

Long Island Spine Specialists INITIAL PATIENT FORM

DATE: _____

REFERRED BY: _____

DOCTOR

CHIROPRACTOR

FRIEND/RELATIVE

LAST NAME: _____ FIRST NAME: _____ Age _____ Date of Birth _____

SOCIAL SECURITY #: _____ PRIMARY CARE PHYSICIAN: _____

Do you see a Pain Management Physician. No Yes If yes, name: _____

Reason For Today's Visit: _____

1. DID YOU HAVE AN INJURY? No Yes. If yes, explain what happened?

2. HOW LONG HAVE YOU HAD THE PAIN? _____

3. IS THE PAIN GETTING WORSE? _____

➡ Please check (✓) box if this problem related to a: On the job injury/Date: _____ Motor vehicle accident./ Date: _____

YOUR CURRENT MEDICATIONS ARE: _____

Do You Take Aspirin Do You Take Fish Oil

Your Pharmacy Name: _____ Address: _____ Phone#: _____

ALLERGIC TO MEDICATIONS: _____

Latex allergy Shellfish allergy Food Allergy _____

Would you like to designate a family member or friend to discuss your medical information? Yes No

If yes please give: Name: _____ Phone: _____ Relationship to you: _____

Medical History Name: _____

➤ Please check the box if you have had any of the following conditions:

- CARDIOVASCULAR** – example (heart problems, high blood pressure, pacemaker, other). List specific: _____
- DERMATOLOGIC** – (skin rashes, psoriasis, other) list specific: _____
- GASTROINTESTINAL** – (Stomach, bowel, intestines, ulcers, other) list specific: _____
- GENITOURINARY** – (urinary problems, kidney disease, other) list specific: _____
- EARS, NOSE, THROAT** – (Chronic tonsillitis, sinus infections, other) list specific: _____
- HEMATOLOGIC** – (anemia, bleeding disorders, other.) list specific: _____
- IMMUNOLOGIC DISORDERS - INFECTIOUS DISEASE** (tuberculosis, HIV, hepatitis, other) list specific: _____
- ENDOCRINE/METABOLIC** – (diabetes, thyroid conditions, other) list specific: _____
- MUSCULOSKELETAL** – (bursitis, gout, arthritis, other) list specific: _____
- NEOPLASTIC CONDITION** – (cancer, tumors, other.) list specific: _____
- NEUROPSYCHIATRIC** – (depression, seizures, anxiety disorder, other.) list specific: _____
- PULMONARY** – (asthma, lung disease, other breathing disorder.) list specific: _____
- WOMEN – HEALTH ISSUES** – (cystic ovaries, dysmenorrhea, other) list specific: _____
- OTHER** – (PLEASE INDICATE) _____

S U R G I C A L H I S T O R Y

PROCEDURE	YEAR	DOCTOR'S NAME	COMMENTS

Family History Name: _____

If deceased please check (v) BOX: MOTHER - Age _____ FATHER - Age _____

Has any family member been diagnosed with the following? Please check (v) box and corresponding condition.

- Mother** Scoliosis Stenosis Degenerative or Herniated Disc Osteoporosis Cancer Arthritis
- Father** - Scoliosis Stenosis Degenerative or Herniated Disc Osteoporosis Cancer Arthritis
- Brother** Scoliosis Stenosis Degenerative or Herniated Disc Osteoporosis Cancer Arthritis
- Sister** Scoliosis Stenosis Degenerative or Herniated Disc Osteoporosis Cancer Arthritis
- Grandparent** Scoliosis Stenosis Degenerative or Herniated Disc Osteoporosis Cancer Arthritis
- Other** Scoliosis Stenosis Degenerative or Herniated Disc Osteoporosis Cancer Arthritis

WORK HISTORY

Please check (v) off boxes that apply to you.

Occupation: _____

RETIRED. Since _____ (give date) Unemployed

DISABLED. If so, please indicate. Full/Permanent Partial/Permanent Full/temporary Partial/temporary

Have you previously missed any days from work due to back pain? Yes No If so, how long? _____

Disabled through Social Security? Yes No Last date worked prior to disability _____

SOCIAL HISTORY

Please check (v) off boxes that apply to you.

Marital status : single married divorced widowed Children Yes No

Living arrangements at home: alone with spouse with family nursing facility retirement community

Tobacco: Yes No Former smoker If so, how much: _____ packs per day. -Yrs Smoked _____ Quit Date: _____(year)

Consume Alcohol: No YES - SOCIAL DAILY How much _____ Type _____

Have you ever been treated for drug or alcohol addiction? Yes No

Current Conditions

NAME: _____

If you have had any of the following conditions in the LAST TWO MONTHS, please check the box (✓).

CONSTITUTIONAL SYMPTOMS

- Fevers/Chills
- Weight loss
- Weight gain
- Fatigue

HEENT

- Headache
- Dizziness
- Difficulty Swallowing

RESPIRATORY

- Shortness of breath
- Cough

CARDIOVASCULAR

- Chest pain
- High Blood Pressure
- Edema

GASTROINTESTINAL

- Nausea/Vomiting
- Abdominal Pain
- Diarrhea
- Constipation

Bowel Incontinence

GENITOURINARY

- Urinary incontinence
- Painful urination
- Blood in urine

REPRODUCTIVE

Significant Health information

Male: _____

Female: _____

DERMATOLOGIC

- Rash
- Itching

HEMATOLOGIC

- Bruising
- Bleed Easily
- Blood Clot

IMMUNOLOGIC

- Hay Fever
- Environmental allergies
- Asthma

Please check (✓) box: Are you right handed? Left-handed? Ambidextrous? (able to use both hands with equal ease)

Do You Wear Glasses? No Yes - Contacts No Yes Both

I give my authorization to discuss "medical care" if I designated persons in this form. I have answered the questions to the best of my ability.

PATIENT SIGNATURE: _____ DATE _____

PLEASE PRINT NAME: _____

NAME: _____

PLEASE USE THE APPROPRIATE SYMBOLS TO DESCRIBE YOUR SYMPTOMS AND MARK THE LOCATION AS ACCURATELY AS POSSIBLE ON THE BODY DRAWING, BELOW

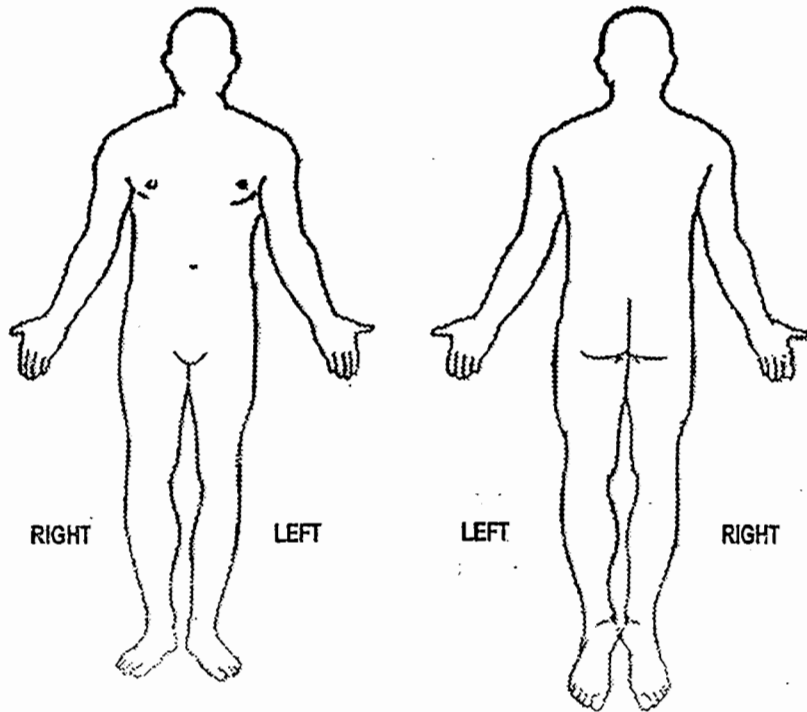
ACHING ^^^^^

STABBING // // // //

TINGLING = = =

BURNING XXXXX

NUMBNESS 0000000



HOW BAD IS YOUR PAIN NOW?

PLEASE INDICATE PAIN LEVEL FROM 1 TO 10

No PAIN | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst PAIN

WHAT POSITION /ACTIVITY MAKES THE PAIN WORSE/BETTER?

	WORSE	BETTER	COMMENTS
BENDING			
BOWEL MOVEMENT			
COUGHING			
GENERAL ACTIVITY			
HOME REMEDIES			
LYING DOWN			
SITTING			
STANDING			
WALKING			

HOW LONG CAN YOU SIT WITH NO PAIN OR MINIMAL PAIN? _____ MINUTES.

HOW LONG CAN YOU STAND WITH NO PAIN OR MINIMAL PAIN? _____ MINUTES.

HOW FAR CAN YOU WALK WITH NO PAIN OR MINIMAL PAIN?
 0-50 FT 50-200 FT 200-500 FT 500+ FT 1/2 mile+

Do you require support to help you walk from a cane or walker? Yes No

Do you wear and neck or back brace? Yes No

PLEASE INDICATE WHICH DIAGNOSTIC TESTS YOU HAVE UNDERGONE FOR YOUR MAIN COMPLAINT/PROBLEM. INCLUDE DATES.

TEST	DATE	TEST	DATE
PLAIN X-RAY		EMG/NVC/ SSEP	
BONE SCAN		MRI	
MYELOGRAM		BONE DENSITY/ DEXA SCAN	
CT SCAN		FACET BLOCKS	
DISCOGRAM		OTHER- INDICATE	



PAIN MANAGEMENT/MEDICATION TREATMENT AGREEMENT

We are committed to doing all we can to treat your chronic pain condition. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of chronic pain and related conditions all of which are strictly regulated by both State and Federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use.

- All controlled substances have a potential for dependency and abuse. I will not increase my dosage unless discussed with my doctor *first*. I understand the risks of not adhering to the recommended dosage.
- All controlled substances must come from this office, unless specific authorization is obtained for an exception.
- I will inform my doctor of any new medical conditions or medications.
- All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies our office must be informed. The pharmacy that you have selected is:
 Phone: _____
- The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
- You may not share, sell, or otherwise permit others including spouse or family members to have access to these medications.
- Routine blood work is required every six months. Unannounced urine or serum toxicology screens may be requested and your cooperation is required. Presence of unauthorized substances may result in your discharge from this facility.
- I will not consume excessive amounts of alcohol in conjunction with narcotics, nor will I use, purchase, or otherwise obtain any illegal drugs.
- Medications will not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told is not enough.
- If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
- Early refills will not be given. Renewals are based upon keeping scheduled appointments, every three months. Please do not phone for prescriptions after hours or on weekends. Refills will require 48 hours notice. All prescriptions must be picked up between 10 a.m. and 4 p.m., and signed for. Photo ID is required.
- In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given. Alteration of a prescription, in any way, is illegal and will result in discharge from this practice.
- It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this office.
- You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

(PRINT) PATIENT'S FULL NAME: _____ DATE OF BIRTH: _____

PATIENT'S SIGNATURE: _____ DATE: _____

INSURANCE FORM

DATE: _____

Referred by: Dr. _____

LAST NAME: _____ FIRST NAME: _____ SOCIAL SECURITY#: _____

Address: _____

SEX: M__ F__

AGE: _____ DATE OF BIRTH: _____

Marital Status: Single Married Separated Divorced

Home Telephone #: _____ Cell#: _____ E-Mail Address: _____

Employer/Address/Phone

Primary Care Physician/Address/Phone

INSURANCE INFORMATION

PRIMARY:

INSURANCE NAME: _____
ID#: _____
ADDRESS: _____

POLICY HOLDER: _____

POLICY HOLDER'S DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

SECONDARY:

INSURANCE NAME: _____
ID#: _____
ADDRESS: _____

POLICY HOLDER: _____

POLICY HOLDER'S DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____

WORKERS' COMPENSATION INFORMATION:

INSURANCE CARRIER: _____
INS. CO. ADDRESS#: _____

WCB# _____

EMPLOYER AT THE TIME OF THIS INJURY: _____

ADDRESS: _____

PHONE#: _____

CARRIER CASE #: _____

LAST DATE WORKED: _____

DATE OF INJURY: _____

NO-FAULT INFORMATION:

-- You MUST PROVIDE YOUR PRIMARY INSURANCE, AS WELL. NO EXCEPTIONS

INSURANCE CARRIER: _____
INS. CO. ADDRESS: _____

POLICY# _____
INSURED PARTY: _____

PHONE#: _____

DATE OF ACCIDENT: _____

CLAIM #: _____

RELATIONSHIP TO INSURED: _____

Release Signed [for office use only]

GUARANTEE AGREEMENT

I. INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES:

In consideration of services rendered by *Long Island Spine Specialists, P.C.*, to the undersigned patient, the undersigned promise(s) to pay to Long Island Spine Specialists, any co-payment, co-insurance, deductible or other changes required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan. In case of denial or termination of benefits, or in the event I fail to inform you of any changes in my insurance coverage, I, the undersigned, understand that I am responsible for payment in full for services rendered.

In the case of denial from No-Fault, the Workers' compensation Board, Workers' Compensation Carrier or termination of my orthopedic benefits, I, the undersigned, am responsible for payment in full of any and all services rendered.

II. ASSIGNMENT OF BENEFIT PROCEEDS:

I hereby assign to *Long Island Spine Specialists*, all monies and/or benefits to which I am entitled from my insurer/HMO/third-party pavor, No Fault, Workers' Compensation policy, government agencies, or those who are financially liable for my medical care.

III. AUTHORIZATION TO RELEASE RECORDS:

I hereby authorize *Long Island Spine Specialists, P.C.*, to release to my insurer/HMO/third-party pavor, government agencies, or to whomever if financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, of pre-certification /prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, which are improperly billed.

IV. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION {PHI}:

I hereby authorize *Long Island Spine Specialists, P.C.*, to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI from LISS, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI from LISS. I voluntarily sign this authorization. I have been provided the opportunity to review the PHI agreement in full and/or access it from the LISS website.

THIS AUTHORIZATION COVERS THE FOLLOWING PHI.

CLAIMS/BILLING INFORMATION DRUG/ALCOHOL ABUSE MENTAL HEALTH RECORDS
SENDING MARKETING MATERIALS TO HOME DIRECTLY FROM LISS CONFIRMING APPOINTMENTS VIA MESSAGE ON ANSWERING MACHINE

AN ADDITIONAL AUTHORIZATION WILL BE NEEDED FOR:

MEDICAL RECORDS

HIV TEST RESULTS RELEASE

PLEASE LIMIT USE AND DISCLOSURE OF MY PHI TO: _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

WITNESS

INITIALS