

EMAIL ADDRESS _____

STREET ADDRESS_____

CITY, STATE, ZIP _____

PHONE (Home)_____ **(Cell)**_____ **(Work)**_____

PHYSICIAN _____ PHONE# _____

PHARMACY _____ PHONE# _____

EMPLOYER _____ SPOUSE'S EMPLOYER _____

SPOUSE NAME_____ **IF UNDER 18 PARENT NAME**_____

EMERGENCY CONTACT _____ **ADDRESS/**
(OTHER THAN SPOUSE) _____ **PHONE** _____

SOCIAL SECURITY#_____ **REFERRED BY**_____

<u>_CHECK</u>	<u>_CASH</u>	<u>_CREDIT CARD</u>	<u>_INSURANCE</u>	<u>_WORKMAN'S COM.</u>	<u>_MVA/PIP</u>
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BILLING NAME
(IF OTHER THAN PATIENT) _____ **RELATIONSHIP** _____

BILLING ADDRESS

1) INSURANCE	EFFECTIVE
COMPANY _____ ADDRESS _____	DATE _____

SUBSCRIBER'S

NAME	I.D. #	GROUP#
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2) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
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SUBSCRIBER'S		
NAME	I.D. #	GROUP#

CLAIM #	DATE OF ACCIDENT

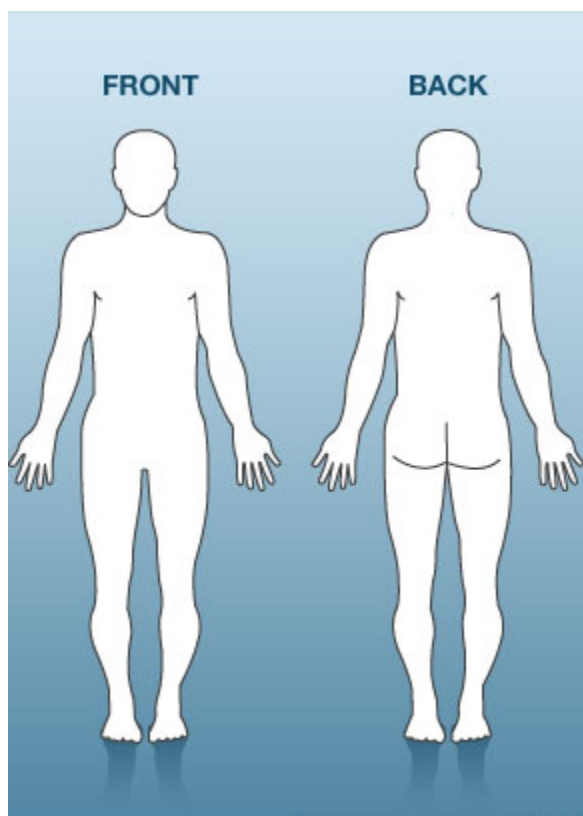
ADJUSTER NAME & PHONE N0. _____

Patient Name: _____

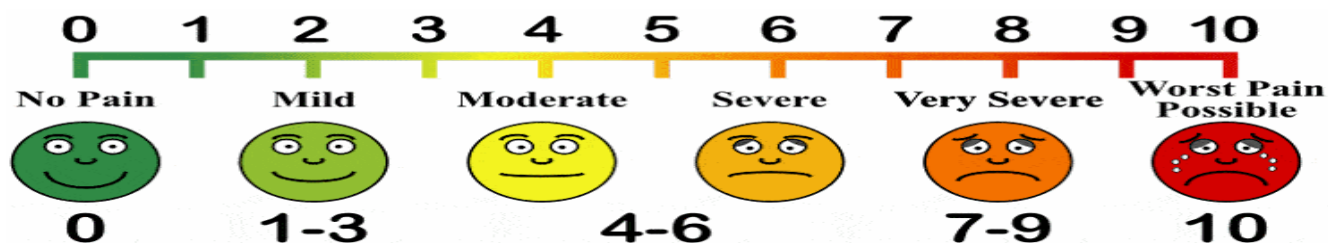
Date: _____

Completing this form can help you talk to your healthcare provider about your symptoms.

CIRCLE ALL OF THE AREAS WHERE YOU FEEL PAIN



USE SCALE TO RATE THE AVERAGE SEVERITY OF PAIN YOU FEEL



- How long have you been experiencing chronic widespread pain? _____
- How would you describe the type of pain you feel? _____
- Is your daily functioning impacted?
 - Very much
 - Somewhat
 - A little
 - Not at all
- What other symptoms do you frequently experience? _____

Pharmacy Name/Phone Number

[illegible]

HEALTH HISTORY

Date_____

Patient Name_____ Birthdate_____

Chief Complaint:_____**History of present illness:****Location:**_____ **Quality:**_____

(Where is the pain/problem?)

(example: normal versus abnormal color, activity)

Severity_____ **Duration**_____(How severe is the pain/problem on a scale of 1-5 with
5 Being the most severe)(How long have you had this pain/problem
or when did it start)**Timing**_____ **Context**_____

(Does the pain/problem occur at specific time?)

(Where were you at the onset of this pain/problem?)

Associated signs/symptoms_____ **Modifying factors**_____

(What other associated problems have you been having?)

(What makes the pain/problem worse or better or
Have you had previous episodes?)**PAST MEDICAL HISTORY:**

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Whooping Cough..... no yes Migraine Headaches... no yes Date of last chest x-ray_____ Bleeding Tendency...no yes
 Measles..... no yes Anemia..... no yes Back trouble..... No yes Hepatitis.....no yes
 Mumps..... no yes Bladder infections..... No yes High blood Pressure...no yes Ulcer.....no yes
 Chickenpox..... no yes Epilepsy.....no yes Low Blood Pressure.....no yes Kidney Disease.....no yes
 Scarlet Fever.....no yes Tuberculosis.....no yes Hemorrhoids.....no yes Thyroid Disease.....no yes
 Diphtheria.....no yes Diabetes.....no yes Asthma.....no yes Any other disease.....no yes
 Smallpox.....no yes Cancer.....no yes Hives /Eczema.....no yes (please list)
 Pneumonia.....no yes Polio.....no yes AIDS or HIV+.....no yes _____
 Rheumatic Fever.....no yes Glaucoma.....no yes Infectious Mono.....no yes _____
 Heart Disease.....no yes Hernia.....no yes Bronchitis.....no yes _____
 Arthritis.....no yes Blood or Plasma _____ Mitral Valve Prolapse.no yes _____
 Venereal Disease.....no yes Transfusions.....no yes Stroke.....no yes _____

Allergies (medication, food, environmental) : _____

When

Hospital, City, State

Surgical History: _____

Hospitalization: _____

Family medical history:

Age

Disease

if deceased, Cause of Death

Father _____

Mother _____

Siblings _____

Spouse _____

Children _____

Patient social history:

Marital status Single:___ Married___ Separated:___ Divorced:___ Widowed___

Use of alcohol: Never:___ Rarely___ Moderate:___ Daily:___

Use of tobacco: Never___ Previously, but quit___ Current packs/day:_____

Use of Drugs: Never:___ Type/Frequency:_____

HEIGHT:___' ___" Weight: _____lbs. Did you have a flu vaccine last fall? Yes no

Review of System: Please indicate any personal history below:**Constitutional Symptom**

Good general health lately.....No Yes
 Recent weight change.....No Yes
 Fever.....No Yes
 Fatigue.....No Yes
 Headaches.....No Yes

Eyes

Eye disease or injury.....No Yes
 Wear glasses/contact lenses.....No Yes
 Blurred or double vision.....No Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing.....No Yes
 Earaches or drainage.....No Yes
 Chronic sinus problem / rhinitis.....No Yes
 Nose Bleeds.....No Yes
 Mouth sores.....No Yes
 Bleeding gums.....No Yes
 Bad breath or bad taste.....No Yes
 Sore throat or voice change.....No Yes
 Swollen glands in neck.....No Yes

Cardiovascular

Heart trouble.....No Yes
 Chest pain or angina pectoris.....No Yes
 Palpitation.....No Yes
 Shortness of breath w/walking
 Or lying flat.....No Yes
 Swelling of feet/ankles/hands.....No Yes

Respiratory

Chronic or frequent coughs.....No Yes
 Spitting up blood.....No Yes
 Shortness of breath.....No Yes
 Wheezing.....No Yes

Gastrointestinal

Loss of appetite.....No Yes
 Change in bowel movements.....No Yes
 Nausea or vomiting.....No Yes
 Frequent diarrhea.....No Yes
 Painful bowel movements
 Or constipation.....No Yes
 Rectal bleeding or blood
 In stool.....No Yes

Genitourinary

Frequent urination.....No Yes
 Burning or painful urination.....No Yes
 Blood in urine.....No Yes
 Change in force strain
 when urinating.....No Yes
 Incontinence or dribbling.....No Yes
 Kidney stones.....No Yes
 Sexual difficulty.....No Yes
 Male - testicle painNo Yes
 Female – pain with periods.....No Yes
 Female – vaginal discharge.....No Yes
 Female - # of pregnancies.....
 Female - # of miscarriages.....
 Female – date of last pap smear.....

Musculoskeletal

Joint pain.....No Yes
 Joint stiffness or swelling.....No Yes
 Weakness of muscles or joints.....No Yes
 Muscle pain or cramps.....No Yes
 Back pain.....No Yes
 Cold extremities.....No Yes
 Difficulty in walking.....No Yes

Integumentary (skin, breast)

Rash or itching.....No Yes
 Change in skin color.....No Yes
 Change in hair or nails.....No Yes
 Varicose veins.....No Yes
 Breast pain.....No Yes
 Breast lump.....No Yes
 Breast discharge.....No Yes

Neurological

Frequent or recurring
 Headaches.....No Yes
 Light headed or dizzy.....No Yes
 Convulsions or seizures.....No Yes
 Numbness or tingling sensation.....No Yes
 Tremors.....No Yes
 Paralysis.....No Yes
 Head injury.....No Yes

Psychiatric

Memory loss or confusion.....No Yes
 Nervousness.....No Yes
 Depression.....No Yes
 Insomnia.....No Yes

Endocrine

Glandular or hormone problem.....No Yes
 Excessive thirst or urination.....No Yes
 Heat or cold intolerance.....No Yes
 Skin becoming dryer.....No Yes
 Change in hat or glove size.....No Yes

Hematologic/Lymphatic

Slow to heal after cuts.....No Yes
 Bleeding or bruising tendency.....No Yes
 Anemia.....No Yes
 Phlebitis.....No Yes
 Past transfusions.....No Yes
 Enlarged glands.....No Yes

Allergic/immunologic

History of skin reaction or other adverse
 reaction to:

Penicillin or other antibiotics.....No Yes
 Morphine, Demerol,
 or other narcotics.....No Yes
 Novocain or other anesthetics.....No Yes
 Aspirin or other pain remedies.....No Yes
 Tetanus antitoxin
 or other serums.....No Yes
 Iodine, Merthiolate or
 other antiseptic.....No Yes
 Other drugs/medications.....

Known food allergies:.....

Environmental allergies:.....

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status, I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian

Date

Doctor's Review

Signature of Doctor

Date

PATIENT REGISTRATION

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr.Dorota M Gribbin M.D., Comprehensive Pain and Rehabilitation Center, for services rendered by her in person of under her supervision. I understand that I am financially responsible for any balance not covered by my insurance

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr.Dorota M. Gribbin M.D., Comprehensive Pain and Rehabilitation Center, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case

SIGNATURE OF PATIENT: _____ DATE: _____

MEDICARE

I certify that the information given by me in applying for payment is correct I authorize release of all my records on request. I request that payment of authorized benefits be made on my behalf

A photocopy of these assignments shall be valid as the original.

SIGNATURE OF PATIENT: _____ DATE: _____

COMPREHENSIVE PAIN AND REGENERATIVE CENTER P.A.**Dorota M. Gribbin, M.D., F.A.A.P.M.R.**

Assistant Clinical Professor Columbia University College of Physicians and Surgeons
Department of Rehabilitation and Regenerative Medicine

ASSIGNMENT OF BENEFITS

Patients Name: _____

Accident Date: _____

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payment go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your action on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Dated:

Patients Signature

PATIENT RESPONSIBILITIES

- Provide accurate information on documents and a copy of your health insurance card, if you have one, as well as a photo ID.
- Report unexpected changes.
- Report whether you clearly understand your plan of care and what is expected of that plan.
- Be responsible for your actions. If you choose to refuse treatment or if you choose not to follow the medical provider's instructions, that is your option.
- Follow procedural rules and regulations.
- Be respectful of others' property.
- Fulfil all financial obligations such as copays, deductibles, and coinsurance as required by law. Copayment is expected at the time of the office visit and if it is not collected, it will be billed. Please note that we are in network with Medicare, Blue Cross Blue Shield, and Cigna. All other insurances we accept out of network.
- Keep all appointments. \$75 no-show fee will be applied if an appointment is canceled within less than 48 business hours.

Print name: _____

Signature: _____ Date: _____

Preferred MRI/ X-Ray Imaging Name: _____

Preferred MRI/ X-Ray Imaging Location: _____

Comprehensive Pain and Regenerative Center



2333 Whitehorse-Mercerville Rd., Suite #8, Mercerville, N.J. 08619

60 Mt. Lucas Rd., Suite #600, Princeton, N.J. 08540

369 Applegarth Rd., Suite #4, Monroe, N.J. 08831

Ph: (609)588-0540 Fax: (609)588-0197

Policy of Cancellation , Rescheduling and not keeping Appointments

Our practice requires twenty-four hours business day notice for appointments that must be cancelled or rescheduled. Cancellation of a Monday appointment must be done on the Friday before (not Saturday or Sunday). This gives the office the opportunity to schedule another patient who may be waiting for an appointment.

Please call to schedule your next appointment, making certain that the appointment accommodates your personal and business schedules. It is the policy of this office to charge \$100.00 for a no show appointment and \$75.00 for an appointment cancelled on shorter notice than 24 hours.

If your appointment is not kept without proper notification we reserve the right to charge you for that missed appointment.

If you fail to keep 3 appointments without prior notice, Dr. Gribbin will provide your care for 30 days to allow you to find another physician. After that time we will transfer your medical records to the Psychiatrist of your choice.

Please call the office and speak to me directly with any questions or concerns.

Date: _____

Patient: _____

Please print your name

Patient: _____

Please sign in agreement

PATIENT CONSENT FORM

I understand that, under the health insurance Portability & Accountability Act of 1966(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment form from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you or fo your *Notice Of Privacy Practices* containing a more complete description of the use and disclosures of my health information. I have been given the right to review such *Notice Of Privacy Practices* prior to signing this consent. I understand this organization has the right to change its *Notice Of Privacy Practices* from time to time and that I may contact this organization at any time to the address below to obtain a current copy of the *Notice Of Privacy Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action replying on this consent

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____