THE SPINE+SPORTS HEALTH CENTER
720 Monroe St
Suite C-208
Hoboken, NJ 07030

123 Tidewater St
Jersey City, NJ 07302

764 Broadway
Bayonne, NJ 07002

PATIENT REGISTRATION. PLEASE COMPLETE ALL ITEMS AND PRINT CLEARLY.

Today's Date_____ /_____ /
_____

Name_____Gender ☐ Male ☐Female ☐Other

Address_____ APT. City_____ State_____ Zip
.

Home phone ( )_____-_____ Work ( )_____-_____ Cell/Alternative( )_____-
_____

E-Mail_____ Is E-Mail OK? Yes/No

D.O.B_____ /_____ /_____ Age_____ Sex_____ Marital Status_____ SS#_____ /_____ /
_____

How did you hear about us?
_____

Cardiologist Name _____ Phone # ( ) _____ -
_____

Primary Care Doctor_____ Phone # ( )_____ -
_____

Emergency contact_____ Phone # ( )_____ -
_____

Relationship Spouse Parent Child Other_____

Employer_____ Phone # ( )_____ -
_____

Check one: **Is this condition related to a: Slip and Fall ☐ MVA ☐ Work-Related ☐ NONE ☐**

Attorney Information:

Firm:
_____
___

Attorney Name:
_____

Address:
_____

Phone # ( )_____ - _____

The information provided above is current and correct. I am responsible for informing The Spine and Sports Health Center of any changes to this information.

- **NOTICE REGARDING RELEASE OF HEALTH INFORMATION**: Under the Health

Insurance Portability and Accountability Act of 1996 (HIPAA) and as further explained in The Spine and Sports Health Center Notice of Privacy Practices, The Spine and Sports Health Center may use and disclose medical information to physicians or other providers for the purposes of providing treatment, and to payors for the purpose of payment for medical treatment. HIPAA also permits The Spine and Sports Health Center and its affiliated companies to use medical information for healthcare operations.

I have read and understand the payment policy and agree to abide by its guidelines.

_____

Signature Date

Reason for your visit today? :_____

_____

_____

_____

_____

For your current back/neck pain, please mark the boxes for the timeframe in which any tests were done.

	< 6 months	< 12 months	Type
X-rays			_____
MRI scan			
_____			
CT scan			
_____			
Myelograms			
_____			
EMG/NCV (nerve test)			_____

Are you taking any blood thinners (aspirin-containing medication, clopidrogel (Plavix®), dabigatran (Pradaxa®), coumadin (Marcumar® and other brand names), rivaroxaban (Xarelto®),? ☐ No ☐ Yes

List all pain medications you had in the past and how they worked for you (side effects).

Medication Name	**Maximum dosage taken**	**Effect/Side effect**

Family History:

Family history (blood relatives): **Cancer** ☐ Yes No **Chronic pain** ☐ Yes ☐ No **Fibromyalgia** ☐ Yes ☐ No **Rheumatoid arthritis/Lupus/scleroderma** ☐ Yes ☐ No **Blood disorders** ☐ Yes ☐ No

Other ☐ Yes ☐ No _____

Social History:

Do you drink alcohol? Yes ☐ _____ / day No ☐

Do you smoke? Yes ☐ How much? _____ No ☐

(Women) Are you pregnant? Yes ☐ No ☐ Due date: _____/_____/_____ Breastfeeding Yes ☐ No ☐

Surgical History: ☐ **NONE**

List any Surgeries:

_____

_____

_____

Health History

Do you or have you had any of the following? check Yes or No

Any Contagious Diseases	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Thyroid Disease	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Thyroid Problems	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	HIV/AIDS	Yes ☐	No ☐
Chest Pain	Yes ☐	No ☐	Bleeding	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Nausea	Yes ☐	No ☐
Asthma/COPD	Yes ☐	No ☐	Arthritis/joint Deformity	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐	Artificial Joint	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Seizure	Yes ☐	No ☐	Fainting	Yes ☐	No ☐
Rheumatoid Arthritis	Yes ☐	No ☐	Depression	Yes ☐	No ☐

Pain Assessment

Please select the type(s) of pain you experience. (Check all that apply.)

c Constant c Intermittent c Periodic c Frequent c Occasional
c Burning c Sharp c Stabbing c Dull c Aching
c Radiating c Shooting c Other (Describe) _____

Since your pain began, which of the following people have you consulted for treatment?

c Acupuncturist c Orthopedist
c Chiropractor c Physical Therapist
c Internal Medicine c Neurologist
c Other _____

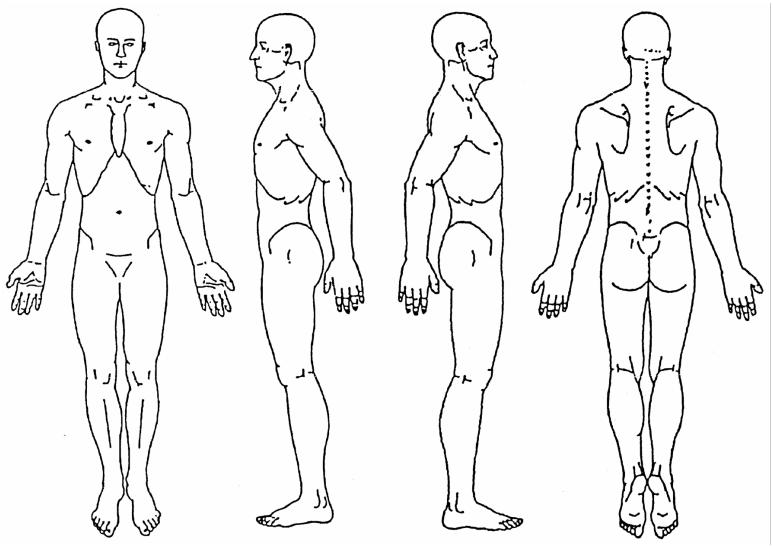
Which of the following pain treatments have you tried?

c Ice c Heat c TENS Unit c Injections
c Massage c Rest c Exercise c Physical Therapy
c Spinal Stimulator c Brace c Other_____

Pain Indicators/Relievers

Activity	Makes Pain	Activity	Makes Pain
Sitting	c Better c Worse	Taking Medications	c Better c Worse
Standing	c Better c Worse	Applying Heat	c Better c Worse
Lying Down	c Better c Worse	Applying Ice	c Better c Worse
Walking	c Better c Worse	Massage	c Better c Worse
Sneezing	c Better c Worse	Pushing/pulling	c Better c Worse
Straining/Coughing	c Better c Worse	Bending/stooping	c Better c Worse
Sleeping	c Better c Worse	Other: _____	c Better c Worse

Mark the area(s) on your body where you feel the described sensations(s). Use the appropriate symbols(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well.



Aches **^^^^** Numbness **OOOO** Radiating ⟶ Pins/Needles ●●●● Burning **XXXX**
Stabbing ////

ASSIGNMENT OF BENEFITS FORM

The Spine and Sports Health Center
720 Monroe Street, C-208
Hoboken, NJ 07030
201-533-9200

Date:_____

Patient: _____

Employer: _____

Claim Group: _____

SS#/ID#:_____

I HEREBY AUTHORIZE AND DIRECT MY INSURANCE COMPANY OR PAYOR TO PAY DIRECTLY TO THE SPINE AND SPORTS HEALTH CENTER, AND THE PHYSICIANS, ANY AND ALL BENEFITS THAT WOULD OTHERWISE BE PAYABLE TO ME (OR THE PATIENT, IF SIGNED BY A RESPONSIBLE PARTY), UP TO THE AMOUNT OF MY BILL, ACCRUING TO ME IN CONNECTION WITH MY TREATMENT AT THE SPINE AND SPORTS HEALTH CENTER.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE, MEDIGAP, OR OTHER HEALTH INSURANCE POLICY BENEFITS FOR SERVICES FURNISHED TO ME BY THE SPINE AND SPORTS HEALTH CENTER BE MADE ON MY BEHALF TO THE SPINE AND SPORTS HEALTH CENTER. IN THE EVENT THAT PAYMENTS ARE MADE TO THE SPINE AND SPORTS HEALTH CENTER AND ME AS JOINT PAYEES, I AGREE TO COOPERATE WITH THE SPINE AND SPORTS HEALTH CENTER TO ENSURE THAT THE CENTER RECEIVES ALL MONIES DUE.

I HEREBY AUTHORIZE THE SPINE AND SPORTS HEALTH CENTER TO PURSUE ANY MEANS NECESSARY TO COLLECT ALL CHARGES ON MY ACCOUNT INCLUDING FOLLOW UP CALLS, APPEALS, ARBITRATION, AND LAWSUITS. This authorization includes assignment of the right to pursue declaratory, equitable, and compensatory relief, or other legal remedies. In the event that the Spine and Sports Health Center or the physician elects to bring an appeal, lawsuit, petition for arbitration against my insurance carrier, PIP carrier, Workers' Compensation carrier, plan administrator, payor or third party, I hereby assign to the Spine and Sports Health Center my rights, title and interests under any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of their

choosing to bring suit or submit to arbitration their claim of unpaid or underpaid bills for treatment at the Spine and Sports Health Center.

If my insurance carrier will not directly pay The Spine and Sports Health Center and/or the physicians, I authorize and direct the insurance company to issue payment for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy jointly to The Spine and Sports Center and _____ (patient name) and send the payment to:

Patient Name:_____
C/o The Spine and Sports Health Center
720 Monroe Street, C-208
Hoboken, NJ 07030

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize The Spine and Sports Health Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at_____this_____ day of _____, 20_____
(Time) (Day) (Month) (Year)

_____ _____
Signature of Policyholder Witness

THE SPINE & SPORTS HEALTH CENTER

Medical Release of Information Form

TO WHOM IT MAY CONCERN:

Please furnish to The Spine and Sports Health Center and/or all personnel, information, copies of any and all hospital and medical record or reports of any sort, charts, notes, x-rays, lab reports and prescription information, including the right to inspect and coy such records. Facility is to be furnished any and all other information without limitation pertaining to any confinement, examination, treatment or condition of myself, including medical, dental, psychological or other treatment, examinations, or counseling for any condition, medical, dental or psychological. This AUTHORIZATION shall be considered as continuing and you may rely upon it in all respects unless you have previously been advised by men in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized to accept a copy of photocopy of this medical authorization with the same validity as though an original had been presented to you.

Dated: _____

Signature: _____
Name: _____
Address: _____
_____

Phone: _____ Email: _____