

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

I 1. 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

I 2. Are you currently taking medication? YES NO If yes: _____

I 3. Are you allergic to any drugs or medications? YES NO If yes: _____

I 4. Do you smoke? YES NO **I 5. How many packs a day?** _____

I 6. Do you have allergies? YES NO If yes: _____

I 7. Have you had any surgery? YES NO If yes: _____

I 8. 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)

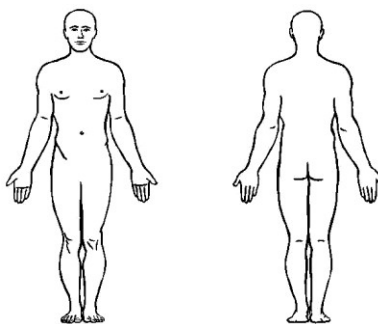
CANCER: Mother Father Brother(s) Sister(s)

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 QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.

PATIENT/ LEGAL GUARDIAN SIGNATURE

DATE

ASSIGNMENT OF BENEFITS/ RIGHTS FOR DIRECT 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

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, except 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