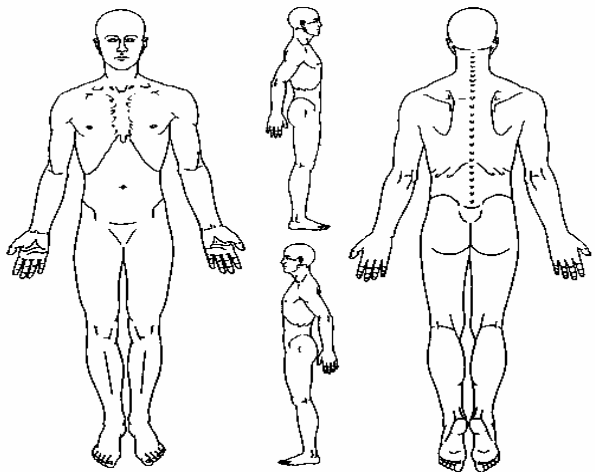


PATIENT INFORMATION

NAME: _____ TODAYS DATE: _____
ADDRESS: _____, CITY: _____
STATE: _____ ZIP: _____ PHONE: _____ WORK: _____
SS#: _____ BIRTHDATE: _____ AGE: _____ EMAIL ADDR: _____
SEX: MALE / FEMALE MARITAL STATUS: Single Married Divorce Widow(er)
WHAT DOCTOR WILL YOU BEE SEEING TODAY: _____
REFERRING: Doctor, Attorney, Therapist, Trainer, Case Worker, Family, Friend, Advertisement, Other
NAME: _____, ADDRESS: _____, PHONE: _____
FAMILY PHYSICIAN OR OTHER TREATING PHYSICIANS:
NAME: _____, ADDRESS: _____, PHONE: _____
HAVE YOU BEEN SEEN FOR THIS INJURY BEFORE _____ (IF YES) HOW LONG _____
AND BY WHOM: _____

INJURY INFORMATION
DATE OF INJURY/ACCIDENT OR ONSET OF SYMPTOMS: _____
PART OF THE BODY BEING SEEN FOR TODAY: _____ (RIGHT / LEFT)
PLEASE GIVE A DESCRIPTION OF HOW SYMPTOM OCCURRED: _____



PLEASE DESCRIBE YOUR PAIN ON THE DIAGRAM ABOVE:
X = PAIN O = PINS AND NEEDLES * = NUMBNESS

MEDICAL INFORMATION

ARE YOU RIGHT ___ LEFT ___ HANDED? HEIGHT ___ ft. ___ in. WEIGHT ___ lbs.
JOB TITLE / OCCUPATION: _____
EMPLOYMENT STATUS: ___ full time, ___ part time, ___ full time student, ___ part time student
 ___ self employed, ___ disabled, ___ unemployed, ___ retired

PATIENT INFORMATION

MEDICAL HISTORY

IF 18 YEARS OR YOUNGER, HAVE YOU RECEIVED ALL OF YOUR PEDIATRIC IMMUNIZATION / VACANATIONS? YES NO.

FEMALE PATIENTS PLEASE GIVE THE LAST DATE OF YOUR MENSTRUAL CYCLE: _____

DO YOU HAVE ANY MEDICAL PROBLEMS, IF SO, PLEASE LIST BELOW:

SURGERY

HAVE YOU EVER HAD ANY SURGERIES? IF YES, PLEASE LIST BELOW AND PROVIDE DATES:

_____/_____/_____
_____/_____/_____

MEDICATIONS

DO YOU TAKE ANY OF THE FOLLOWING MEDICINES ON A REGULAR BASIS:

___ ASPRIN ___ BIRTH CONTROL ___ TYLENOL ___ COUMADIN ___ ANTI-INFLAMATORY

PLEASE LISTS ANY PRESCRIPTION MEDICATION, WITH DOSE & FREQUENCY, THAT YOU ARE TAKING:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ___ yes ___ no IF YES PLEASE EXPLAIN:

SOCIAL HISTORY

___ # OF CHILDREN DO YOU USE TOBACCO ___ yes ___ no IF YES how many years ____, and ___ # packs per day

ALCOHOL USE: ___ none, ___ social, ___ # of drinks per day OR ___ # of drinks per week

HAVE YOU EVER BEEN TREATED FOR CHEMICAL DEPENDENCE? ___ yes, ___ no

EDUCATION (HIGHEST LEVEL ACHIEVED) ___ elementary school, ___ high school, ___ technical, ___ college, ___ advanced degree

FAMILY MEDICAL HISTORY

PLEASE LIST ANY FAMILY HISTORY OF ILLNESS

MOTHER _____
FATHER _____
SISTERS _____
BROTHERS _____

REVIEW OF SYSTEMS: HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS SINCE THE ONSET OF YOUR ORTHOPAEDIC PROBLEM(S):

- | | | |
|--------------------------------|----------------------------------|---------------------------------|
| ___ CHEST PAIN | ___ UPSET STOMACH | ___ FRACTURE |
| ___ HEART PALPATION | ___ GI DISTRESS | ___ LOW BACK PAIN / SCOLIOSIS |
| ___ IRREGUALR HEART RATE | ___ NAUSEA / VOMITTING | ___ NUMBNESS / WEAKNESS |
| ___ SHORTNESS OF BREATH | ___ DIARRHEA | ___ LEG / ANKLE SWELLING |
| ___ DIFFICULTY BREATHING | ___ BLEEDING PROBLEM/ BRUISING | ___ INFECTION |
| ___ LOSS OF CONSCIOUSNESS | ___ URINARY PROBLEMS | ___ DIFFICULTY HEARING |
| ___ FAINTING | ___ DIFFICULTY WITH URINATION | ___ VISUAL CHANGES |
| ___ DIZZINESS | ___ JOINT PAIN / SWELLING | ___ RASHES / SKIN INFECTIONS |
| ___ ABDOMINAL PAIN | ___ JOINT SPRAIN / MUSCLE STRAIN | ___ EMOTIONAL/ANIEXTY DISORDERS |
| ___ DIFFICULTY WITH SWALLOWING | ___ DISLOCATION / SEPERATION | ___ OTHER |

DOCTOR SIGNATURE _____ DATE

PATIENT INFORMATION

IS THIS INJURY WORK RELATED? yes, no. IS THIS INJURY MOTOR VEHICLE RELATED? yes, no.

If worker's comp or MVA please fill out insurance information below:

INSURANCE COMPANY: _____ ADJUSTER / CASE WORKER: _____
TELEPHONE #: _____ ADDRESS: _____
CLAIM #: _____ ATTORNEY: _____
EMPLOYER: _____

PRIMARY INSURANCE COVERAGE

TYPE OF COVERAGE: HMO, POS, PPO, MEDICARE, SCHOOL, SELF PAY, OTHER

NAME OF INSURANCE PLAN: _____

CLAIM ADDRESS: _____, CITY _____

STATE _____, ZIP CODE _____, PHONE NUMBER _____

SUBSCRIBER'S NAME: _____, DATE OF BIRTH ___/___/___

SUBSCRIBER'S SS# _____

SEX: male female RELATIONSHIP TO PATIENT: _____

SUBSCRIBER INSURANCE ID #: _____, GROUP # _____, EFFECTIVE DATE: ___/___/___

SUBSCRIBER'S EMPLOYER NAME: _____

IS THE INSURANCE COVERAGE THROUGH THE SUBSCRIBER'S EMPLOYER? yes, no

SECONDARY INSURANCE COVERAGE

TYPE OF COVERAGE: HMO, POS, PPO, MEDICARE, SCHOOL, SELF PAY, OTHER

NAME OF INSURANCE PLAN: _____

CLAIM ADDRESS: _____, CITY _____

STATE _____, ZIP CODE _____, PHONE NUMBER _____

SUBSCRIBER'S NAME: _____, DATE OF BIRTH ___/___/___

SUBSCRIBER'S SS# _____

SEX: male female RELATIONSHIP TO PATIENT: _____

SUBSCRIBER INSURANCE ID #: _____, GROUP # _____, EFFECTIVE DATE: ___/___/___

SUBSCRIBER'S EMPLOYER NAME: _____

IS THE INSURANCE COVERAGE THROUGH THE SUBSCRIBER'S EMPLOYER? yes, no

PLEASE READ AND SIGN

DO YOU HAVE AUTHORIZATION TO BE SEEN IN OUR OFFICE? IF NO, PLEASE BE ADVISED THAT IF YOUR INSURANCE COMPANY DOES NOT PAY YOU WILL BE RESPONSIBLE FOR YOUR BILL.

It is our office policy that all services rendered are charged directly to the patient, and that you are ultimately and personally responsible for payment of all services rendered, regardless of personal insurance you may have.

1. Patients with no insurance: payment is expected at the time of service. A specific payment plan acceptable between you and billing office may be arranged.
2. Patients with insurance: deductibles and all co-payments are expected at the time of service. Your co-payment is an amount, which is not covered by your insurance and is not always and exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility.
3. If a patients account balance remains unpaid for more than 90 days, and no response has been made to our office billing department, the patient's account may be turned over to our attorney for collection.

INSURANCE POLICY

We extend to our patients, the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out of pocket expenses. Please also note the following:

1. The privilege of insurance assignments begin when your insurance is qualified and forms are received. Until that time you must pay for services rendered.
2. All deductibles must be made prior to submitting any insurance claims.
3. Since we do not own your insurance policy we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.
4. This office does not promise that an insurance company will pay the usual and customary charges of this office, nor does this office enter into any dispute with an insurance company concerning the amount of the reimbursement.
5. Lastly, it is the goal of this office to provide you with the finest quality care available. If you have any questions regarding your health care or any of our office policies, please do not hesitate to let us know.

PLEASE SIGN BELOW

I have reviewed and am aware of the payment policies of New Jersey Spine Group, LLC.

_____, _____ / ____ / _____ _____ / ____ / _____
Signature of responsible party Date Signature of patient Date

I authorize my insurance company to make payment for my unpaid balance directly to the New Jersey Spine Group, LLC.

_____, _____ / ____ / _____ _____ / ____ / _____
Signature of responsible party Date Signature of patient Date

I hereby authorize the release of any information relating to my care directly to my insurance company, attorney, school or any other treating specialists.

_____, _____ / ____ / _____ _____ / ____ / _____
Signature of responsible party Date Signature of patient Date

OUT OF NETWORK

I HAVE BEEN MADE FULLY AWARE THAT NEW JERSEY SPINE GROUP, LLC AND THEIR PROVIDERS DO NOT PARTICIPATE WITH MY INSURANCE. I AGREE THAT I WILL BE HELD RESPONSIBLE FOR ANY AND ALL REMAINING BALANCES THAT MY INSURANCE WILL NOT PAY.

_____, _____ / ____ / _____ _____ / ____ / _____
Signature of responsible party Date Signature of patient Date

MEDICATION POLICY

MEDICATION PRESCRIPTIONS OR REFILLS WILL NOT BE CALLED IN ON WEEKNIGHTS, FRIDAYS, WEEKENDS OR HOLIDAYS UNDER ANY CIRCUMSTANCES. IT IS YOUR RESPONSIBILITY TO MONIOTR THE AMOUNT OF MEDICATION YOU HAVE. THEREFOR, YOU CAN NOT EXPECT THE PHYSICIANS TO CALL IN REFILLS ON THE SAME DAY OF YOUR REQUEST. YOU MUST ALLOW THE DOCTORS AT LEAST 2 DAYS TO CALL IN YOUR REFILL OF YOUR CURRENT MEDICATION.

_____, _____ / ____ / _____ _____ / ____ / _____
Signature of responsible party Date Signature of patient Date