

COMPREHENSIVE SPINE CARE, P.A.
PATIENT INFORMATION

Patient's Name _____

Address _____

Home # _____ Cell # _____ Work # _____

Email Address _____

Sex: ___ Male ___ Female Marital Status _____

Date of Birth _____ Social Security # _____

Employer's Name _____ Occupation _____

Who referred you to our office? _____

Is today's visit related to an **Auto Accident** or **Work Injury** (circle one)

Are you currently working? (circle one) **YES** or **NO** / Out of work since: DATE: _____

INSURANCE INFORMATION

Name of Insured _____ SS # of insured _____

Name of Primary Insurance Co. _____ Phone # _____

Address of Carrier _____

Insurance ID# _____ Group# _____

Subscriber Sex: ___ Male ___ Female Subscriber Date of Birth _____

Relationship to patient: _____

SECONDARY INSURANCE

Name of Insured _____ SS # of insured _____

Subscriber Date of Birth _____ Sex: Male/Female Relationship to patient _____

Insurance Carrier _____ Address _____

Insurance Phone # _____ Insurance ID# _____ Group # _____

Emergency Contact: Name _____ Phone# _____

Relationship to Patient _____

Address _____

PHARMACY NAME: _____ Phone# _____

Address _____

COMPREHENSIVE SPINE CARE, P.A.

PRIVATE PATIENT INTAKE FORM

Patient's Name:	Date of Birth:
	Sex: Male OR FEMALE
Health Insurance:	Member ID #:
Please describe why you are here:	
Please describe how your got hurt and when the injury occurred:	
Where are you feeling pain? Please describe:	
Previous Workers Compensation Claims: YES or NO Date of Accident: Please describe:	
Have you ever been treated for this issue in the past or something similar? If yes, please provide name of the physician who treated you.	
Please list any medications you are taking for this condition or injury.	
Have you ever been in a motor vehicle accident (MVA)? YES or NO If yes, please provide date of MVA and details of injury:	
Have you ever seen a Chiropractor? YES or NO If YES: Name: Address: Date:	
Name of Primary Care Provider (PCP):	Address:
	Phone #:
Have you ever received pain management treatment? If yes, please provide name of physician and time frame of treatment.	
Are you involved in any recreational or sporting activities? If yes, please describe....	
I CERTIFY THAT THE ABOVE ANSWERS MADE BY ME ARE CORRECT.	

Patient Signature: _____

Today's Date: _____

COMPREHENSIVE SPINE CARE, P.A.

COMPREHENSIVE PHYSICAL THERAPY

Nomaan Ashraf, M.D.

Board Certified Adult & Pediatric Spinal Surgery

RAFAEL LEVIN, M.D.

Board Certified Adult & Pediatric Spinal Surgery

JONATHAN P. LESTER M.D.

Board Certified Adult Physical Medicine & Rehabilitation

JAY GREENSPAN, PT, CERT, MDT

Physical Therapy

PATIENT'S NAME _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (please read and sign)

The patient is responsible for all fees, deductible and co-payments regardless of insurance coverage unless forbidden by prior insurance contracts. You are expected to pay for services at time they are rendered unless arrangements have been made in advance.

I hereby authorize payment to Comprehensive Spine Care, P.A./Comprehensive Physical Therapy of any benefits otherwise payable to me for their services.

I hereby authorize Comprehensive Spine Care, P.A./Comprehensive Physical Therapy to receive and furnish to insurance companies, their representatives or designated attorney and requesting physicians, any information concerning my treatment.

I hereby assign to Comprehensive Spine Care, P.A./Comprehensive Physical Therapy all payments for medical services rendered to my dependants or myself. I agree that if my insurance company sends me a check for services rendered by Comprehensive Spine Care, P.A./Comprehensive Physical Therapy to my dependants or me, I will enclose this check and forward it to Comprehensive Spine Care, P.A./Comprehensive Physical Therapy within 5 days.

If any collection proceedings are required to cover any outstanding balance, I understand I will be responsible for said costs including attorney fees of 33.3% of the unpaid balance. These costs are above and beyond for services rendered.

Comprehensive Spine Care, P.A./Comprehensive Physical Therapy reserves the right to charge 1.5% interest per month on any balance that remains after 60 days.

SIGNATURE OF PATIENT _____

DATE _____

SIGNATURE OF INSURED _____

DATE _____

466 OLD HOOK ROAD, SUITE 16, EMERSON, NJ 07630, TEL # 201-634-1811, FAX # 201-634-9170

MAILING ADDRESS: P.O. BOX 631, WESTWOOD, NJ 07675

www.comp spinecare.com

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FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below.

1. My authorization applies to the information described below. Only his information may be used and/or disclosed pursuant to this authorization.

_____ All information/no restrictions
_____ Restrictions as listed _____

2. I authorize the following persons (or class of person) to make the authorized use and/or disclosure of my protected health information.

_____ Physician: Ari Ben-Yishay, M.D., Rafael Levin, M.D., Nomaan Ashraf, M.D.,
Jonathan Lester, M.D., Jay Greenspan, PT, CERT, MDT
_____ Physician Staff: Medical Assistant, Receptionist, Biller, Collectors, Physical
Therapist

3. I authorize the following persons (or class of persons) to receive my protected health information.

_____ Family (please list names) _____
_____ No Fault Carriers (Automobile) and adjustors associated with No Fault
(automobile)
_____ Medical Insurance Company
_____ Workers Compensation including adjusters and case managers associated with
my case and any insurance claim review companies associated with Workers
Compensation insurance.
_____ Employer _____

4. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

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6. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
7. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons that I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
8. This authorization expires upon 3 years after my last treatment by Comprehensive Spine Care, P.A. and /or Comprehensive Physical Therapy.
9. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Comprehensive Spine Care, P.A., nor will it affect my eligibility for benefits.
10. My protected health information will be used or disclosed upon request for the following purpose.
 - Obtaining authorization for treatment
 - Disability (with proper authorization)
 - Scheduling treatment (hospital, outpatient facility, physical therapy facility, pain management facility, diagnostic facility)
 - Social Security (with proper authorization)
 - Collecting payment for medical services
 - Attorney (when appropriate authorization from attorney is received)
 - Billing for medical services
 - Referral to other physicians by Comprehensive Spine Care, P.A.
11. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed.
12. Changes to the above document must be submitted in writing to Comprehensive Spine Care, P.A. Changes will be effective immediately upon receipt of request.

By signing this form, you are granting consent to Comprehensive Spine Care P.A. and/or Comprehensive Physical Therapy to use and disclosure your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed

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information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling 201-634-1811.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature

Date

Name

Name of personal representative

Relationship to patient

If you have any questions, please feel free to speak to any of the staff members.

Thank you,

Comprehensive Spine Care, P.A
Comprehensive Physical Therapy



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PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ **DOB:** _____

I hereby authorize the release any and all of my medical records to Comprehensive Spine Care, P.A. if requested for the purpose of continued care, insurance, legal or personal reasons.

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication.

Signature: _____

Today's Date: _____

Updated 8.7.17

COMPREHENSIVE SPINE CARE, P.A.

NAME _____

DATE _____

PLEASE CHECK ALL **POSITIVE** CONDITIONS

- **General:** ___ Fever ___ Chills ___ Unexplained weight loss ___ Cancer
- **Eyes:** ___ Glaucoma ___ Blurred Vision ___ Other _____
- **Cardiac:** ___ Shortness of Breath ___ Chest Pain ___ Irregular heart beat
 ___ Palpitations ___ High Blood Pressure ___ Other _____
- **Vascular:** ___ Swelling of feet and ankles ___ Other _____
- **Neurologic:** ___ Frequent Headaches ___ Seizures ___ Double Vision
 ___ Ringing in ears ___ Dizziness ___ Other _____
- **Urinary:** ___ Frequent urination ___ Hesitancy ___ Blood in urine
 ___ Painful urination ___ Kidney Disease
- **Gastrointestinal:** ___ Nausea ___ Vomiting ___ Blood in Stool ___ Heartburn
 ___ Ulcers ___ Other _____
- **Respiratory:** ___ Shortness of Breath ___ Wheezing ___ Coughing
 ___ Asthma ___ Other _____
- **Musculoskeletal:** ___ Arthritis ___ Joint Swelling ___ Other
 ___ Back Pain ___ Neck Pain
- **Endocrine:** ___ Thyroid Abnormalities ___ Cold or Heat Intolerance
 ___ Diabetes ___ Other _____
- **Skin:** ___ Rashes ___ Other _____
- **Blood:** ___ Anemia ___ Easy bruising or bleeding ___ Past blood transfusion
 ___ Other _____

ALL SYSTEMS ARE **NEGATIVE:** YES NO

PATIENT SIGNATURE: _____

COMPREHENSIVE SPINE CARE, P.A.

DATE _____ **NAME** _____ **SEX** _____ **AGE** _____

HEIGHT _____ **WEIGHT** _____ **DATE OF BIRTH** _____

SMOKER: YES NO AMOUNT PER DAY _____ **ALCOHOL:** YES NO HOW OFTEN _____

MEDICAL HISTORY: YES NO **FAMILY:** YES NO

DIABETES	___	___	___	___
CANCER	___	___	___	___
HIGH BLOOD PRESSURE	___	___	___	___
ASTHMA	___	___	___	___
KIDNEY DISEASE	___	___	___	___
ULCERS	___	___	___	___
ARTHRITIS	___	___	___	___
DEPRESSION	___	___	___	___

ALLERGIES: YES NO **NAME OF DRUG** **REACTION**

ANTIBIOTICS	___	___	_____	_____
SHELLFISH/IODINE	___	___	_____	_____
MEDICATIONS	___	___	_____	_____
ANESTHESIA	___	___	_____	_____

MEDICATIONS PRESENTLY TAKING: _____

PAST SURGICAL PROCEDURES AND DATE: _____

COULD YOU BE PREGNANT TODAY? _____

FAMILY PHYSICIAN: _____ **ADDRESS:** _____ **PHONE:** _____

FAMILY HISTORY:	ALIVE/WELL (NUMBER OF EACH)	DECEASED (NATURE OF DEATH)
PARENTS	_____	_____
SIBLINGS	_____	_____
CHILDREN	_____	_____

COMPREHENSIVE SPINE CARE, P.A.

NAME _____

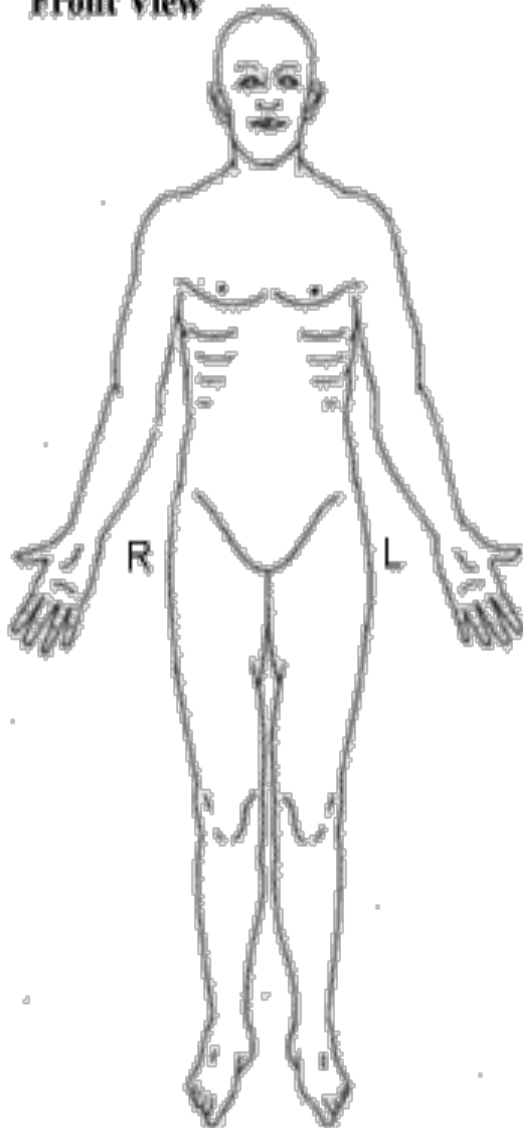
DATE _____

WHERE IS YOUR PAIN NOW?

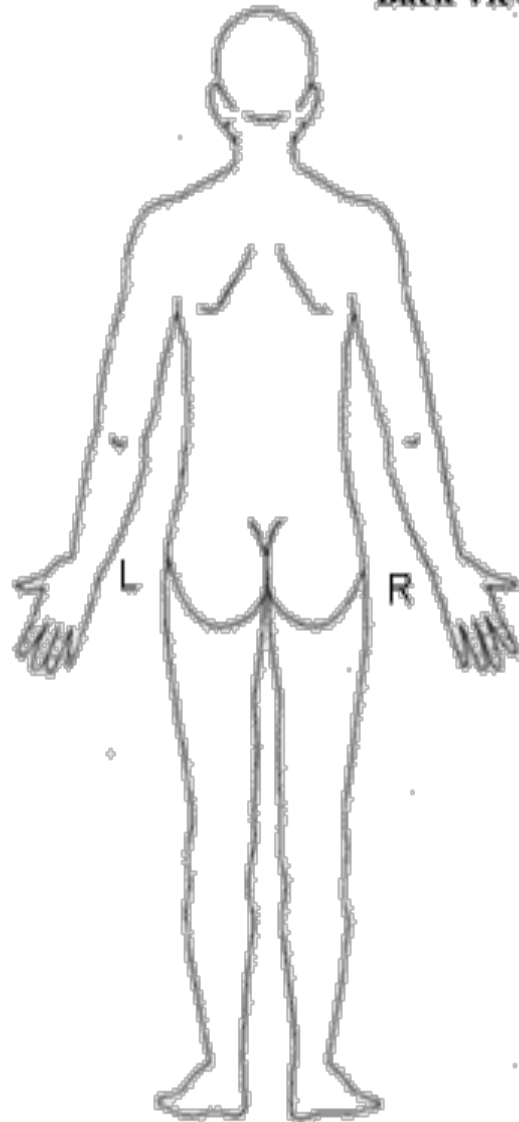
MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
AAA	OOO	----	XXX	IIII
AAA	OOO	----	XXX	IIII
AAA	OOO	----	XXX	IIII

Front View



Back View





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SUBSTANCE REPORT

Name: _____

Mark each box that applies

Family History of Substance Abuse Alcohol []

Illegal Drugs []

Prescription Drugs []

Personal History of Substance Abuse Alcohol []

Illegal Drugs []

Prescription Drug []

History of Preadolescent Sexual Abuse []

Psychological Disease Attention Deficit Disorder []

Obsessive Compulsive Disorder []

Bipolar, Schizophrenia, Depression []

Have you felt the need to **Cut down** on your drinking? [] Yes [] No

Do you feel **Annoyed** by people complaining about your drinking? [] Yes [] No

Do you feel **Guilty** about your drinking? [] Yes [] No

Do you ever drink an **Eye-opener** in the morning to relieve shakes? [] Yes [] No

Patient Signature

Date

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Dear Patient,

It is the mission of our practice to have a strong and supportive relationship with our patients. The following information should be useful to you.

If you have any questions, please feel free to contact our office at (201) 634-1811. Our staff will be happy to assist you.

OFFICE HOURS: EMERSON, CLIFTON, SOMERSET

- Monday – Thursday 9:00am – 5:00pm
- Friday 9:00am – 3:00pm

APPOINTMENTS

- If you need to cancel your appointment, please notify our office as soon as possible.

PRESCRIPTIONS

- Medication prescriptions are given and refilled during your office visit. Please be aware of your medication needs and address this with your Physician during your office visit.

XRAY'S, MRI'S & CT SCANS

- Please be sure to bring the actual films with you to EACH appointment. The films should be kept dry and out of the sun.

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