



Please circle the areas in which you are experiencing pain. This will help us identify the cause of your pain and possible treatment methods.

Patient Name: _____ SS# _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Home# () _____ Work# () _____ Cell# () _____

Date of Birth: ___/___/___ Age: _____ Male

Female

Race: _____ Marital Status: S M D W Other

Height: _____ Weight: _____

Spouse/Significant Other: _____ Phone # () _____

Employer: _____ Phone # () _____

Referring Physician: _____

Primary Physician: _____

Primary Insurance: _____

Contract# _____ Group# _____

Cardholder: _____ Phone # () _____

Relationship (if other than patient): _____ Date of Birth: ___/___/___

Secondary Insurance: _____

Contract# _____ Group# _____

Cardholder: _____ Phone # () _____

Relationship (if other than patient): _____ Date of Birth: ___/___/___

Is this a Workman's Compensation Claim? Yes No If Yes, Claim

Is this a motor vehicle accident claim? Yes No If Yes, Claim # _____

Adjustor's Name: _____ Phone # () _____

Agreement: I understand I am totally responsible for all charges to my account. I understand that this office will file my insurance and that I am responsible for any amount not paid. If this account has to be collected by an attorney, I understand that I will be responsible for the attorney fees also. I authorize release of my medical information to my physicians and insurance carriers. I also authorize payment of benefits directly to my physicians.

PATIENT SIGNATURE _____ DATE _____

I, _____ (please print) give permission for NJ Spine and Pain Center Inc to take an identification photograph to be maintained in my medical

records. I understand that this picture will be used in a confidential manner related only to my personal care in the above named office.

PATIENT SIGNATURE _____ DATE _____

PATIENT HISTORY

How long have you had this problem?

Was there an injury responsible for pain, such as fall/accident? If so, please describe:

Please check all that apply:

Pain Type: Sharp Aching Burning Shooting Constant Intermittent

Pain Increases when: Sitting Lying down Walking Bending Weather Coughing/Sneezing

Pain Decreases when: Sitting Lying down Walking Bending Weather Coughing/Sneezing

Associated Symptoms: Weakness Numbness Tingling Fever Weight loss

Bowel/Bladder problems Insomnia Pain wakes at night Sexual dysfunction Other

SOCIAL HISTORY

Marital status: Yes No

Children: Yes No

Uses Alcohol/tobacco: Yes No

Pregnant: Yes No

PAST SURGERY HISTORY

CURRENT MEDICATIONS (LIST ALL)

Currently Uses:

Coumadin: Yes No

Heart Medication: Yes No

Aspirin: Yes No

Insulin: Yes No

RADIOLOGICAL STUDIES

X-Rays Yes No

When: ___/___/_____ Where: _____

MRI: Yes No

CT scan: Yes No

EMG (nerve study): Yes No

Bone Scan: Yes No

TENS Unit: Yes No

Phys. /Occ. Therapy: Yes No

Biofeedback: Yes No

Psychological Evaluation: Yes No

Hypnosis: Yes No

Chiropractic: Yes No

Nerve Blocks: Yes No

PAST MEDICAL HISTORY

CNS Cardiovascular Respiratory Metabolic

Cerebral Aneurysm Yes No

Hypertension Yes No

Infection Yes No

Liver Disease Yes No

Stroke Yes No

Valve Disease Yes No

Asthma Yes No

Chemo/Radiation Yes No

Paralysis Yes No

Heart Attack Yes No

Emphysema Yes No

Diabetes Yes No

Seizure Disorder Yes No

Chest Pain Yes No

Bronchitis Yes No

Thyroid Yes No

Neuropathy Yes No

Arrhythmia Yes No

Pneumonia Yes No

Clotting Disorder Yes No

Gastrointestinal Genitourinary Bone/Muscle Infectious

Hiatal Hernia Yes No

Kidney Disease Yes No

Arthritis Yes No

Hepatitis Yes No

Ulcer Yes No

Pregnancy Yes No

Cancer Yes No

Other Yes No

AIDS Yes No

Psychiatric

Depression Yes No

Anxiety Yes No

FAMILY HISTORY

Cancer Yes No

Diabetes Yes No

Heart Disease Yes No

High Blood Pressure Yes No

ADDITIONAL COMMENTS

CONSENT FOR TREATMENT:

I, the undersigned, authorize treatment by NJ Spine and Pain Center Inc. I further understand that any treatment ordered with NJSAPC will be under the directions of Dr. Uday N Bhatt.

ASSIGNMENT OF INSURANCE BENEFITS:

I assign payment directly to NJ Spine and Pain Center Inc accepting this assignment of all treatment and applicable and otherwise payable to me but not to exceed the reasonable and customary charge for these services rendered by said group. The undersigned certifies that he/she has read and understands the above.

PATIENT SIGNATURE _____ DATE _____

RELEASE OF INFORMATION

This is an authorization of _____ to convey to NJ SPINE AND PAIN CENTER INC any all information requested by Dr Uday Bhatt. The questions of privacy between your institution, my attending physician or physicians, and myself are waived. This authority extends to the furnishing of copies of all or any desired parts of my medical record.

PATIENT NAME _____ DATE _____

PATIENT SIGNATURE _____ WITNESS _____

PAIN MANAGEMENT AGREEMENT

Uday N Bhatt, M.D.

The purpose of this agreement is to prevent misunderstands about certain medications you will take for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines. In this case, my doctor will taper off the medicine over a period of several days, if necessary, to avoid withdrawal symptoms. Also a drug dependence treatment program may be recommended. Will communicate fully with my doctor about the character and intensity of my pain, the effects of the pain on my daily life, and how well the medicine is helping to relieve the pain. I will not use any illegal controlled substance, including marijuana, cocaine, etc. I will not share, sell or trade my medication with anyone. I will not attempt to obtain any controlled medicines, including steroid pain medicines, controlled stimulants, or anxiety medicines from any other doctor. I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. I agree that refills of my prescriptions of pain medicine will be made only at the time of an office visit or during regular office hours. No refills will available during evenings or on weekends. I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state’s Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also agree to only use on pharmacy. I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. I agree to follow these guidelines that have fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. A copy of this Agreement will be given to me and to any physician with whom I seek treatment from.

PHARMACY _____ TELEPHONE # () _____
PATIENT SIGNATURE _____ DATE _____
WITENESS SIGNATURE _____ DATE _____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

Uday N Bhatt, M.D.

Provider Notice of Information Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Thank you!

We use health information about you for treatment (diagnostic testing, prescription, referral etc.) to obtain payment (submit claims and/or encounters to billing services and/or clearinghouses, and/or collection agencies, etc.) for administration purposes (reporting, utilization management, quality improvement and surveys, etc.) and to evaluate the quality of care that you receive. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose identifiable health information without your authorization for several other reasons. Subject to certain requirements, we may give out health information with your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may apply a change to our policies at any time. Before we make a significant change in our policies, we will change out notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights:

You have the right to look at, get a copy of receive electronically protected health information about you that we use to make decisions about you. If you request copies, there will be a charge of \$.05 for each page. You also have the right to receive a list of instances where we have disclosed protected health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information is incorrect or if important information is missing you have the right to request in writing that we amend the existing information. You may request in writing that we restrict and/or use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to agree to it. If you are concerned that we have violated your privacy rights, or you disagree with a section we made access or amendment to your records, you may contact the person listed below. You may send a written complaint to U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. We are required by law to protect the privacy of your information, provide this notice about your information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

UDAY N BHATT, M.D**2109-2111, Klockner road****Hamilton, New Jersey, 08690****Tel 609-587-6070****Tel 1-877-SPINE 81**