



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: _____



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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: Back Pain Neck Pain Other: _____

PAST MEDICAL HISTORY:
 Heart Disease Lung Disease Diabetes Blood Clots/Blood Thinners
Name of Cardiologist: _____ EKG Echocardiogram Stress Test
Name of Pulmonologist: _____
Name of Endocrinologist: _____
Name of Hematologist: _____
 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 Apnea/Disorder Emphysema Lung Fibromyalgia Gastritis Gastric ulcer GERD Hepatitis A B C Heart Attack HIV/AIDS Herniated Disc Lumbar Cervical Hypercholesterolemia
 Hypertension/High Blood Pressure 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



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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

<input type="checkbox"/> Alcohol abuse _____	<input type="checkbox"/> Coronary artery disease _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Obesity _____
<input type="checkbox"/> Bleeding disorder _____	<input type="checkbox"/> Cancer _____	<input type="checkbox"/> HIV _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cerebrovascular disease _____	<input type="checkbox"/> Depression _____	<input type="checkbox"/> Hypertension _____	
<input type="checkbox"/> Cerebrovascular accident _____	<input type="checkbox"/> Diabetes Mellitus _____	<input type="checkbox"/> 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 <input type="checkbox"/> Rash <input type="checkbox"/> Bruising <input type="checkbox"/> Non-Healing Wound <input type="checkbox"/> Skin color Changes	Respiratory <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Wheezing	Gastrointestinal <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Change in Bowel Habits	FemaleGenitourinary <input type="checkbox"/> Flank Pain <input type="checkbox"/> Urinary Urgency <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Urinary Retention <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Urinary Leakage <input type="checkbox"/> Pelvic pain	Neurological <input type="checkbox"/> Loss of Bowel Control <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Trouble Walking <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Seizures	Endocrine <input type="checkbox"/> Weight Loss/Gain (Unintentional) <input type="checkbox"/> Hot or Cold Intolerance <input type="checkbox"/> Hair or Nail Changes
HEENT: <input type="checkbox"/> Headaches <input type="checkbox"/> Double Vision <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness	Cardiovascular <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling of the Extremities	MaleGenitourinary <input type="checkbox"/> Flank Pain <input type="checkbox"/> Urinary Urgency <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Urinary Retention <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Retrograde Ejaculation <input type="checkbox"/> Decreased Libido <input type="checkbox"/> Impotence	Musculoskeletal <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Redness <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Decreased Range of Motion	Psychiatric <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Alcohol/Drug Dependency <input type="checkbox"/> Memory Loss	Hematological <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Enlarged Lymph Nodes <input type="checkbox"/> Anemia <input type="checkbox"/> Deep Vein Thrombosis / DVT

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

Name (Print) _____ Date of Birth _____ Reviewed By _____



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
Initial Here typically valid for up to 6 months.

As per state regulations, patients on a medication regimen 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



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