Registration Form

Please complete this form print it out and bring to your appointment

PATIENT NAME: ______________________________ DATE: ______________

ADDRESS: ____________________ CITY: ____________ ST: ____ ZIP: ________

DATE OF BIRTH: ____/____/____ HOME PHONE: ____________ CELL PHONE ____________

AGE: ______ MARITAL STATUS: M S W D SOCIAL SECURITY#________-______-________

EMPLOYER: ______________________________ FT / PT

ADDRESS: ____________________ CITY: ____________ ST: ____ ZIP: ________

WORK PHONE: ______________ E-MAIL: ______________________________

OCCUPATION: ______________ DRIVERS LIC. #:______________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

SPOUSE/EMERGENCY CONTACT: ______________________________

ADDRESS: ____________________ CITY: ____________ ST: ____ ZIP: ________

HOME PHONE: ____________ CELL PHONE: ____________ RELATIONSHIP: ____________

INSURANCE INFORMATION

PRIMARY COVERAGE (IF MOTOR VEHICLE ACCIDENT – LIST MOTOR VEHICLE INSURANCE FIRST)

NAME OF INSURANCE CO.:______________________________

ADDRESS: ____________________ CITY: ____________ ST: ____ ZIP: ________

CONTACT PERSON (ADJUSTER): ____________________ PHONE: ____________

POLICYHOLDER'S NAME & RELATIONSHIP: ______________________________

POLICY ID#: ______________________________ GROUP #: ____________

SECONDARY COVERAGE (PLEASE WRITE "NONE" IF THERE IS NO SECONDARY INSURANCE)

NAME OF INSURANCE CO.:______________________________

ADDRESS: ____________________ CITY: ____________ ST: ____ ZIP: ________

CONTACT PERSON (ADJUSTER): ____________________ PHONE: ____________

POLICYHOLDER'S NAME & RELATIONSHIP: ______________________________

POLICY ID#: ______________________________ GROUP #: ____________

CHECK IF APPLICABLE:

MOTOR VEHICLE ACCIDENT ______ **WORK INJURY** ______ **DATE OF ACCIDENT** ____________

CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name: ______________________________ Date: ______________

CURRENT COMPLAINTS:

□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain
□ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other ______________

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain: ______________________________

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

□ Angina □ Angioplasty □ Arrhythmia □ Arthritis □ Asthma □ Bypass
□ Caner – Where? ______________ □ Diabetes □ Dialysis □ Diverticulosis
□ Emphysema □ Hypertension □ Headaches □ Heart Attack □ Heart Disease □ Heart Failure
□ Hemophilia □ Hemorrhoids □ High Cholesterol □ Impotence □ Kidney Stone □ Kidney Problem
□ Leg Swelling □ Liver Problems □ Murmur □ Obesity □ Pacemaker □ Pass Out
□ Pneumonia □ Reflux □ Rheumatic Fever □ Rheumatoid □ Sleep Apnea □ Stroke
□ Surgeries: ______________ □ Thyroid □ Tuberculosis
□ Ulcer □ Varicose Veins □ Other: ______________

FAMILY MEDICAL HISTORY:

Mother: Age: ________ ( ) Living ( ) Deceased
Father: Age: ________ ( ) Living ( ) Deceased
Siblings: Age: ________ ( ) Living ( ) Deceased

Please check each box with if any family member (mother, father or siblings) has had any of the following:

□ Angina □ Angioplasty □ Arrhythmia □ Arthritis □ Asthma □ Bypass
□ Caner – Where? ______________ □ Diabetes □ Dialysis □ Diverticulosis
□ Emphysema □ Hypertension □ Headaches □ Heart Attack □ Heart Disease □ Heart Failure
□ Hemophilia □ Hemorrhoids □ High Cholesterol □ Impotence □ Kidney Stone □ Kidney Problem
□ Leg Swelling □ Liver Problems □ Murmur □ Obesity □ Pacemaker □ Pass Out
□ Pneumonia □ Reflux □ Rheumatic Fever □ Rheumatoid □ Sleep Apnea □ Stroke
□ Surgeries: ______________ □ Thyroid □ Tuberculosis
□ Ulcer □ Varicose Veins □ Other: ______________

CURRENT MEDICATIONS: Please list **all** current medications below or provide us with a list of medications:

Name of Medicine	Strength	Dosage

List of known ALLERGIES: ____

____

( ) Tobacco ( ) Type: ______________ ( ) Alcohol Type: ______________
( ) Year begun: ______________ How often: ______________
( ) Still smoking: ______________ How much: ______________
( ) Year quit: ______________ How many years: ______________
( ) Packs per day: ______________

( ) Exercise ( ) None ( ) Light ( ) Moderate ( ) Heavy

Other: ____

____

____

REVIEW OF SYSTEMS: Do you have (had) the following:

Check the appropriate box(s)

GENERAL: □ Weight gain □ Weight loss □ Fever □ Hair loss
□ Weakness □ Other: ______________

EYES: □ Eye strain □ Wear glasses or contact lenses □ Sensitivity to light

EAR, NOSE THROAT □ Ringing in ears □ Hearing loss □ Discharge or pain □ Dizziness
□ Runny nose □ Difficulty Breathing through nose □ Sinusitis
□ Painful teeth, gums or palate □ Growths in the mouth
□ Pain or difficulty swallowing □ Hoarseness

CARDIOVASCULAR: □ Palpitations □ Chest pain □ Fainting □ Dizziness
□ Varicose veins □ Difficulty Climbing Stairs □ Pain in the legs
□ Cold Feet/Hands □ Shortness of breath

RESPIRATORY: □ Shortness of breath while walking □ Cough with or without phlegm
□ Asthma/Wheezing □ Spit up blood
□ Other: ______________

GASTROINTESTINAL: □ Abdominal pain □ Nausea □ Vomiting □ Diarrhea
□ Hemorrhoids □ Change in shape or color of stool

GENITOURINARY: □ Discharge □ Pain □ Frequent urination □ Pain with urination

MUSCULOSKELETAL: □ Weakness □ Back Pain □ Neck Pain □ Leg Pain
□ Arm Pain □ Shoulder Pain □ Numbness □ Headaches
□ Other: ______________

SKIN: □ Jaundice □ Dry Skin □ Pigment Change □ Growths
□ Moles that have changed color, shape or bleed

NEUROLOGIC: □ Tremors □ Weakness □ Numbness □ Memory Loss
□ Confusion □ Other: ______________

DETAILS REGARDING CURRENT PAIN/DISCOMFORT: Please complete the following with as much detail as possible.

How long have you suffered or worried about this pain/discomfort?

- ❏ Haven't, this is prevention
- ❏ A few days
- ❏ 1-2 weeks
- ❏ 2-4 weeks
- ❏ 1-3 months
- ❏ Long enough
- ❏ Seems like too long (years)

What concerns you most?

- ❏ Not knowing what's wrong
- ❏ Depending upon painkillers
- ❏ Losing mobility or independence
- ❏ The risk of facing surgery

Other concerns (specific)

____

____

____

____

____

Number one thing you would like to achieve?

____

____

____

____

____

What does this pain/discomfort stop you from doing?

____

____

____

____

____

PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures, I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to **Disc, Sport and Spine Center of Morris** to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose the protected health information. You have a legal right to review our Notice of Privacy Practices before you sign the consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at **201 – 798 – 2922**. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request, however, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSET TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration for its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, not is pregnancy suspected or confirmed at this particular time. Date of last menstrual period ________________________________

____

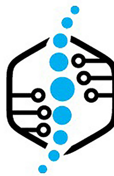
X Print Patient's Name

X ____

Patient's Signature

X ____

Parent / Guardian (If under the age of 18)



DISC
SPORT AND SPINE
CENTER
of MORRIS

10 Pine Street
Morristown, NJ 07960
P: 201-798-2922 / F: 201-798-0307

ATTENTION PATIENTS

As a courtesy to our patients, we will submit claims to your health insurance for all services rendered in our office. Please be aware that your insurance company **may** send payments made directly payable to you instead of this office. We ask that you bring in the check(s) and the explanation of benefits statement to this office immediately upon receipt.

Please note that these payments **must** be presented to the office, otherwise **you** will be held responsible for the payment to your account.

If you have any questions or concerns, please do not hesitate to speak with me.

Please sign and return to the front desk.

____

Print Patient Name

____

Patient Signature

ASSIGNMENT OF BENEFITS FORM

Disc, Sport and Spine Center of Morris
10 Pine Street
Morristown, NJ 07960
P: 201-798-2922

Date: ____________________________

Patient Name:
Employer:
Claim Group:
SS# / ID#:

I hereby instruct and direct ____ Insurance Company to pay by check made payable to and mailed to:

Disc, Sport and Spine Center of Morris
10 Pine Street
Morristown, NJ 07960

or 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 debtedness to 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 the 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 or my health care provider for any reason on my behalf.

X ____ Date: ______________________________
Signature of Policyholder

X ____ Date: ______________________________
Signature of Claimant if other than Policyholder

X ____ Date: ______________________________
Witness