PATIENT REGISTRATION DATE_____

NAME:_____MARITAL STATUS____DATE OF BIRTH_____AGE___

EMAIL ADDRESS_____

STREET ADDRESS_____

CITY, STATE, ZIP_____

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

PHYSICAN_____PHONE#_____

PHARMACY_____PHONE#_____

EMPLOYER_____SPOUSE'S EMPLOYER_____

SPOUSE NAME_____IF UNDER 18 PARENT NAME_____

EMERGENCY CONTACT (OTHER THAN SPOUSE)_____ADDRESS/ PHONE_____

SOCIAL SECURITY#_____REFERRED BY_____

_CHECK _CASH _CREDIT CARD _INSURANCE _WORKMAN'S COM. _MVA/PIP

BILLING NAME (IF OTHER THAN PATIENT)_____RELATIONSHIP_____

BILLING ADDRESS_____

1) INSURANCE COMPANY_____ADDRESS_____EFFECTIVE DATE_____

SUBSCRIBER'S NAME_____I.D. #_____GROUP#_____

2) INSURANCE COMPANY_____ADDRESS_____EFECTIVE DATE_____

SUBSCRIBER'S NAME_____I.D. #_____GROUP#_____

CLAIM #_____ DATE OF ACCIDENT_____

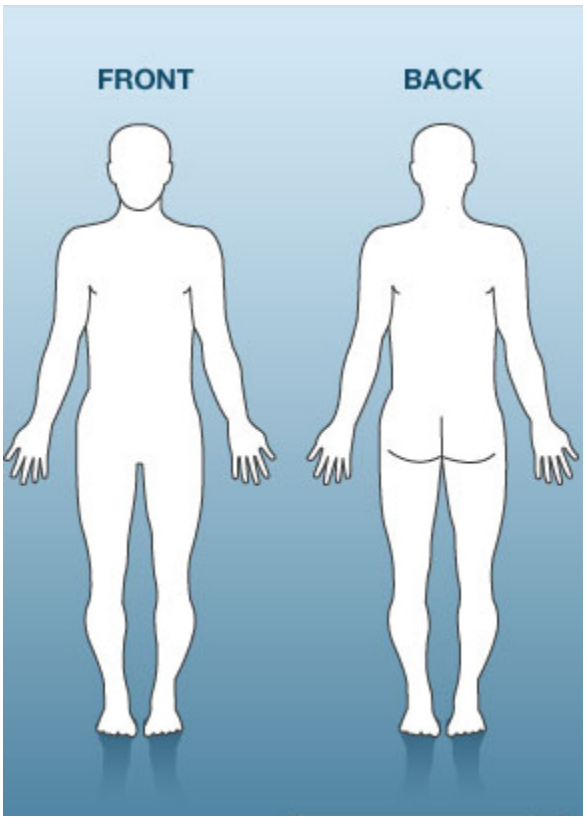
ADJUSTER NAME & PHONE N0._____

Patient Name:_____

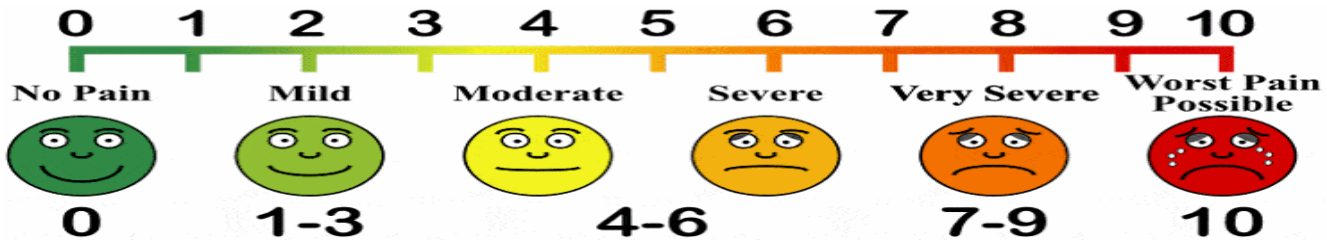
Date:_____

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

CIRCLE ALL OF THE AREAS WHERE YOU FEEL PAIN



USE SCALE TO RATE THE AVERAGE SEVERITY OF PAIN YOU FEEL



1. How long have you been experiencing chronic widespread pain?_____
2. How would you describe the type of pain you feel?_____
3. Is your daily functioning impacted?
   a. Very much b. Somewhat c. A little d. Not at all
4. What other symptoms do you frequently experience?_____

PATIENT MEDICATION LIST

PLEASE PRINT

_____ _____

Patient Name /Date **Pharmacy Name/Phone Number**

Please complete the following, and bring with you to your next appointment

Medication	Dosage	Prescribing Physician	Medical Reason for Medication

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 pain ……..No 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 relase 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 Physiatrist 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:_____

COMPREHENSIVE PAIN AND REGENERATIVE CENTER

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- We will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered after your visit. We are OON with all payers except Medicare, Horizon BCBS, and Cigna
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient