use of my otherwise protected health information for the purpose of my ongoing treatment, New Jersey Spine Center's operations, and/or to secure reimbursement for services. A copy of the privacy policy has been made available to me as per HIPAA requirements.

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby instruct and direct assignment of all allowable insurance benefits under my policy otherwise payable to me to be issued to:

New Jersey Spine Center, 40 Main Street, Chatham, NJ 07928.

I have received a copy of NJSC financial policy and will make the appropriate payment for today's services. I understand that if my account is not paid directly by my insurance company I may be responsible for the full amount. I acknowledge the fact that my insurance policy may exclude certain services that may be medically necessary and that I could be responsible for payment of such services. I have provided information for all potential payers including No Fault/PIP, worker compensation, and group health without exception.

I authorize a representative of New Jersey Spine Center to initiate a complaint to the insurance commissioner for any reason on my behalf. This includes assigning a NJSC representative the right to proceed via Arbitration or Superior Court to collect any unpaid bills on my behalf. I acknowledge there will be a returned check fee of $35.00 assessed for each item not honored by my bank. I agree that if my account is referred to an outside agency or attorney for collection, I could be held responsible for additional fees. A photocopy of this assignment shall be considered as valid as the original.

I understand the following administrative fees:

- All forms, payable upon receipt of the form and prior to completion: $15.00
- Medication Authorization as required by your insurance carrier: $15.00
  You may speak to your physician about alternative medications.
- Same day Cancellation of an epidural injection: $125.00
- Cancellation of a surgical procedure: $300.00

I acknowledge receipt of New Jersey Spine Center's policy guidelines. This includes but is not limited to financial policy, patient responsibilities, prescription renewal, privacy policy, appointment cancellations, health information services and medical records.

By signing this form, you acknowledge that you have read and agree to the consent and assignment of benefits, and receipt of our practice policies

____ Date of Birth:__________________

Print Patient/Guardian Name

____ ____________________________

Signature of Patient/Guardian Date

WATCH YOUR EMAIL FOR YOUR INVITATION TO OUR PATIENT PORTAL!

REGISTER to receive a $10.00 credit toward your next visit

We are pleased to offer online access to your personal health record

Welcome to our Patient Portal

FOLLOW MY HEALTH

-------View or Update------

☑ **Demographic Information**

☑ **Allergies**

☑ **Insurance Information**

------As well as Request------

☑ **Medication Refills**

☑ **Appointments**

-------And------

☑ **Send secure messages to your doctor and our staff**

❖❖❖

The following instructions are provided for your reference:

- Check your Email for Invitation and accept by clicking on the link provided: “Register now with Follow My Health”
- Click “Create An Account”
- Choose the method you wish to use to create your account: Google, Yahoo, Facebook, Windows, Cerner Health or FMH (email users not listed above: Optonline, Verizon,etc.)
- Follow instructions to create your user name and password. You will be asked to once again type your newly created username and password to officially log in.
- Your login will be confirmed and you will be asked to follow the five steps to access your account for one time only.
  - Step #1: Welcome
  - Step #2: Agreement Terms
  - Step #3: Invite code (Your birth year)
  - Step #4: Release of Information: Accept
  - Step #5: Your health information will upload to your secure portal account from your Electronic Health record with NJ Spine Center.

COUPON VALIDATION:

- Step #6: Once you are in your new portal account there will be an immediate message on your home page that documents have been added for you to view. One of these is the FMH Privacy Terms and Conditions Agreement which you will have to click on to sign and submit. When this is successfully submitted you are eligible for your one time use coupon.

If you have any questions or need assistance accessing your portal account please feel free to contact our portal manager at 973-635-6403 x 271

www.njspinecenter.com