CONFIDENTIAL NEW PATIENT QUESTIONNAIRE DATE:

Referred By: _____ **Email Address**: _____

Last Name: _____**First Name**: _____ **MI** _____

Address: _____ **City**: _____ **State**: _____**Zip**:_____

Home #: ( ) - **Cell#:** ( ) - **Work#:** ( ) -

Date of Birth: ____ /____ /_____ **Age**: _____ **Sex**: **M** **F** **Soc.Sec. #**:_____

Marital Status: S M D W **Spouse's Name**: _____

Type of Insurance: Auto Worker's Comp Personal Injury Private Health Medicare None

NAME OF PRIMARY CARE PHYSICIAN: _____

EMPLOYER INFORMATION

Occupation: _____

Employer: _____

Address: _____ **City**: _____**State**:_____**Zip**:_____

AUTO INJURY/WORK INJURY/PERSONAL INJURY DATA

Insurance Type: Auto Work Injury Private Lien **Did you report the injury?** YES NO

Patient's Relationship to Insured: Self Spouse Child **To Whom**? _____

Date of Injury: _____ **Insurance Company**: _____

How did the accident happen? _____

_____

Claim Number: _____ **Policy Number**: _____**WC#:**_____

Hospitalized? YES NO **Where**? _____ **X-Rays Taken**? YES NO

Where you working at time of injury? YES NO **Dates Lost from Work**: _____

What were you? DRIVER PASSENGER PEDESTRIAN **Wore Seatbelt?** YES NO **Airbag Inflate?** YES NO

Name of Attorney: _____**Attny's Phone#**:_____

PRIVATE HEALTH/ MEDICARE INSURANCE

Insured's Name: _____ **Insured's Date of Birth:** _____

Patient's Relationship to Insured: SELF SPOUSE CHILD **OTHER:** _____

Name of Insurance Company: _____ **Policy#:** _____

Insurance Phone: _____ **Insurance Address:** _____

SECONDARY INSURANCE **Name of Insured:** _____ **DOB:** _____

Name of Insurance Company: _____ **Policy#**:_____

PATIENT HEALTH INFORMATION

1. **Major Health Complaint(s)**_____

_____

2. Check Your Present and Past Symptoms

- ☐ Neck Pain
- ☐ Middle Back Pain
- ☐ Low Back Pain
- ☐ Headache
- ☐ Dizziness
- ☐ Convulsions
- ☐ Fainting, Visual Disturbances, Nausea
- ☐ Shoulder Pain
- ☐ Pain in Upper Arms or Elbows
- ☐ Hand Pain
- ☐ Pain in Upper Leg/ Hip
- ☐ Pain in Lower Leg/ Knee
- ☐ Pain in Ankle/Foot
- ☐ Swelling/ Stiffness of Joints
- ☐ Jaw Pain
- ☐ Tinnitus
- ☐ Rapid Heartbeat
- ☐ Chest Pain
- ☐ Loss of Appetite
- ☐ Blood Disorder

- ☐ Excessive Thirst
- ☐ Chronic Cough
- ☐ Chronic Sinusitis
- ☐ General Fatigue
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Angina
- ☐ Heart Attack
- ☐ Stroke
- ☐ Asthma
- ☐ Cancer
- ☐ Emphysema
- ☐ Arthritis
- ☐ Diabetes
- ☐ Ulcer
- ☐ Bladder Infection
- ☐ Colitis

3. Describe your current pain: ☐ Sharp/ Shooting ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Soreness ☐ Weakness

☐ Throbbing/ Gnawing ☐ Numbness ☐ Shooting ☐ Gripping/ Constricting ☐ Burning ☐ Tingling

4. Did your problem begin: ☐ Due to an accident ☐ Multiple Incidents ☐ Gradually ☐ No specific reason

☐ Other: _____

6. What treatment have you received for this present condition? ☐ Surgery ☐ Spinal Injections ☐ Physical Therapy

☐ Chiropractic ☐ Medicine ☐ X-Ray ☐ Acupuncture ☐ Occupational Therapy ☐ Other: _____

7. Have you been treated previously for the same condition? ☐ YES ☐ NO **If yes, by**: ☐ MD ☐ Chiropractor

☐ Physical Therapist ☐ Occupational Therapist ☐ Other:_____

8. What makes your problem better? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Moving/ Exercise

☐ Inactivity/ Not Moving ☐ Other:_____

9. What makes your problem worse? ☐ Nothing ☐ Lying Down ☐ Walking ☐ Standing ☐ Sitting ☐ Moving/ Exercise

☐ In activity/ Not Moving ☐ Other: _____ **10. Do you work?** ☐ YES ☐ NO

10. If Yes: ☐ Sitting more than 50% ☐ Light Manual Labor ☐ Manual Labor ☐ Heavy Manual Labor

CONTINUED

11. Are your complaints affecting your ability to work or otherwise be active?

□ No effect □ Some physical restrictions (able to perform light duty housework and household tasks) □ Need limited assistance with everyday tasks □ Need assistance often □ Have a significant inability to function without assistance □ Cannot care for self

12. Are you currently taking medication? □ YES □ NO If yes: _____

_____

13. Are you allergic to any drugs or medications? □ YES □ NO **If yes:** _____

_____

14. Do you smoke? □ YES □ NO **15. How many packs a day?** _____

16. Do you have allergies? □ YES □ NO **If yes:** _____

17. Have you had any surgery? □ YES □ NO **If yes**: _____

18. Women: Are you pregnant? □ YES □ NO □ NOT SURE **Patient Initials**: _____

FAMILY HISTORY

DIABETES: □ Mother □ Father □ Brother(s) □ Sister(s)

HEART: □ Mother □ Father □ Brother(s) □ Sister(s)

KIDNEY: □ Mother □ Father □ Brother(s) □ Sister(s)

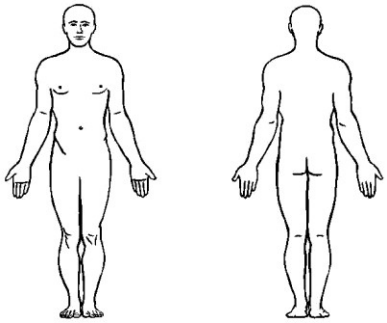
CANCER: □ Mother □ Father □ Brother(s) □ Sister(s)

BACK: □ Mother □ Father □ Brother(s) □ Sister(s)

OTHER: _____

PAIN/ SYMPTOMS PICTURE

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN/ SYMPTOMS, INCLUDE SYMPTOMS OF PAIN, NUMBNESS/ TINGLING.



I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNARIE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT/ LEGAL GUARDIAN SIGNATURE DATE

ASSIGNMENT OF BENEFITS/ RIGHTS FOR DIRECET PAYMENT TO DOCTOR

PRIVATE & GROUP ACCIDENT & HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Bergen Medical Sports & Spine, PC

405 Northfield Ave, Suite 102

West Orange, NJ 07052

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment, expect in instances where No-Fault or Worker's Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

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

_____ _____

Name of Patient (Please PRINT) Date

_____ _____

Signature of Patient Signature of Guardian (if minor)

MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of Medicare benefits be made to Bergen Medical Sports and Spine, PC for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____ _____

Patient Signature Date