

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.

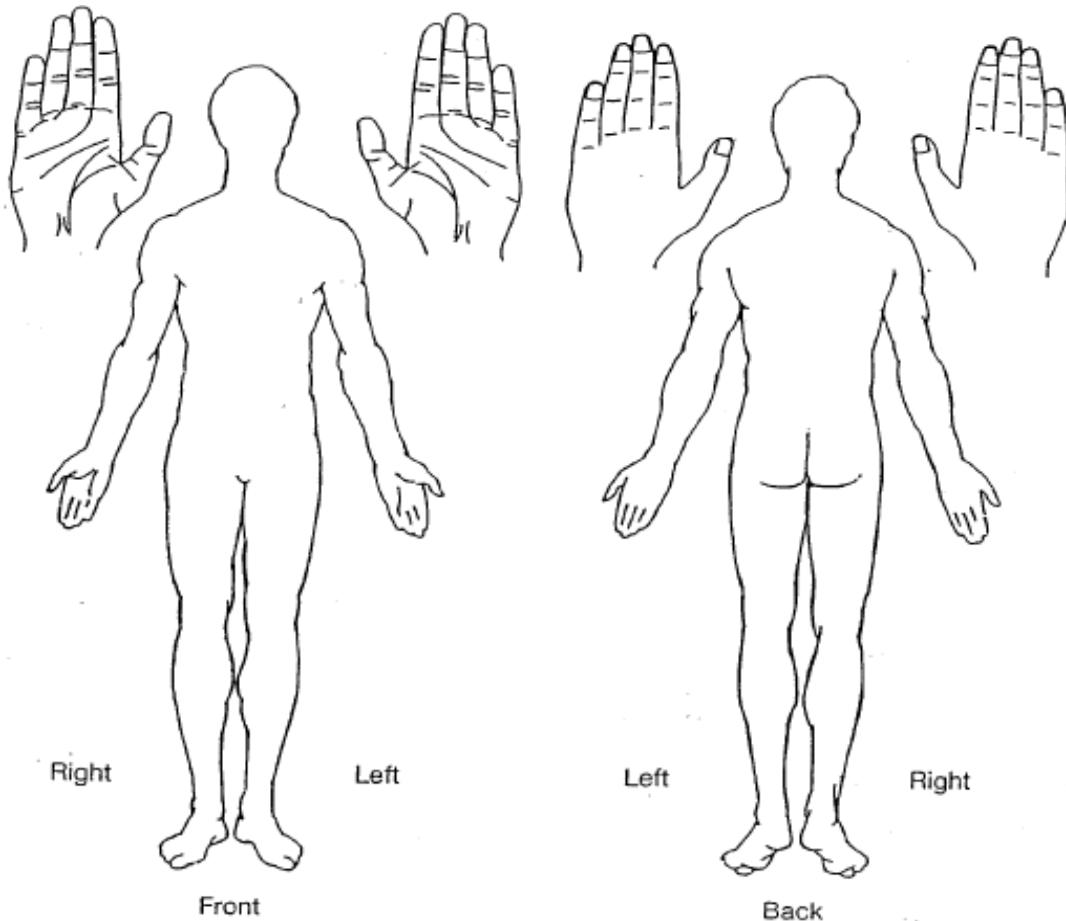
Aching
▲ ▲ ▲

Numbness
= = =

Pins and needles
○ ○ ○

Burning
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

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

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** _____

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

Name:
DOB:
Chart:
Date:



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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

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visit us at: www.orthospineinst.com

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: _____

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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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ASSIGNMENT OF BENEFITS/APPOINTMENTS OF ATTORNEYS

I hereby authorize payment directly to the above named doctors, of any insurance benefits otherwise payable to me for services provided to me (or a minor for whom I am the guardian) for their services.

I understand that the doctors of Orthopaedic Institute of Central Jersey, PA and their assistants may each bill for services rendered independently. I authorize this office to submit their bills to any insurance company with which I (or my spouse) have an insurance policy or any company against which I may proceed for medical expense benefits.

In the event that the doctors elect to bring a lawsuit or petition for arbitration against the insurance carrier, I assign my rights, title, and interest under the medical expense benefits and/or PIP section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim of any unpaid bills for treatment rendered for injuries I sustained in this or any accident. Orthopaedic Institute of Central Jersey, PA may designate an attorney of their choosing for the purpose of filing said action beginning thirty-one (31) days after any bill for services rendered becomes due. I agree to fully cooperate with them in the collection of the medical expense benefits/personal injury protection claim for the insurance carrier, including full cooperation with the attorney chosen by the assignee.

In the event this assignment is held invalid for any reason, I hereby authorize Orthopaedic Institute of Central Jersey, PA, to appoint an attorney of its choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of his/her choice. This appointment is intended to enable the designated attorney to collect the bills of Orthopaedic Institute of Central Jersey, PA and this appointment does not authorize the selected attorney to represent me in any third-party action. Further, this appointment shall not conflict with any other attorney who currently represents me.

I further authorize Orthopaedic Institute of Central Jersey, PA to release any and all information concerning my injury or illness and its treatment to the attorney designated by the assignee or third persons who are involved in the action to collect benefits. A photostat or copy of this authorization shall be deemed valid as original.

I have read, understand, and agree to the above.

Date

Patient (or guardian if a minor)

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Patient Questionnaire

Your Name: _____

Your Primary/Family Doctor:

Age: _____

Height: _____

Weight: _____

Occupation: _____

Please circle or answer:

Was this injury the result of a fall? Yes No

Have you fallen more than once within the last year?
Yes No

Date of the accident: _____

Approximately what date did your current pain begin? _____

Were you hospitalized overnight?
YES NO

Were you the...(check all that apply)

- Driver?
- Front seat passenger?
- Rear seat passenger?
- Restrained?
- Unrestrained?

Was the impact to your vehicle...

- Head-on? Side?
- Rear?

How severe is your pain...

- Today? (0 - 10) _____
- When at its worst? (0 - 10) _____

Is the pain...

- Sharp or dull? Burning?
- Aching or stabbing?

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)

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?

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)

Social History?

Currently working? YES NO

Retired? YES NO

Are you on disability? YES NO

Smoking Currently? No Yes

_____packs per day for _____years

Start date (year): _____

Quit Smoking? > 1 year > 5 years > 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: _____

APPLICATION FOR BENEFITS

DATE	POLICYHOLDER'S NAME	DATE OF ACCIDENT	CLAIM NUMBER
------	---------------------	------------------	--------------

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE POLICYHOLDER'S INSURANCE CONTRACT, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

1	YOUR NAME	SEX	MAIDEN NAME
	HOME	BUSINESS	IF MINOR, PARENT'S NAME
	PHONE NUMBER		
2	YOUR ADDRESS (NO. STREET, CITY OR TOWN, STATE AND ZIP CODE)		DATE OF BIRTH
3	YOUR PERMANENT ADDRESS. IF DIFFERENT FROM ABOVE ENTRY - HOW LONG HAVE YOU LIVED IN THIS STATE?		SOCIAL SECURITY NUMBER
4	DATE AND TIME OF ACCIDENT	A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
5	BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:		
6	DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD AS OF THE DATE OF THE LOSS.		
	AUTOMOBILE AND ITS LOCATION AT TIME OF LOSS	OWNER	INSURER POLICY NUMBER
7	AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES NO		
	IF YOUR ANSWER IS YES. COMPLETE THE REST OF THIS FORM. IF NO. SIGN HERE AND RETURN THIS FORM TO US.		
	SIGNATURE _____		DATE: _____
	DESCRIBE YOUR INJURY:		
	NAME AND ADDRESS OF YOUR (APPLICANT'S) HEALTH INSURANCE CARRIER:		
	NAME AND ADDRESS OF YOUR (APPLICANT'S) PHARMACY:		
	WERE YOU TREATED BY A DOCTOR?	YES NO	DOCTOR'S NAME AND ADDRESS
	IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN INPATIENT OR OUTPATIENT?		HOSPITAL'S NAME AND ADDRESS
	AMOUNT OF MEDICAL BILLS TO DATE \$	WILL YOU HAVE MORE MEDICAL EXPENSE? YES NO	WERE YOU ON THE JOB AT THE TIME OF YOUR ACCIDENT? YES NO
	DID YOU LOSE WAGES OR SALARY AS RESULT OF YOUR INJURY? YES NO	IF YES, AMOUNT LOST TO DATE \$	HAVE YOU BEEN ABLE TO CARRY OUT YOUR USUAL HOUSEHOLD TASKS? YES NO
	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? \$		
	IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK	

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKERS COMPENSATION, UNEMPLOYMENT LAW, MEDICAID OR MILITARY BENEFITS FOR THIS ACCIDENT?	YES NO	IF YES, SHOW AMOUNT: \$ _____	PER WEEK PER MONTH
LIST NAME AND ADDRESS OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH:			
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?		YES NO	IF YES, EXPLAIN:
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.			
SIGNATURE _____ (INJURED PERSON OR REPRESENTATIVE)		_____ DATE	

- IMPORTANT: TO HELP US DETERMINE YOUR ELIGIBILITY FOR COVERAGE AND EXPEDITE THE HANDLING OF YOUR CLAIM PLEASE:**
1. COMPLETE AND SIGN THIS APPLICATION.
 2. SIGN THE AUTHORIZATION BELOW.
 3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the PERSONAL INJURY PROTECTION BENEFITS LAW. This authorization shall remain valid for the duration of the claim.

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the PERSONAL INJURY PROTECTION BENEFITS LAW. This authorization shall remain valid for the duration of the claim.

SIGNATURE: _____ **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: _____