New Jersey Spine Center

PLEASE COMPLETE ALL SECTIONS IN THEIR ENTIRETY

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

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

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

Insurance Carrier: _____

Claim #: _____

Date of Injury: _____

Nurse Case Manager: _____

Phone: _____

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: _____

New Jersey Spine Center

PLEASE COMPLETE ALL SECTIONS IN THEIR ENTIRETY

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

Sex at Birth: □ M □ F **Gender Identity**: □ M □ F **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 □ Burning □ Itching **PAIN SCORE** (0-10) :_____

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:

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

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	_____	□ Coronary artery disease	_____	□ Heart Disease	_____	□ Obesity	_____
□ Bleeding disorder	_____	□ Cancer	_____	□ HIV	_____	□ Other	_____
□ Cerebrovascular disease	_____	□ Depression	_____	□ Hypertension	_____		
□ Cerebrovascular accident	_____	□ Diabetes Mellitus	_____	□ Hypothyroidism	_____		

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) _____ Date of Birth_____ Reviewed By_____

NEW JERSEY SPINE CENTER

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.

PATIENT PORTAL

An email invitation to our patient portal was sent to you. Simply click on the link in the body of the email to begin registration. For security purposes a second email was sent providing your portal activation code. If you have not received an invitation or if you have any questions regarding the registration process, please contact our office for further assistance: (973) 635-0800, Ext. #273.

PRESCRIPTION RENEWAL POLICY

Effective January 1, 2020 all prescription renewal requests must come through our patient portal.

- All medication refill requests, including opioids, must be made two (2) days in advance.
- Refill requests must be made Monday thru Friday between the hours of 9am and 4pm.
- Call your pharmacy to confirm that your renewal is ready for pick-up.
- We do not mail prescriptions.

_____ There is a $15.00 fee for each prescription that requires authorization. Authorizations are typically valid for up to 6 months.
Initial Here

As per state regulations, patients on a medication regiment are required to visit their physician periodically. Please be sure to schedule your follow-up visits with your physician.

New Jersey Spine Center has a dedicated phone line for all prescription related inquiries:
(973) 635-0800, Ext. #199. Follow the instructions carefully.
Please do not call more than once to inquire about your prescription as this will delay the renewal process.

I certify that I have read and understand the consent and policy statements outlined above. I acknowledge and agree to the terms of the Treatment and HIPAA consents, Portal and Prescription Renewal Policies.

_____ _____
Print Patient/Guardian Name Date of Birth

_____ _____
Signature of Patient/Guardian Date

NEW JERSEY SPINE CENTER

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

To provide timely and accurate payment to New Jersey Spine Center for any services furnished the patient named below by New Jersey Spine Center physicians and health care providers:

- I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I assign my right to receive payment of authorized benefits to New Jersey Spine Center.
- I request that payment of authorized benefits be made on my behalf to New Jersey Spine Center for any services furnished the patient listed below by New Jersey Spine Center physicians and health care providers.
- I authorize New Jersey Spine Center to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I further authorize a representative of New Jersey Spine Center to initiate a complaint to the Department of Banking and Insurance for any reason on my behalf.
- If my Health Insurance Plan will not direct payment to New Jersey Spine Center, I agree to forward to New Jersey Spine Center all health insurance payments which I receive for the services rendered by New Jersey Spine Center and its health care providers.
- I authorize New Jersey Spine Center or any holder of medical information about me, or the patient named below, to release to my Health Insurance Plan such information needed to determine benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for and agree to pay all charges for services provided to the patient named below which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- I further agree that, if permissible by law, I will assume all costs, expenses and attorney's fees that may be incurred by New Jersey Spine Center to collect those charges. 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.
- That this financial form with assignment of benefits applies and extends to subsequent visits and services rendered by New Jersey Spine Center.

I understand the following administrative fees: (Please initial)

_____	Forms, payable upon receipt of the form and prior to completion:	$15.00
_____	FMLA (Family Medical Leave Act) Forms, payable upon receipt of the forms and prior to completion:	$29.00
_____	Medication Authorization as required by your insurance carrier: (You may speak to your physician about alternative medications)	$15.00
_____	Same day Cancellation of an epidural injection:	$125.00
_____	Cancellation of a surgical procedure at anytime:	$300.00
_____	Returned check fee:	$35.00

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____ _____

Print Patient/Guardian Name Date of Birth Relationship to Patient

_____ _____

Signature of Patient/Guardian Date