

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.

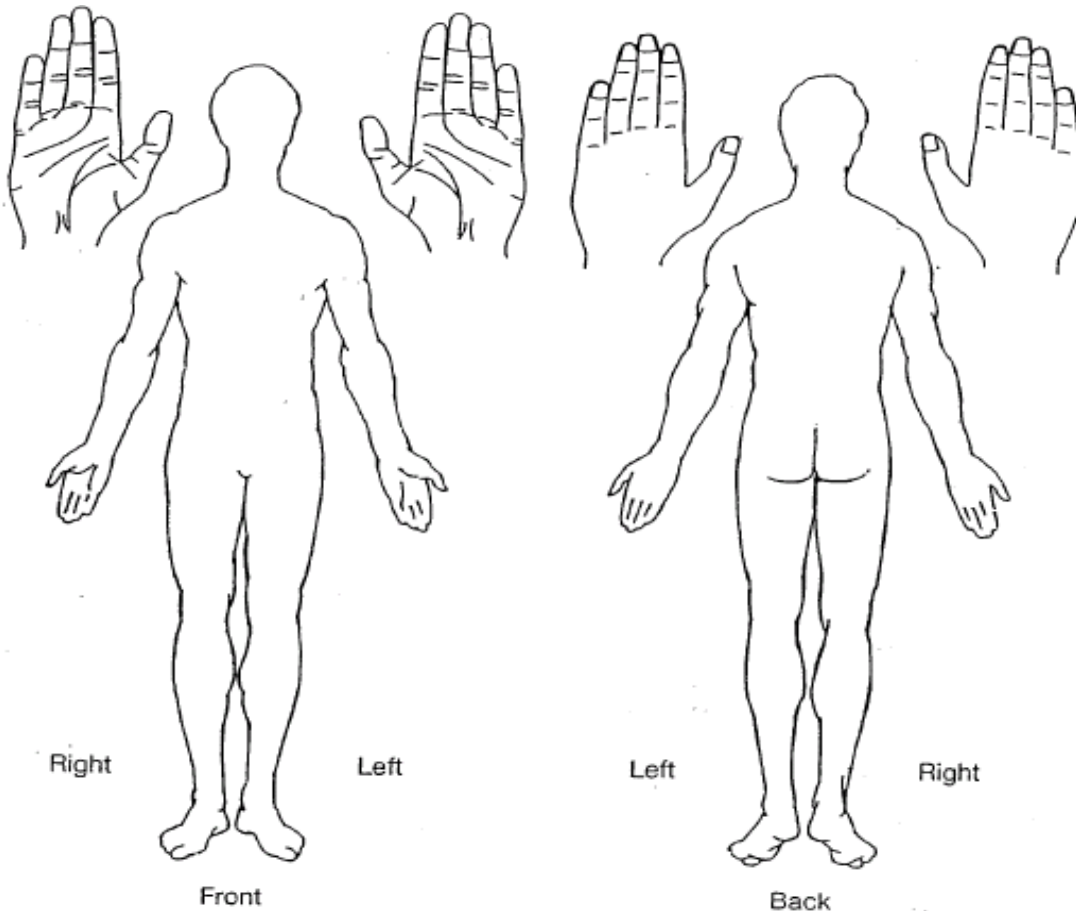
Aching  
▲ ▲ ▲

Numbness  
= = =

Pins and needles  
o o o

Burning  
x x x

Stabbing  
/ / /



### 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**

*Please present your insurance card 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: \_\_\_\_\_

**WORKER'S COMPENSATION CLAIMS**

Comp. Company: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Claim No. \_\_\_\_\_ Date of Injury: \_\_\_\_\_

**PREFERRED PHARMACY INFORMATION**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Relationship to Patient

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

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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PHYSICIAN ASSISTANT

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 authorize Orthopaedic Spine Institute to discuss my care, progress, work status, etc with my employer or representative thereof.

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.

**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.

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**SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

Name:  
DOB:  
Chart:  
Date:

---



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**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: \_\_\_\_\_

732-359-5777 • Fax 732-933-0389

3499 Route 9, Freehold, NJ 07728 • 365 Broad Street, Red Bank, NJ 07701 • 226 Route 37 W. Toms River, NJ 08755

2315 Route 34 S. Manasquan, NJ 08736 • 1301 Route 72 West, Ste 290, Manahawkin, NJ 08050

visit us at: [www.orthospineinst.com](http://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...

- Gradually or Suddenly

Was it caused by an injury?      **Yes**      **No**

How severe is your pain...

- Today? (0 - 10) \_\_\_\_\_

- When at its worst? (0 - 10) \_\_\_\_\_

Is the pain...

- Sharp or dull?  
 Aching or stabbing?  
 Burning?

Is it painful...

- First thing in the morning?  
 During the day?  
 At night while sleeping?

What makes the pain better?

- Lying down?  
 Standing?  
 Sitting?  
 Walking?  
 Ice or heat?

What makes the pain worse?

- Lying down?  
 Standing?  
 Sitting?  
 Walking?  
 Exercise?  
 Stair climbing?  
 Reaching over head?  
 Bending?  
 Coughing/sneezing?

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

\_\_\_\_\_

Have you ever had (for this problem):

- Xrays?  
 CT scan  
 MRI?  
 EMG?

Have you tried the following for this problem?

- Oral medications?

Please list: \_\_\_\_\_

- Physical Therapy?  
 Joint injections?

Steroid (cortisone)

Synvisc/Orthovisc/Euflexxa

- Epidural injections  
 Chiropractic care  
 Surgery



Name:  
DOB:  
Chart:  
Date:

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

Heart disease

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

Endocrine disease

- Diabetes
- Thyroid condition

Vascular disease

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

Neurologic/Spine disease

- Stroke/mini-stroke
- Peripheral neuropathy
- Spinal stenosis
- Herniated disc

Kidney disease

Gastrointestinal disease

- GERD
- Ulcers
- Bleeding ulcers

Bleeding/Clotting disorders

Lung disease

- Asthma
- COPD
- Emphysema
- Sleep apnea

Cancer

- Please list: \_\_\_\_\_

Rheumatologic conditions

- Rheumatoid arthritis
- Psoriatic arthritis
- Ankylosing spondylitis
- Lupus

HIV/AIDS

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

Mental illness

- Depression
- anxiety

Other: please list \_\_\_\_\_

**No Medical Problems**

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

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

**Medications:**

(include vitamins, supplements, herbs)

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---

**Allergies:**

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---

---

Doctor initials: \_\_\_\_\_ Date: \_\_\_\_\_

Name:  
DOB:  
Chart:  
Date:

**Have you ever had anesthesia?**

YES or  NO

**If YES, what type?**

- General
- Spinal
- Epidural

**Have you ever had problems or complications with anesthesia?**

**If YES, please describe:**

---

---

**Past Surgery (and year performed)**

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---

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**Family History:**

	Medical Problems
<b>Father</b>	
<b>Mother</b>	
<b>Brother(s)</b>	
<b>Sister(s)</b>	

**Social History?**

Currently working? YES NO

Retired? YES NO

Are you on disability? YES NO

Are you currently smoking?

**Never smoked**

**No**, I quit. Date quit: \_\_\_\_\_

**Yes...**

\_\_\_\_\_ packs per day

How many years? \_\_\_\_\_

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?

---

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: \_\_\_\_\_