PROGRESSIVE SPINE & SPORTS MEDICINE

48 South Franklin Turnpike, Suite 101
Ramsey, NJ 07446
P: (201) 962-9199 F: (201) 962-9198

Name: _____ DOB: ___ / ___ / _____ Gender: ○Male ○ Female

Address: _____ Race: _____ Age: _____

City: _____ State: _____ Zip: _____ SS #: _____

Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Marital Status: _____

Email: _____ Preferred Language: _____

HOW WERE YOU REFERRED TO THIS OFFICE?

○ Doctor (Name: _____) ○Patient ○ Friend ○ Yellow Pages ○ Google ○ Newspaper

IN CASE OF EMERGENCY: PLEASE FILL OUT EMERGENCY CONTACT INFORMATION

Name: _____ Phone: (_____) _____ - _____

Relationship: _____

Primary Care Physician: _____ Phone: (_____) _____ - _____

Pharmacy Name: _____ Phone: (_____) _____ - _____

Pharmacy Address:_____

HEALTH INSURANCE INFORMATION (PLEASE FILL OUT IF APPLICABLE):

Name of Insured (If different from above): _____ Insured's DOB: ___ / ___ /_____

Primary Insurance Name: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Relationship to Insured: ○ Self ○ Spouse ○ Child ○Other _____

EMPLOYER INFORMATION

Name: _____ Occupation: _____

Address: _____ Phone: (_____) _____ - _____

City: _____ State: _____ Zip: _____

AUTO ACCIDENT & WORK RELATED INJURY: (PLEASE FILL OUT IF APPLICABLE)

Auto Insurance Company: _____

Policy #: _____ Claim #: _____ Date of Injury: ___ / ___ /_____

Adjuster's Name: _____ Adjuster's Phone: (_____) _____ - _____

WORKER'S COMP: (FILL OUT ALL APPLICABLE)

Comp Case #: _____ Date of Injury: ___ / _____

Adjuster's Name: _____ Adjuster's Phone: (_____) _____ - _____

Attorney's Name: _____ Attorney's Phone: (_____) _____ - _____

The above information is true to the best of my knowledge. I authorized my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorized my insurance company to release any information required to process my claims.

Signature: _____ Date: ___ / ___ /_____

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Authorization to Release Information

Progressive Spine & Sports Medicine, LLC is authorized to release all or any part of the medical record and other information of the patient named on this form to such insurance companies, organizations or agencies including, if applicable, The Centers for Medicare & Medicaid Services and its agents, as may be concerned with payment of the services rendered and is needed to determine benefits payable for services furnished. A copy of this authorization will be sent to the Centers for Medicare & Medicaid, if applicable, my insurance company or other entity if requested. The original authorization will be kept on file by Progressive Spine & Sports Medicine, LLC.

Assignment of Insurance Benefits

I request that payment for authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Progressive Spine & Sports Medicine, LLC for any services provided to me. I assign Progressive Spine & Sports Medicine, LLC all my rights, entitlements and interest under any policy under which I have benefits and medical insurance, automobile personal injury protection, workers' compensation or other third-party payer benefits, otherwise payable to me for those services provided. I obtained any needed pre-certification or authorizations and have fulfilled other requirements or conditions of my insurance coverage that are my responsibility.

I further authorize Progressive Spine & Sports Medicine and its designated agents to pursue all appeal/settlement options available to me. In addition, I authorize payer to communicate with Progressive Spine & Sports Medicine and/or its agents with all pertinent documentation that I am entitled to, including but not limited to: 1) plan language; 2) certificate of benefits; 3) documentation of how the allowable amounts were calculated.

Your health care provider has the right to take certain claims to an independent claims arbitration process through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI). To arbitrate claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports.

_____ Date: _____ /_____ /_____

Signature of Patient or Authorized Representative

_____

Patient Name (Printed)

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This notice is effective as of ____ /____ /_____

I have read HIPAA and understand my rights contained in this notice.

By way of my signature, I provide Progressive Spine & Sports Medicine, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment healthcare operations as outlined and described in the Privacy Notice.

_____
Patient's Signature

_____
Patient's Name (printed)

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CLINICAL INTAKE FORM

Today's Date: _____

Name: _____ DOB: _____

Age: _____ Height: _____ Weight: _____

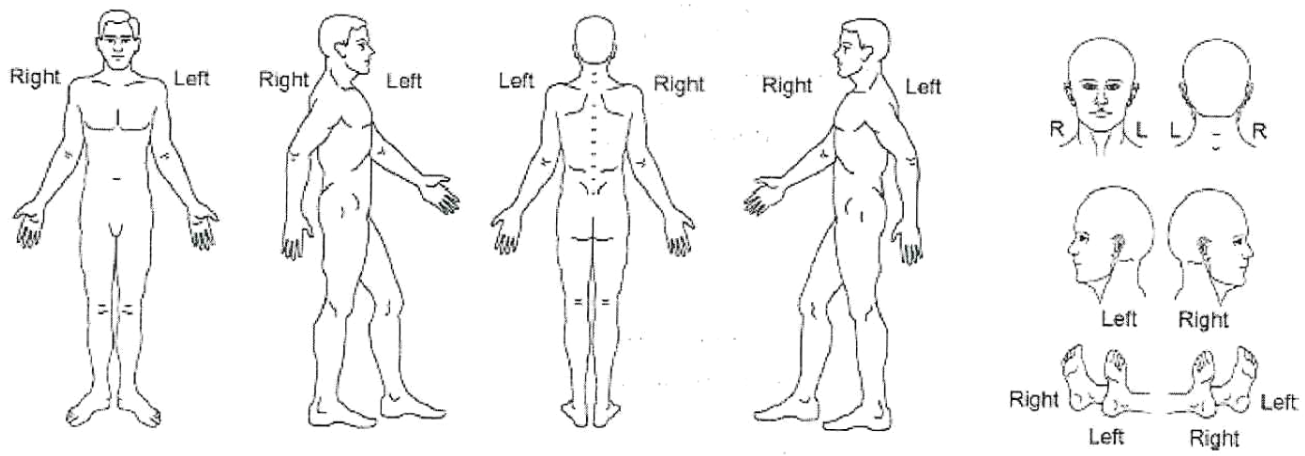
PAIN HISTORY

What is the reason for your visit today? _____

Location of pain (include side): _____ Are you left or right hand dominant? _____

Does this pain radiate? _____ If so, where? _____

Use this diagram to indicate the area of your pain. Circle or mark the location



On a scale of 1-10, 1 being very little and 10 being the worse,
indicate how severe the pain is: (Please circle): 1 2 3 4 5 6 7 8 9 10

Approximately, when did this pain begin? _____

How did this pain occur? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

When does it occur? ☐At Rest ☐ With Activity ☐ At Night ☐ Other _____

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes & goes)

What makes your pain better? ☐ Pain Medicine ☐ Ice ☐Heat ☐ Rest ☐ Elevation

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Associated symptoms:

☐ Numbness/Tingling ☐ Weakness ☐ Balance Problems ☐ Bladder/Bowel Incontinence

☐ Fever/Chills ☐ Joint Swelling

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PAST MEDICAL HISTORY

Check all that apply:

- ☐Blood or plasma transfusions
- ☐Cancer
- ☐Clotting Disorders (DVT/PE)
- ☐Diabetes
- ☐Hypertension
- ☐Stomach/Intestinal Disorder
- ☐Heart Disease
- ☐Thyroid Issues
- ☐Anemia
- ☐Lung Disorders
- ☐Heart Attack
- ☐Stroke

Please list any other past medical conditions:

_____

_____

_____

SOCIAL HISTORY

Do you exercise regularly? ☐Yes ☐No Is so, how many time per week? _____

Have you ever abused narcotic or prescription medications? ☐Yes ☐No

Alcohol Use: ☐Social Use ☐History of alcoholism ☐Current alcoholism
☐Daily use of alcohol ☐Never

Tobacco Use: ☐Current user ☐Former user ☐Never used ☐Packs per day____
☐How many years? ____

Illicit Drug Use: ☐Denies any illegal drug use ☐Currently uses illegal drugs
☐Formerly used illegal drugs (not currently using)

SURGICAL HISTORY

Please list any surgical procedures you have had done in the past, including complications:

1) _____ Date _____
2) _____ Date _____
3) _____ Date _____
4) _____ Date _____
5) _____ Date _____

☐ I have NEVER had any surgical procedures performed

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MEDICATIONS: Please list all current medications (including vitamins) below:

	Name	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

ALLERGIES: Please list all allergies and reactions including medications, food, environmental, etc)

	Allergy	Reaction
1.		
2.		
3.		
4.		
5.		

FAMILY HISTORY:

Relative	Alive (age)	Deceased (age)	Cause of death	Health Issues
Mother				
Father				
Siblings				
Other				

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REVIEW OF SYSTEMS

Constitutional: ☐Difficulty sleeping ☐Fatigue ☐ Fevers ☐ Insomnia
☐ Tremors ☐ Unexplained Weight Loss

Eyes: ☐ Recent Visual changes ☐ Glasses

Ears/Nose/Throat/Neck: ☐ Jaw Discomfort ☐ Earaches ☐ Hearing Problems
☐ Nosebleeds ☐ Sinus problems

Cardiovascular: ☐ Chest Pain ☐ Bleeding Disorder ☐ High Cholesterol
☐ Palpitations ☐ Shortness of breath

Respiratory: ☐ Asthma ☐ Wheezing ☐ Shortness of breath ☐Cough

Gastrointestinal: ☐ Constipation ☐ Acid Reflux ☐Abdominal Cramps
☐ Diarrhea ☐ Nausea/Vomiting

Musculoskeletal: ☐ Joint Pains ☐ Joint Stiffness ☐ Joint Swelling
☐ Muscle Spasms ☐ History of Broken Bones

Integumentary: ☐ Rashes ☐ Skin Disorders ☐ Connective Tissue Disorders ☐ Hay Fever

Bladder: ☐ Urinary Tract Infections ☐ Blood in Urine ☐ Painful Urination ☐ Decreased Urine

Neurological: ☐ Dizziness ☐ Headaches ☐ Tremors ☐ Numbness/Tingling
☐ Seizures ☐ Fainting

Psychiatric: ☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems
☐ Changes in mood or behavior

The above information is true to the best of my knowledge.

_____ Signature of Patient or Authorized Representative

_____ Patient Name (Printed)

Date: _____ /_____ /_____

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WORKERS' COMPENSATION & NO FAULT

If this problem is related to a work or car accident,
please complete the following questions

Name: _____ Date of Birth: _____

Work related? _____ Car accident related? _____ Date of accident/onset _____

Which part(s) of your body was injured (include side)? _____

Prior to this accident, did you have a problem/pain in the affected area? _____

Did you sustain other injuries due to this accident? _____ If yes, please give details (ex: left hand laceration): _____

Did you have immediate pain of the affected area at the time of the accident or a few days later?

_____

Where (address and state) and how did the injury occur?_____

_____

Job title on date of injury _____

What were your usual work activities on the date of the injury/onset? _____

Employer when injury occurred (include address & phone #): _____

_____

Have you been treated by another health care provider for this injury? If so, give details

_____

_____

Are you currently working? _____

If you are NOT working, what was the date you first missed work due to this injury? _____

Are you being counseled by a lawyer for this injury? _____

If car accident, where you the driver or passenger? _____ Did the air bag deploy? _____

Were you wearing your seat belt at the time of the accident? _____

The above information is true to the best of my knowledge.

_____ Signature of Patient or Authorized Representative

_____ Patient Name (Printed)

Date: ____ /____ /_____