



PRIMARY PAIN
— CONSULTANTS —

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www.primarypain.com

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Phone: (908) 864-7725 Fax: (888) 874-5226

Today's Date: _____

Name: _____ Date of Birth: _____
Address: _____ Male ☐ Female ☐
City: _____ State _____ Zip Code _____ Social Security # _____-____-____
Home Phone: _____ Cell Phone: _____
Email: _____
Who is your primary care doctor? _____ Primary doctor phone: _____

How were you referred to our practice? _____

Employment Information: Full-time ☐ Part-time ☐ N/A ☐ Employer Name: _____

Race: ☐ Native American ☐ Asian ☐ Black ☐ White **Preferred Language:** ☐ English ☐ Spanish ☐ Other
☐ Refuse to Answer ☐ Other **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Answer

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Address (if different from above) _____
Phone Number: _____

HEALTH INSURANCE INFORMATION

PRIMARY Insurance Company Name: _____
Name of Insured: _____ DOB of Insured: _____
Member ID #: _____ Group #: _____
Relationship to insured: Self ____ Spouse ____ Child ____ Other ____

SECONDARY Insurance Company Name: _____
Name of Insured: _____ DOB of Insured: _____
Member ID #: _____ Group #: _____
Relationship to insured: Self ____ Spouse ____ Child ____ Other ____

FOR AUTO ACCIDENT RELATED INJURY

Auto Insurance Company Name: _____
Claim #: _____ Date of Accident: _____
Policy #: _____
Adjusters Name: _____ Phone Number: _____

FOR WORKER'S COMP:

Employer Name: _____ Date of Injury: _____

PLEASE FILL OUT IF APPLICABLE:

Attorney Name: _____ Attorney Phone Number: _____

CURRENT HISTORY:

1. What is the main reason for your visit today? (Check all that apply)

☐ Back Pain ☐ Neck Pain ☐ Leg Pain ☐ Arm Pain ☐ Other: _____

2. How did your pain begin?

☐ On the job ☐ After a fall ☐ I don't know when it began ☐ After a certain activity _____
☐ Motor Vehicle Accident (Date of Accident: _____)

3. How long has this been a problem?

☐ Less than 2 months ☐ 2-6 months ☐ 6-12 months ☐ greater than 1 year
☐ I've had it a long time (about ____ years)

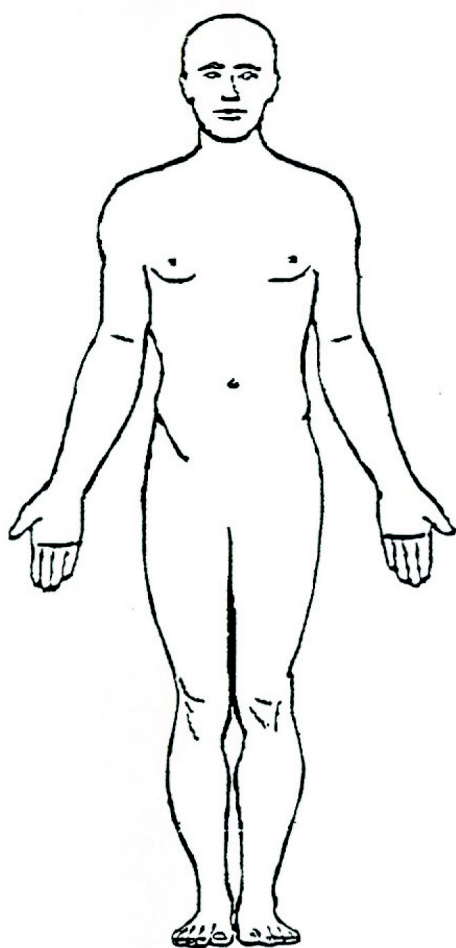
Please briefly describe the circumstances around your injury or onset of problem:

How does each of the following affect your pain? Please check.

Sitting	☐ Better	☐ Worse	☐ No Change
Standing	☐ Better	☐ Worse	☐ No Change
Walking	☐ Better	☐ Worse	☐ No Change
Lying Down	☐ Better	☐ Worse	☐ No Change
Rising from Chair	☐ Better	☐ Worse	☐ No Change
Heat	☐ Better	☐ Worse	☐ No Change
Cold/Ice	☐ Better	☐ Worse	☐ No Change
Massage	☐ Better	☐ Worse	☐ No Change
Physical Activity	☐ Better	☐ Worse	☐ No Change

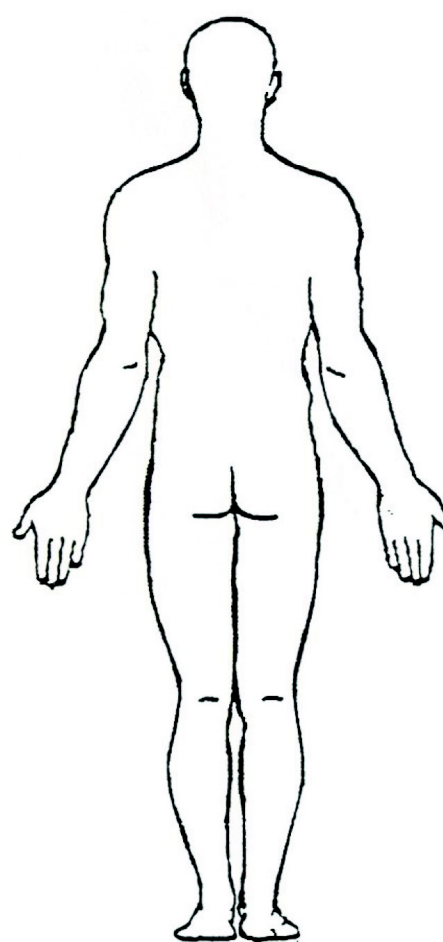
Please mark these drawings according to where you are hurt or feel pain.
For example, if the right side of your neck hurts, mark the drawing on the right side of the neck.
Please indicate which sensations you feel by referring to the symbols below.

////STABBING ◆XXXX BURNING ◆++++ PINS & NEEDLES ◆OOOO NUMBNESS ◆^^^^ ACHING



Right

Left



Left

Right

Do your affected areas have weakness?

☐ Yes

☐ No

If yes, where?

Arm ☐ Right ☐ Left

Hand ☐ Right ☐ Left

Leg ☐ Right ☐ Left

Foot ☐ Right ☐ Left

Other: _____



Patient Name: _____

On a scale of 0-10 (10 being the worst) what is your AVERAGE pain level?:

Low Back Pain: _____

Right Leg Pain: _____

Left Leg Pain: _____

Right Buttock Pain: _____

Left Buttock Pain: _____

Middle Back Pain: _____

Neck Pain: _____

Right Arm Pain: _____

Left Arm Pain: _____

PAIN LEVEL	No Pain	0
	Mild	1-3
	Moderate	4-6
	Severe	7-9
	Excruciating	10

Please circle your overall pain level TODAY from 0-10:

0 1 2 3 4 5 6 7 8 9 10

Please circle your LOWEST pain level in the past week from 0-10:

0 1 2 3 4 5 6 7 8 9 10

Please circle your HIGHEST pain level in the past week from 0-10:

0 1 2 3 4 5 6 7 8 9 10

Please circle how much your pain interfered with your activities this week from 0-10:

0 1 2 3 4 5 6 7 8 9 10

Is your pain worse at night? ☐ Yes ☐ No

Does your pain wake you up at from sleep? ☐ Yes ☐ No

Does coughing affect your pain? ☐ Yes ☐ No

Do your legs tire/hurt if you walk too far? ☐ Yes ☐ No

How far can you walk before symptoms begin? ☐ Less than 1 block ☐ 1-3 blocks ☐ more than 3 blocks

Bladder control: ☐ No problem ☐ Can't empty bladder ☐ Loss of urine (accidents)

Bowel control: ☐ No problem ☐ Constipation ☐ Loss of control (accidents)



Patient Name: _____

Please list the physicians you have treated with and when:

Primary care:	_____	Phone:_____	Date:_____
Chiropractor:	_____	Phone:_____	Date:_____
Pain Management:	_____	Phone:_____	Date:_____
Spine Surgeon:	_____	Phone:_____	Date:_____
Orthopedic:	_____	Phone:_____	Date:_____
Physical Therapy:	_____	Phone:_____	Date:_____
Acupuncture:	_____	Phone:_____	Date:_____

Previous tests (check all that apply):

- ☐X-Ray ☐Discography ☐CAT Scan ☐CT/Myelogram ☐Bone Scan
☐MRI ☐Nerve Test (EMG/NCV) ☐Other_____

Please list all current medications: (Include over-the-counter and supplements)

Medication	Reason Taken	Dosage	Prescribing Doctor

Are you allergic to:

Medications: ☐Yes ☐No Latex: ☐Yes ☐No Contrast Dye: ☐Yes ☐No

If yes, please list allergies:



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Patient's Name: _____

PAST MEDICAL HISTORY

Conditions you have had in the past (check all that apply):

☐ NONE

CARDIAC

- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Heart Valve Disorder
- ☐ Arrhythmia
- ☐ High Blood Pressure
- ☐ Other _____

NEUROLOGICAL

- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Headaches
- ☐ Migraines
- ☐ Other _____

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ Other _____

VASCULAR

- ☐ Stroke/ TIA
- ☐ Peripheral Vascular Disease
- ☐ Migraines
- ☐ Mitral Valve Prolapse
- ☐ Other _____

RENAL

- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis
- ☐ Other _____

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Other _____

GASTROINTESTINAL

- ☐ GI Bleeding
- ☐ Gastric Ulcer
- ☐ Acid Reflux
- ☐ Other _____

ENDOCRINE

- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Diabetes
- ☐ Other _____

CANCER (type)

PAST SURGICAL HISTORY

Have you ever had a reaction to anesthesia? _____

Type of Surgery	Surgery Date

FAMILY HISTORY

Please list any significant family health history. (Heart attack, Lung Disease, Genetic Disease)



Patient's Name: _____

SOCIAL HISTORY

Alcohol	Do you drink alcohol? _____	☐ Yes	☐ No
	If yes, what kind? _____		
	How many drinks per week? _____		
Tobacco	Do you use tobacco? _____	☐ Yes	☐ No
	☐ Cigarettes – packs/day ____	☐ Chew - #/day ____	☐ Pipe - #/day ____ ☐ Cigars - #/day ____
	☐ # of years _____	☐ Or year quit _____	
Drugs	Do you currently use recreational or street drugs? _____	☐ Yes	☐ No If so, what drug? _____
	Have you ever used recreational or street drugs? _____	☐ Yes	☐ No
Do you have any pending litigation? ☐ Lawsuit ☐ Worker's Comp ☐ Disability Claim ☐ S.S. Claim			

REVIEW OF SYSTEMS

CONSTITUTIONAL ☐ Weight loss or gain ☐ Fever ☐ Fatigue ☐ Chills ☐ Night sweats EYES ☐ Double vision ☐ Vision changes ☐ Cataracts ☐ Glaucoma ENT/MOUTH ☐ Tooth pain ☐ Hearing loss ☐ Ringing ears ☐ Swallowing difficulties	NEURO ☐ Dizziness ☐ Lightheadedness ☐ Headache ☐ Balance problems PSYCH ☐ Depression ☐ Mood swings ☐ Memory problems ☐ Anxiety ENDO ☐ Excessive thirst ☐ Heat intolerance ☐ Cold intolerance ☐ Hot flashes HEM/LYMPH ☐ Bruising ☐ Nosebleeds ☐ Lack of energy	GENITOURINARY ☐ Excessive urination ☐ Incontinence of urine ☐ Blood in urine ☐ Frequent bladder/kidney infections MUSC/SKELETAL ☐ Difficulty walking ☐ Joint stiffness ☐ Muscle pains ☐ Pain during walking GASTROINTESTINAL ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Acid reflux ☐ Incontinence of bowels ☐ Blood in stools	RESPIRATORY ☐ Shortness of breath ☐ Wheezing ☐ Persistent cough ☐ Asthma CARDIOVASCULAR ☐ Palpitations ☐ Chest pain ☐ Swelling hands/ feet ☐ Irregular heart beat SKIN ☐ Skin rashes ☐ Bruising ☐ Changes in skin lesions ☐ Wounds ☐ Ulcers
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Patient's Name: _____

Agreement and Assignment of Benefits

I have read and understand the financial policy of **Primary Pain Consultants**, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment to Primary Pain Consultants. I understand that I am financially responsible for all services I receive from Primary Pain Consultants. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Patient/Parent/Guardian or Legal Representative Signature

Date

Patient/Parent/Guardian or Legal Representative (printed name)

Notice of Privacy Practices

I acknowledge that I have read and understand **Primary Pain Consultants'** Notice of Privacy Practices, which is available for public inspection at our facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

Patient/Parent/Guardian or Legal Representative Signature

Date

Patient/Parent/Guardian or Legal Representative (printed name)

Primary Pain Consultants Assignment of Benefits Form

I, _____ (Print Name) hereby authorize benefits to be assigned to **Primary Pain Consultants ("Provider")** for healthcare services provided to me by Provider. I hereby certify that the insurance information that I have provided Provider is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that all fees and services are due and payable on the date services are rendered and agree to pay all such charges incurred I full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

I hereby authorize Provider to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided Provider. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by Provider, including exclusive and irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize Provider to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by Provider.

I hereby irrevocably designate, authorize and appoint Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by Provider. This power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby instruct and direct my insurance company to pay Provider directly for medical services and care provided by Provider, and to provide to Provider any and all relevant information and documentation in connection with such payments and claims for payment. I understand that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I instruct that the insurer make out the check to me and mail payment directly to Provider at **350 Grove Street, Bridgewater, NJ, 08807** for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Provider to be my personal representative, which allows Provider to: (1) submit any and all appeals if and when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of Provider's billed charges within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, I agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Provider for acting as my personal representative.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient/Guarantor

Date

Signature of Policy Holder

Date

Signature of Witness

Date



CONTROLLED SUBSTANCE AGREEMENT

This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to the facility and the words "I", "you", and "me", or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or, the covering physician, all drugs that I am taking, have purchased, or have obtained over the counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physicians, healthcare provider or dentist.
2. Medication use must be specifically followed according to the doctor's recommendation and Controlled Substance Agreement. **NO REFILLS** will be given before proper expiration date and will only be given according to our guidelines. Our guidelines are as followed:
 - ALL controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies; our office must be informed.
 - Patients must provide 3 business days for the office to refill prescriptions.
 - Prescriptions cannot be mailed.
 - The Pharmacy you have selected is _____ Phone: _____
3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility,
4. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase or otherwise obtain illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination substances (e.g. alcohol and prescription drugs), which impairs my driving ability, may result in DUI charges.
5. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. IF your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough. Early refills will not be given. Renewals are based upon keeping scheduled appointments.
6. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
7. I UNDERSTAND that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility, and that law enforcement officials maybe be contacted. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

Patient's Name: _____

Date: _____

Patient's Signature: _____

Witness Signature: _____