THE SPINE & SPORTS HEALTH CENTER

PATIENT REGISTRATION. PLEASE COMPLETE ALL ITEMS AND PRINT CLEARLY.

PATIENT INFORMATION Today's Date_____ /_____ /_____

NAME_____.

ADDRESS_____ APT. CITY STATE ZIP .

HOME PHONE ( )_____-_____ WORK ( )_____-_____ CELL/ALTERNATE ( )_____-_____

IS TEXTING OK? Yes/No E-MAIL_____ IS E-MAILING OK? Yes/No

D.O.B_____ /____ /_____ AGE_____ SEX_____ MARITAL STATUS_____

SS#_____ /_____ /_____

HOW DID YOU HEAR ABOUT US?_____

PARENT OR RESPONSIBLE PARTY (If different from patient) ☐ Check here if Patient is the responsible party.

INSURED'S NAME_____ RELATIONSHIP TO PATIENT _____DOB_____

PRIMARY CARE DOCTOR_____ PHONE # ( )_____-_____ ADDRESS_____

EMERGENCY CONTACT?_____ RELATIONSHIP_____

PHONE # ( )_____-_____ ADDRESS_____ CITY STATE ZIP .

ADDITIONAL INFORMATION

LANGUAGE ☐English ☐Spanish ☐ Other _____

RACE ☐Caucasian ☐American Indian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander

☐Other Race

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.

_____

Patient /Patient's Personal Representative /Guardian Relationship to Patient Date

THE SPINE & SPORTS HEALTH CENTER

Reason for your visit today? :_____

_____

_____

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

Health History Form

Do you have or have you ever had diseases or conditions of (please check Yes or No)

Respiratory:

Bronchitis	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐
Asthma	Yes ☐ No ☐
Chronic Cough	Yes ☐ No ☐
Morning Cough	Yes ☐ No ☐
Shortness of Breath	Yes ☐ No ☐
Wheezing	Yes ☐ No ☐

Cardiovascular:

High Blood Pressure	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐
Arrhythmia	Yes ☐ No ☐
Pacemaker	Yes ☐ No ☐

Other Systemic:

Hepatitis	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐
Thyroid Problems	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐
Dialysis	Yes ☐ No ☐
Bladder Problems	Yes ☐ No ☐

Gastrointestinal:

Nausea	Yes ☐ No ☐
Vomiting	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐
Arthritis/joint Deformity	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐
Epilepsy, Seizures	Yes ☐ No ☐
Fainting	Yes ☐ No ☐
Depression	Yes ☐ No ☐

List any **other diseases or conditions**:_____

_____

List **surgeries and hospitalizations**:_____

_____

List all **medications**:_____

_____

List all **allergies to medications**:_____

_____

List all **food allergies** :_____

_____

Family History:

Please list any **conditions affecting related family members**:_____

_____

_____

Social History:

Do you drink alcohol?	Yes □ _____ / day	No □
Do you smoke?	Yes □ How much?	No □

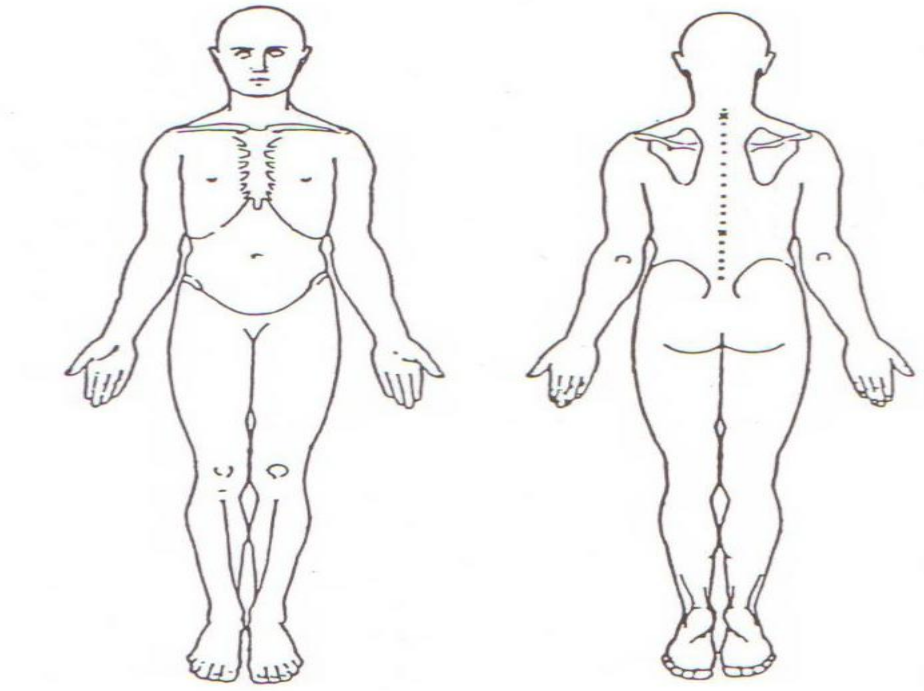
What is your occupation?_____

(Women) Are you pregnant? Yes □ No □ Due date: ___/____/____ Breastfeeding Yes □ No □

Signature below authorizes and acknowledges the following:

Please be sure to fill this form out extremely accuracy. 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 Pins/Needles •••• Burning xxxx Stabbing ////



Mark with an X the severity of your symptoms TODAY on the line below:

_____

None Most Severe

Mark with an X the severity of your symptoms in the LAST 6 MONTHS on the line below:

_____

None Most Severe

ASSIGNMENT OF BENEFITS FORM

The Spine and Sports Health Center
739 Bloomfield St. Suite 1
Hoboken, NJ 07030
201-533-9200

Date:_____

Patient: _____

Employer:
_____

Claim Group: _____

SS#/ID#:_____

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to:

The Spine and Sports Health Center
739 Bloomfield St. Suite 1
Hoboken, NJ 07030

Or

If my current policy prohibits direct payment to Doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Patient Name:_____
C/o East Coast Spine, Joint & Sports Medicine
739 Bloomfield St. Suite 1
Hoboken, NJ 07030

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. 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 Doctor 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