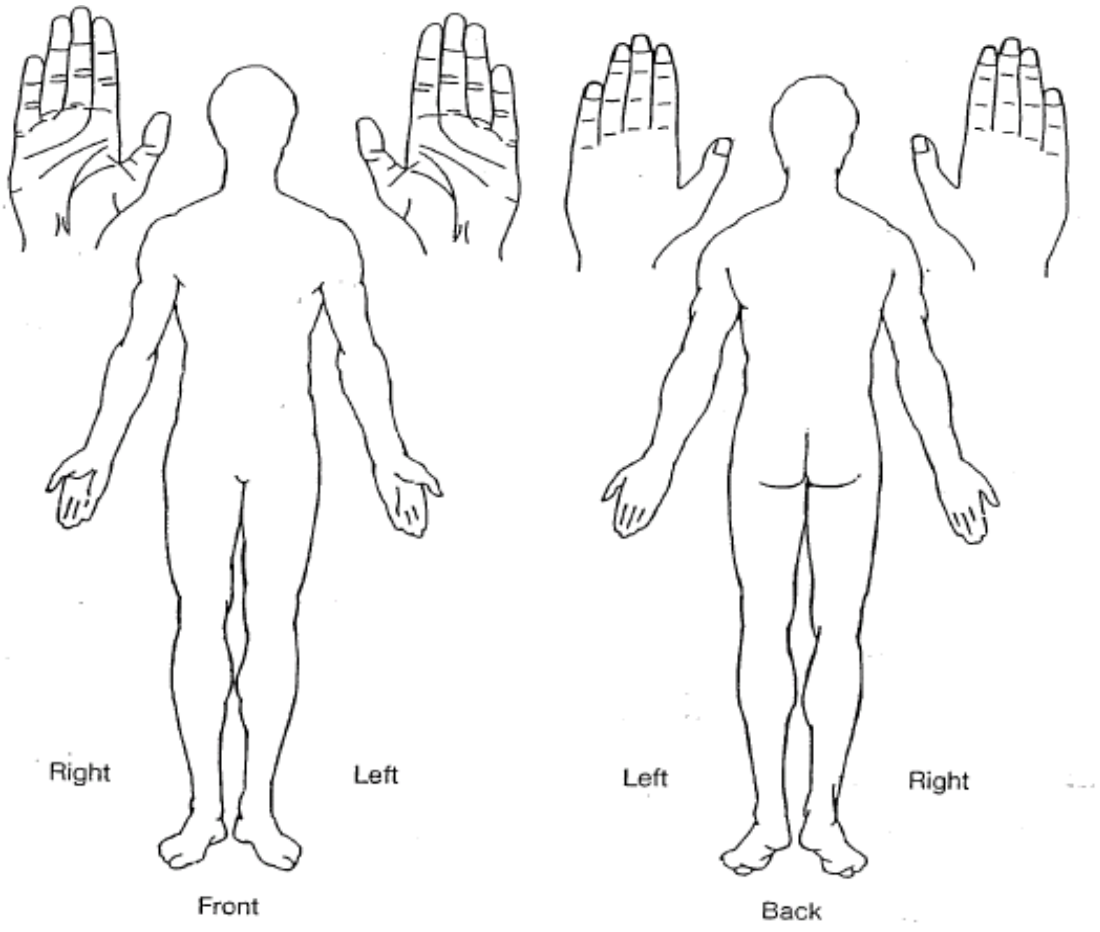
Name:
DOB:
Chart:
Date:

PATIENT PAIN DRAWING

Name _____ Date _____

Where is your pain now?
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Include all affected areas and please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing
▲ ▲ ▲	= = =	o o o	x x x	/ / /



How bad is your pain now?
Please mark with an x on the body form where the pain is worst now.
Please mark on the line how bad your pain is now.

No pain _____ Worst possible pain

Name:
DOB:
Chart:
Date:

ORTHOPAEDIC SPINE INSTITUTE

a Division of Orthopaedic Institute of Central Jersey

JOEL M. GOLDSTEIN, MD — SPINAL SURGERY
MICHAEL F. LOSPINUSO, MD — SPINAL SURGERY
RAMIL S. BHATNAGAR, MD — SPINAL SURGERY
PETER A. RIENZO, MD — PAIN MANAGEMENT & ANESTHESIOLOGY
STEVEN PIETROFESA — PHYSICIAN ASSISTANT
SETH AMSTER — PHYSICIAN ASSISTANT

PATIENT INFORMATION: *Please print*

Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Sex: _____ Marital Status: _____

Address: _____ Town: _____ Zip: _____

Phone: _____ Cell: _____

Social Security: _____ Email: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

Spouse/Parent Name: _____ Phone: _____

Family Physician: _____ Phone: _____

Family Physician Address: _____

INSURANCE INFORMATION

Primary Insurance:

Please present your insurance card(s) to the receptionist with this form.

Is this visit due to an automobile accident? Yes / No **Work related accident?** Yes / No

Insurance Co. Name: _____ Phone _____

Address: _____

ID#: _____ Group No.: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Address (If different than above) _____

Social Security No.: _____ Relationship to Patient: _____

Secondary Insurance (if any):

Insurance Co. Name: _____ Phone _____

Address: _____

ID#: _____ Group No.: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Address (If different than above) _____

Social Security No.: _____ Relationship to Patient: _____

PREFERRED PHARMACY INFORMATION

Name: _____ Phone Number: _____

Address: _____

Name:
DOB:
Chart:
Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____
(Patient Name)

have received a copy of this office's Notice of Privacy Practices.

I authorize communication between this office and

_____ (family member/friend).
(name)

_____ We can leave a message for you at home regarding your care.

_____ We may NOT leave a message for you at home regarding your care.

Comments: _____

_____

_____
Patient Signature

_____
Date

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Name:
DOB:
Chart:
Date:

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PATIENT BILL OF RIGHTS

As a patient, you have the right to:

- Considerate respectful care at all times, and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy, within the law.
- Information concerning your diagnosis, treatment, and prognosis, to the degree known.
- Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns about your health.
- Make decisions about medical care including the right to accept or refuse medical or surgical treatment and the right to initiate advance directives such as living will or a durable power of attorney. Information concerning the implementation of any advance care directive.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Request to review and be provided with an explanation of your bill, even though it may be covered by insurance.
- Know the identity and professional status of individuals providing service to you.
- Report any comments concerning the quality of services provided to you and receive fair follow up on our comments.
- Appropriate assessment and management of pain.

As a patient, you are responsible for:

- Providing, to the best of your knowledge, accurate and complete information about your present health status and past medical history and reporting any unexpected changes to the appropriate practitioner.
- Following the treatment plan recommended by the primary practitioner involved in your case.
- Indicating whether you clearly understood a contemplated course of action and what is expected of you.
- Your actions if you refuse treatment, leave the facility against the advice of the practitioner, and/or do not follow the practitioner's instruction relating to your care.
- Assuring that the financial obligations of your health care are fulfilled as expediently as possible.
- Providing information about and/or copies of any living will, power of attorney, and other directives that you desire us to know about.

If you have any questions regarding your rights or responsibilities, please discuss your concerns with us.

I have received a copy of the above information.

Patient's Signature _____ **Date** _____

Name:
DOB:
Chart:
Date:

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SETH AMSTER — PHYSICIAN ASSISTANT

Name: _____ Date: _____

I authorize the release of any information necessary to process health claims resulting from this or any other care by the office of Orthopaedic Spine Institute. I authorize the release of information to my PHYSICIAN and/or ATTORNEY.

I understand that I am financially responsible for all bills incurred under the care of Orthopaedic Spine Institute. In the event that my account is not paid, I shall be liable for any and all cost of collection, including, but not limited to additional 25% agency fee, should my account go to collection and attorney fees on appeals.

The physicians of Orthopaedic Spine Institute are participating with Medicare. Medicare patients will be responsible for their deductibles and Medicare co-pay.

The physicians of Orthopaedic Spine Institute DO NOT PARTICIPATE WITH NJ MEDICAID OR ANY MANAGED MEDICAID PROGRAM. Medicaid patients acknowledge that they are voluntarily seeking treatment and have been advised that they WILL BE RESPONSIBLE for payment of all services received from Orthopaedic Institute of Central Jersey, PA.

I understand that if I use my out of network benefits. I will be responsible to pay Orthopaedic Institute any and all balances incurred during my treatment. (Paying your co-pay at the time of service does not mean that your insurance will pay the balance. The amount due by you will be determined after your insurance has made their payment.

I further acknowledge that I have requested the specialized treatment offered by Orthopaedic Spine Institute. The charges of such treatment may be higher than other physicians and may be more than allowed by some health insurance companies. I specifically agree to be personally responsible for the prompt payment of any difference between the total charges of Orthopaedic Spine Institute, and the amount paid by my health insurance carrier or other such plan covering me.

I am aware that I will be subject to a fee for every returned check to the practice.

I authorize payment of medical benefits to Orthopaedic Spine Institute for services described.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

Name:
DOB:
Chart:
Date:

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SETH AMSTER PHYSICIAN ASSISTANT

Due to the recent changes in the healthcare insurance industry we are required to have you sign and date this form.

It is the patient's responsibility to know their exact insurance coverage. In the event you fail to notify us about any changes in your coverage you hereby agree to have those claims become your responsibility.

Patient's Name: _____

Patient's Signature: _____

Date: _____

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visit us at: www.orthospineinst.com

Name:
DOB:
Chart:
Date:

ORTHOPAEDIC SPINE INSTITUTE
HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

I hereby authorize: **OSI** _____ to disclose my protected health information in accordance with this authorization.

Please disclose my protected health information, as set forth below, to: _____

_____

Please indicate the information or types of information to be disclosed (including dates if necessary):

_____

_____

_____

*The purpose(s) of this authorization is: _____

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to_____

_____. If not revoked by me, this authorization will terminate on: _____ (include date or event).

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for **drug and/or alcohol abuse, mental health, (psychiatric records, psychological records, etc.) sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS).** This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE_____

Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

_____ _____

Patient or Legal Representative Date

_____ _____

Representative's authority to act on behalf of individual Witness

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Name:
DOB:
Chart:
Date:

ORTHOPAEDIC SPINE INSTITUTE
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Patient Questionnaire

Your Name: _____

Your Primary/Family Doctor:

_____

Who referred you to the **Orthopaedic Spine Institute?**

_____

Age: _____
Height: _____
Weight: _____
Occupation: _____

Please circle or answer the following:

When did your pain begin? _____
Did your pain begin…
- O Gradually or Suddenly

Was it caused by an injury? **Yes No**
Was this injury the result of a fall? **Yes No**
Have you fallen more than once within the last year? **Yes No**

How severe is your pain…
- O Today? (0 - 10) _____
- O When at its worst? (0 - 10) _____

Is the pain…
- O Sharp or dull?
- O Aching or stabbing?
- O Burning?

Is it painful…
- O First thing in the morning?
- O During the day?
- O At night while sleeping?

What makes the pain better?
- O Lying down?
- O Standing?
- O Sitting?
- O Walking?
- O Ice or Heat?

What makes the pain worse?
- O Lying down?
- O Standing?
- O Sitting?
- O Walking?
- O Exercise?
- O Stair climbing?
- O Reaching over head?
- O Bending?
- O Coughing/sneezing?

Name of physicians whom have treated this problem for you before:

_____

Have you ever had (for this problem):
- O Xrays?
- O CT scan
- O MRI?
- O EMG?

Have you tried the following for this problem?
- O Oral medications?
  Please list: _____
- O Physical Therapy?
- O Joint injections?
  Steroid (cortisone)
  Synvisc/Orthovisc/Euflexxa
- O Epidural injections
- O Chiropractic care
- O Surgery

Name:
DOB:
Chart:
Date:

Your Medical History:
(check or circle all that apply)

Heart disease
- O High blood pressure
- O High cholesterol
- O Heart attack
- O Congestive heart failure
- O Arrhythmia/atrial fibrillation

Endocrine disease
- O Diabetes
- O Thyroid condition

Vascular disease
- O Blood clots
- O Pulmonary embolism
- O Varicose veins
- O Peripheral vascular disease

Neurologic/Spine disease
- O Stroke/mini-stroke
- O Peripheral neuropathy
- O Spinal stenosis
- O Herniated disc

Kidney disease

Gastrointestinal disease
- O GERD
- O Ulcers
- O Bleeding ulcers

Bleeding/Clotting disorders

Lung disease
- O Asthma
- O COPD
- O Emphysema
- O Sleep apnea

Cancer
- O Please list: _____

Rheumatologic conditions
- O Rheumatoid arthritis
- O Psoriatic arthritis
- O Ankylosing spondylitis
- O Lupus

HIV/AIDS

Hepatitis - please circle type: **A B C**

Mental illness
- O Depression
- O anxiety

Other: please list _____

No Medical Problems

Review of Systems/Symptoms
(check or circle all that apply)

- O fevers/chills/sweats
- O rapid recent weight loss
- O headaches
- O vision problems
- O hearing problems
- O skin problems/rashes/psoriasis
- O easy bruising/nose bleeds
- O chest pain or palpitations
- O short of breath/cough/wheeze
- O reflux/heartburns
- O diarrhea/constipation
- O bladder problems
- O kidney stones
- O sexual difficulties
- O numbness/tingling
- O balance/coordination problems
- O back pain
- O neck pain
- O swelling of the legs or feet
- O anxiety

Medications:
(include vitamins, supplements, herbs)

_____
_____
_____
_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

Have you had the current season's Influenza vaccine?
Yes _____ No _____ If yes, date: _____
Have you ever had a Pneumonia vaccine?
Yes _____ No _____ If yes, date: _____

Name:
DOB:
Chart:
Date:

Have you ever had anesthesia?

O **YES or NO**

If YES, what type?

O **General**
O **Spinal**
O **Epidural**

Have you ever had problems or complications with anesthesia?

If YES, please describe:

_____

_____

Past Surgery (and year performed)

_____

_____

_____

_____

_____

_____

Social History?

Currently working? YES NO
Retired? YES NO
Are you on disability? YES NO

Smoking Currently? O No O Yes
_____packs per day for _____years
Start date (year):_____
Quit Smoking? O > 1 year O > 5 years O > 10 years
_____packs per day
Start date (year): _____
Quit date (year): _____

How much alcohol do you drink each day? _____

Any history of other drug use?

YES NO

Do you have a spouse or partner?

YES NO

How many children do you have? _____

Who lives in your home with you?

_____

Family History:

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)				
Grandfather (mom's)				
Grandmother (dad's)				
Grandfather (dad's)				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Doctor initials:_____ Date:_____

Patient Easy Pay Consent

I authorize Orthopaedic Institute of Central Jersey, PA to charge my credit or debit card for any items as listed below that are not paid within 30 days. Once charged, a receipt will be mailed to the patient's address on file. *Card will never be charged over $250 per month without prior authorization.* (Please be assured that your credit card information is kept in a secure, locked location, separate from your medical record.)

* Copays, or co-insurance
* Deductibles
* Services not covered under my insurance plan

I agree that if my credit card expires, I will supply the provider above with my new credit card information and that my credit/debit card will remain on file and be charged accordingly for the balances listed above.

Cardholder signature _____

Patient name _____ Date _____

Cardholder name _____

Cardholder address _____

City _____ State _____ Zip _____

Credit card number _____ - _____ - _____

Security number on back/front of card: _____ Exp date _____

Office note: _____