Pain Management ASSOCIATES

Patient Health History - Intake Form

Patient Information

Name: (Last, First, Middle):				Date:
Date of Birth:	Soc. Sec #:			Home Phone:
E-mail Address:				Cell Phone:
Address:				May We Text You? □ Yes □ No
City:	State:	Zip Code:		Sex M F
Marital Status: Single	Married	Divorced	Widow	Separated

Primary Insurance

Insurance Company:	Effective Date:
Insurance ID #:	Group #:
Please enter the policyholder's information below. If you are the policy holder, check here □ and continue to the next section.	
Policyholder's Name (Last, First, Middle)	
Relationship to Patient: / Soc. Sec # / Date of Birth:	
Insured's Employer:	
Address:	Phone:

Secondary Insurance

Insurance Company:	Effective Date:
Insurance ID #:	Group #:
Please enter the policyholder's information below. If you are the policy holder, check here □ and continue to the next section.	
Policyholder's Name (Last, First, Middle)	
Relationship to Patient: / Soc. Sec # / Date of Birth:	

MVA / Worker's Compensation

Insurance Company		
Claim #:	Date of Loss:	
Adjuster's Name:	Phone #:	
Employer:	Occupation:	
Address:		
City:	State:	Zip Code:
Full Time	Part Time	Unemployed
Lawyer:	Phone:	City:

Contact

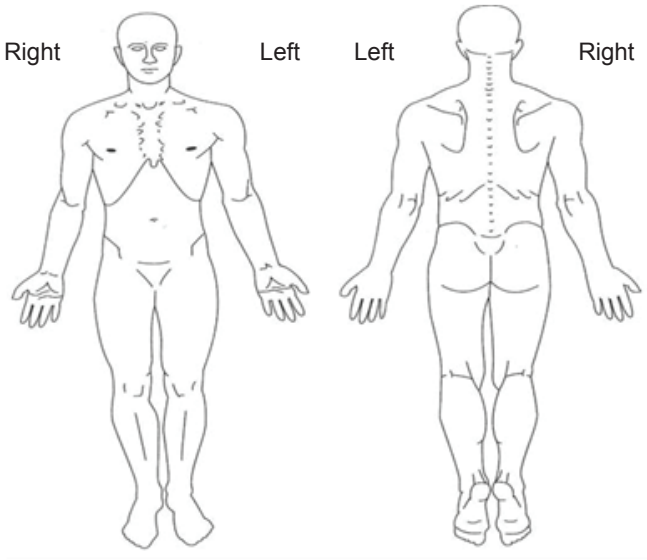
Emergency Contact:	
Relationship:	Phone:
Who Referred You to Pain Management Associates?:	
Primary Care Physician:	Phone:

By signing this form, I certify that the consultations I am having today are NOT related to an auto or work related accident.

Signature: _____ Date: _____

Patient Name: _____ Date: _____

Please Draw the Location of Your Pain Using the Symbols Shown Below



D = Dull B = Burning N = Numb S = Stabbing T = Tingling C = Cramping

What is your Pain Right Now?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What is your pain level at its best?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What is your typical or Average Pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

What is your pain at its worst?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible

Venous History

Please circle which symptoms you currently have or have had:

Leg Pain	Tenderness	Ankle Swelling	Leg Cramps
Heaviness	Open Sore/Ulcer	Red Warm Areas	Restless Legs

Injury / Pain Information

What caused your pain?: □ Work Related □ Car Accident Date: _____

□ Other Describe: _____

When did your current episode begin?

How often does the pain occur? □ Continuously □ Daily □ Several Times a Week

What makes it worse? □ Sitting □ Standing □ Walking □ Other: _____

What makes it better?

Where is your 1st problem? _____

Where is your 2nd problem?_____

Does the pain interrupt your sleep: □ Yes □ No

Patient Name: _____ Date: _____

Past Treatment

Have you tried other treatments for this condition? Yes No

Please indicate below the improvement seen with any other treatments you have received.
Improvement Rating: 1 = Better 2 = Little to No Improvement 3 = No Change 4 = Worse

Treatment	Duration / # of Times	Area	Rating
Chiropractor			1 2 3 4
Physical Therapy			1 2 3 4
Pain Management Injections	□ Yes □ No *When* _____ *Where* _____ *Type* _____ *Area* _____		
Back Surgery	□ Yes □ No *When* _____ *Where* _____		

Diagnostic Testing	Yes	No	Area
MRI			
Nerve Testing			

Medications

Have you tried any pain/sleep medication treatments for this condition? Yes No

Please indicate below the improvement seen with any other treatments you have received.
Effectiveness Rating: 1 = Great Help 2 = Some Help 3 = No Help

Pain/Sleep Medication	Are You Currently Taking This Medication?	How Long Did You Take the Medication?	Effectiveness Rating
	Yes No		1 2 3
	Yes No		1 2 3
	Yes No		1 2 3
	Yes No		1 2 3
	Yes No		1 2 3

Please List All Other Medications You Are Currently Taking:

Medication	Dosage	Medication	Dosage

Occupational History

Are you currently working? Yes No Occupation? _____

Does your pain affect you ability to perform your job duties? Yes No

Are you unable to work because of your pain? Yes No

If yes, please describe: _____

_____

History and Physical

Patient Name: _____

Age: _____ Sex: Female Male Height: _____ Weight: _____

Allergies: □ None □ Yes □ NKDA □ Latex □ Dye □ Contrast □ Other ____

Reaction to Allergies: _____

Medications: □ None □ Yes Please List _____

_____

_____

Are you on blood thinners: □ None □ Yes □ Coumadin □ Plavix □ Other _____

Patient Medical History

Condition					Other
Endocrine	□ None	□ Diabetes: Insulin	□ Diabetes: Non-Insulin	□ Thyroid	
Eyes	□ None	□ Glaucoma: Narrow Angle	□ Glaucoma: Wide Angle		
Cardio	□ None	□ High Blood Pressure	□ Heart Attack	□ Valve Problem	
		□ Heart Surgery	□ Angina		
Circulation	□ None	□ Peripheral Vascular Disease	□ Chronic Edema	□ Varicose Veins	
				□ Spider Veins	
Neurological	□ None	□ CVA/Stroke	□ Seizures		
Respiratory	□ None	□ Emphysema	□ Asthma	□ COPD	
Gastrointestinal	□ None	□ Ulcers	□ Heartburn/Reflux	□ Liver Problems	
Genitourinary	□ None	□ Urination Problems	□ Kidney Stones	□ Erectile Dysfunction	
Musculoskeletal	□ None	□ Arthritis	□ Joint Replacement		
Psychiatric	□ None	□ Depression	□ Anxiety	□ Claustrophobia	
Hematologic	□ None	□ Low Platelets	□ Bleeding	□ Poor Clotting	
Venous Disease	□ None	□ Varicose	□ Spider Veins		

Surgical History: □ None □ Yes Type: _____

If Yes - Any difficulty with Anesthesia? _____

Social History: Smoking: No Yes How Much: _____

Alcohol: No Yes How Much: _____

Drugs: No Yes

Family History: _____

Office Use Only --- Do Not Write Below

Physical Exam

	Normal	Abnormal	If Abnormal, please specify:
HEENT			
Chest/Lung			
Heart			
Neurological			
Mental Status			

Physician Signature: _____ **Date**: _____

If the History and Physical Examination was performed more than seven(7) days prior to surgery
□ The above was reviewed by me. No change has occurred since the H&P was completed.
□ The patient's current medical status has changed since the last H&P was performed in that: ____

_____

Physician Signature: _____ Date: _____

Office Use Only --- Do Not Write Below

Physical Exam

Vitals	HT:	WT:	HR:	BP:	R:

	Range of Motion	
	C-Spine	L-Spine
F. Flexion	_____ / 45	_____ / 80
Extension	_____ / 45	_____ / 30
R. Lateral	_____ / 45	_____ / 40
L. Lateral	_____ / 45	_____ / 40
R. Rotation	_____ / 60	_____ / 45
L. Rotation	_____ / 60	_____ / 45
R. SLR		_____ / 60
L. SLR		_____ / 60

DTR's		
Bicep	_____ / 2	_____ / 2
Patella	_____ / 2	_____ / 2
Achilles	_____ / 2	_____ / 2
Strength		
UE	_____ / 5	_____ / 5
LE	_____ / 5	_____ / 5
Sensory		
UE		
LE		

Orthopedic Exam

Elbow	Shoulder
Medial Epicondylitis	+ - Neer Impingement Sign/Rotator Cuff
+ - Pain Resisted Wrist Flexion	+ - Pain or Resisted Abduction/Supraspinatus
Lateral Epicondylitis	+ - Pain or Resisted Lateral Rotation (infraspinatus)
+ - Firm Hand Grasping	+ - Medial Rotation (subscapularis)
+ - Pain Resisted Wrist Extension	+ - Elbow Flexion (Biceps)
	+ - Supination (Biceps)
Knee	
+ - Valgus Stress Test (Medial Collateral Ligament)	+ - Varus Stress Test (Lateral Collateral Ligament)
+ - McMurray Test (Medial Meniscus)	(Extension = Lateral Movement)

Notes:

Physician Signature: _____ Date: _____

Pain Management Associates

Assignment of Benefits and LTD Power of Attorney

I hereby assign benefits and authorize payment directly to Pain Management Associates and/or its staff (hereinafter collectively "You") of any insurance benefits made as payment to me (or a minor for whom I am guardian) as reimbursement for services provided to me(or a minor for whom I am the guardian) for their services. I agree to immediately forward to this office any insurance payments which are made directly to me.

I, _____, irrevocably assign to you, Pain Management Associates, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically included filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code. I request that the insurance carrier consent to my assignment of benefits Within 10 days of receipt otherwise it is deemed consented to.

As a medical provider I agree to attempt to reasonably comply with the PIP carrier's decision point review/pre-certification plan and to hold the patient harmless if I fail to comply with same, in consideration for the carrier's consent to this assignment.

In the even the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against the carrier in my name or in your name as a medical provider rendering services to me and designate your collection agency as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release call such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

I understand that I am responsible for all fees charged, whether they are covered by insurance or not. Also, I am aware it is my personal responsibility to monitor insurance payments and maximums. If I receive any payment from an insurance carrier relating to the services rendered, I agree that I will hold such payment in trust for _____ and I also agree to send such payment to _____ within one week after receipt of same. I also agree to pay attorney's fees equal to 33 1/3% of the outstanding balance, plus court costs, in the event the account is turned over to an attorney for collection.

Patient's Signature: _____ Date: _____

Patient's Name (printed): _____

Pain Management Associates

305 West Grand Avenue Suite 500
Montvale, NJ 07645
Tel: 201-326-4777 ● Fax: 201-391-1196

Acknowledgement of Patient Rights and Privacy Practices

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by our practice listed at the beginning of this notice, and how I may obtain access to and control this information.

_____ _____

Signature(Patient) Date

_____

Print Name

Pain Management Associates

305 West Grand Avenue Suite 500
Montvale, NJ 07645
Tel: 201-326-4777 Fax: 201-391-1196

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

_____ Complete record

_____ Records of care from _____ to _____ only

_____ Records of care concerning the following condition(s)

_____

_____ Other. Specify: _____

_____ Confer with other person orally about information in my medical record

to the following person(s):

_____
Name

_____
Street

_____
City State ZIP

The reasons or purposes for this release of information are:

_____

_____

_____

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Signed:_____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)