Garden State Pain Control Center

Interventional Pain Medicine – Orthopaedic Surgery – Sports Medicine
Regenerative Medicine - Vein Therapy - Electrodiagnostic Testing

Phone: 973-777-5444 Fax: 973-777-0304

Pain Medicine

Neil Sinha, MD

Dev Sinha, MD

Saurabh K. Dang, MD

Dipan G. Patel, MD

Jahnna H. Levy, DO

Andrew So, MD

Tyler Duggan, PA-C

Orthopaedic Surgery

Deepan N. Patel, MD

Jake Pawela, PA-C

Locations

1117 Route 46 East
Suite 301
Clifton, NJ 07013

25 S. Main St
Suite 12
Edison, NJ 08837

631 Grand St
Suite 2-100
Jersey City, NJ 07304

226 Middle Rd
Suite #4
Hazlet, NJ 07730

DEMOGRAPHICS

Name (first, m, last):_____DOB: ____/ __ / _____
Address : _____
SSN: _____- _____ - _____

Gender: (please circle) Male Female Marital Status: (please circle) S M D W
Ethnicity:(please circle) Latino /Not Latino / Declined
Race:(please circle) White /African American /Asian /Indian /Other /Declined
Primary Language:(please circle) English/ Spanish/ Indian /Russian /Other /Declined

Home #: _____Cell #:_____Work #: _____
Email: _____
Occupation: _____Employer: _____
Employer Address: _____
Referring MD: _____Primary MD: _____
Emergency Contact: _____Phone #: _____ Relationship: _____
Pharmacy Name: _____Pharmacy Address: _____
Pharmacy Phone: _____Pharmacy Fax: _____
How did you hear about our office? _____

INSURANCE INFORMATION

Is your visit related to: 1) Worker's Comp? 2) Motor Vehicle Accident? (If yes, circle one)

Primary Health Insurance: _____
Health Ins. Address: _____
Member ID#_____ Group #: _____
Policyholder's Name: _____Referral required: Y N
Policyholder's DOB: _____ / _____/ _____ SSN# _____- _____ - _____
Deductible $ _____Co-Pay $ _____ Relation to Insured: _____
Policyholder's Employer: _____

Secondary Health Insurance:_____
Health Ins. Address: _____
Member ID#_____Group #: _____
Policyholder's Name: _____Referral required: Y N
Policyholder's DOB: _____ / _____/ _____ SSN# _____- _____ - _____
Deductible $ _____Co-Pay $ _____ Relation to Insured:_____
Policyholder's Employer: _____

Prescription Plan:_____ID#:_____Group#:_____
Primary Policy Holder's Name:_____Phone#:_____

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This notice describes how your health information may be used, disclosed and how you can get access to this information. **PLEASE REVIEW IT CAREFULLY**.

PRIVACY PROMISE
We understand that your medical and health information is personal and that protecting this information is important to you. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

UNDERSTANDING YOUR HEALTH RECORD INFORMATION
Each time you visit our practice, we make a record of your visit. Typically this record contains your health history, current symptoms, diagnosis, examinations, test results and treatments. We may use your health information to operate and evaluate the quality of your care, conduct cost management and/or planning activities. It may also contain plans for future care and treatments such as:

• Means of communication among health care professionals who contribute to your care, such as a prescription to order lab tests
and/or to another health care provider.
• Legal document describing the care that you received.
• Mean by which you or a third party payer can verify that the services billed were actually provided.
• We may use your information to obtain payment from an insurance company, you or third party payer.
• We may share your information with other providers/entities to assist in their billing and collection efforts.
• Tool in educating health professionals.
• Source of information for public health officials charged with improving the health of the nation.
• Tool with which we can access and continually work to improve the care we render and the outcomes we achieve.

YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARD
Although your health records are physical property of Garden State Pain Control or the facility that compiled it, the information belongs to you. You have the right to:

• Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully, but
we are not required to agree to any restriction.
• Request that we use a specific telephone number or address to communicate with you.
• Inspect and obtain a copy of your health record upon written request. Fees may apply. We may deny you access to a portion of
your health information, and you may request a review of the denial.
• Request corrections or additions to your health information.
• Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures
made for treatment, payment, health care operations and some disclosures required by law. Your request must state the period of
time desired for the accounting, which must be within the six years prior to your request and excludes dates prior to April 14, 2003.

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The first accounting is free, but a fee will apply if more than one request is made in a 12 month period of time.
• Request a paper copy of this notice of privacy practices.
• Revoke your authorizations to use or disclose health information, except to the extent that action has been taken.

OUR RESPONSIBILITIES UNDER THE FEDERAL PRIVACY STANDARD
My practice is required by law to:
• Maintain the privacy of your health information.
• Maintain the privacy of your health information.
• Provide this notice that describes the ways we may use and share your health information.
• Follow the terms of the notice currently in effect.
We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. You may request a copy of the changes from our office.

WE MAY USE YOUR HEALTH INFORMATION TO:
• Recommend treatment alternatives.
• Tell you about health services and products that may benefit you.
• Share information with your family or friends involved in your care or payment of your care when appropriate.
• Remind you of appointments.
• Share information with third parties who assist us with treatment, payment, and health care operations. Our business associates must follow the privacy practices.
• Disclose your health information as required by federal, state and local law.

SHARING YOUR HEALTH INFORMATION
In some limited situations, we are permitted or required to disclose health information without your signed authorization. These situations are:

• For public health purposes such as reporting communicable diseases, work related illnesses or other disease and injuries permitted by law.
• Reporting births, deaths, reactions to drugs and problems with medical devices.
• To protect victims of abuse, neglect or domestic violence.
• For health oversight activities such as Investigations, Audits and Inspections.
• For lawsuits and similar proceedings.
• When requested by law or court order.
• For workers compensations or similar programs if you are injured at work.
• For coroners, medical examiners and funeral directors.
• For organ and tissue donation.
• For research under strict federal guidelines.
• To reduce or prevent serious threat to public health and safety.
• For government functions such as Intelligence and national security.

All other uses and disclosures not described in this notice require your signed authorization. We have provided a place to write those names. You may revoke your authorization at any time with a written statement.
If you feel your privacy rights have been violated, you can file a complaint with our office or with the Secretary of Health and Human Services. You will not be penalized for filing a complaint.

PATIENT SIGNATURE:_____**DATE**:_____

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NOTICE TO PATIENTS WITH OUT OF NETWORK BENEFITS

Please be advised that when using you out of network benefits, your insurance company may be mailing payments for our services directly to you (the patient).

It is **THE PATIENT'S RESPONSIBILITY** to make sure our office receives those payments by promptly endorsing the back of the received check(s) and either mailing or hand delivering the endorsed check(s), along with the explanation of benefits (EOB) to Garden State Pain Control. For your protection, please make copies of all checks for your files before sending them to our office.

I understand that I am utilizing my **OUT OF NETWORK BENEFITS**. Failure to complete the above in a timely matter is considered non-compliant and no future appointments will be scheduled.

PATIENT'S INITIALS:_____

ASSIGNMENT OF MEDICAL BENEFITS
I authorize my insurance carrier to assign all surgical and/or medical benefits, if applicable, to Garden State Pain Control Center, PA. I also authorize the release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY
Co-payments are to be collected at the time services are received; we accept cash or money orders. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

Returned checks will be subject to $40 collection charge. Any unpaid balances over 90 days are subject to collections via small claims court, attorney, and/or collection agency with applicable collections fees. Collection fees are the
responsibility of the patient.

I HAVE READ, UNDERSTOOD AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION ANY PAYMENT POLICIES.

PATIENT SIGNATURE:_____**DATE:**_____

I,_____(PLEASE PRINT NAME) give permission to Garden State Pain Control Center, PA to take an identification photograph to be maintained in my medical records. I understand that this picture will be used in a confidential manner related only to my personal care I the above named office.

PATIENT SIGNATURE:_____**DATE:**_____

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OUT OF NETWORK DISCLOSURE FORM

Dear Patient,

On behalf of Garden State Pain Control Center (hereinafter" health service provider" or Garden State Pain Control"), kindly accept this disclosure in accordance with P.L.2018 c.32, ("Out-of network Consumer Protection, Transparency, Cost Containment and AccountabilityAct") as it applies to health care providers and physicians. Pursuant to this new legislation, notice if required to be provided by all health care providers, physicians and health centers, including Garden State Pain Control, as follows. Pursuant to the above captioned legislation, health care providers are required to inform patients whether or not they participate in certain health insurance plans. Please note, in accordance with this requirement, accept notice that Garden State Pain Control is considered an "in-network" provider with/for the following insurance companies/plans:

QUALCARE
HORIZON BLUE CROSS BLUE SHIELD
AMERIVANTAGE
AMERIGROUP
GHI

Garden State Pain Control has agreed to accept the rate of reimbursement for services performed at Garden State Pain Control Center as offered and reimbursed in accordance with these aforementioned plans, subject to copay, deductible, and/or co-insurance, as may be applicable. For all other plans/companies not listed above Garden State Pain Control is considered an "Out-of-Network" Provider. If you have any questions, or do not see your health insurance plan listed above, please contact a representative at Garden State Pain Control Center to assist you.

Garden State Pain Control is a Medicare participant; meaning Garden State Pain Control will accept the rates of reimbursement in accordance with Medicare coverage provided to its patient`s subject to all applicable co-pay, deductible and/or co-insurance. Pursuant to the above captioned legislation, please take notice that, upon request prior to the scheduling of nonemergency procedure(s), you may receive, in writing, the amount, or estimated amount that will be billed by Garden State Pain Control for medical treatment and/or health care service you receive from Garden State Pain Control. This disclosure will include the Current Procedural Terminology (CPT) Codes associated with the service or procedure.

Pursuant to the above captioned legislation, please take notice that you may be financially responsible for services provided that are deemed "out -of-network" by your health insurance carrier, including costs in excess of, but not limited to, co-pay, deductible, and/or coinsurance (if applicable). Garden State Pain Control reserves the right to seek additional reimbursement from you for procedures or services in excess of those benefits provided by your health insurance benefits plan and/ or rates of reimbursement allowed by your health benefits plan for "out-of-network" providers, in excess of, and in addition to, co-pay, deductible, or co-insurance (if applicable). Please take notice that it is advised that you contact your health benefits plan with any questions and for further consultation on costs.

UNDERSTOOD AND AGREED:

_____ _____
PRINT NAME **DATE**

_____
PATIENT SIGNATURE

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ASSIGNMENT OF BENEFITS

Garden State Pain Control Center
Garden State Anesthesia Associates, PA
Oradell Anesthesia Associates LLC

PATIENT NAME:_____
PATIENT ADDRESS:_____
INSURANCE CO.:_____
NAME OF POLICY HOLDER:_____DATE OF LOSS:_____
ID/CLAIM NUMBER:_____

I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interest to Garden State Pain Control Center, Garden State Anesthesia Associates and Oradell Anesthesia Associates hereafter referred to as "the medical provider" to pursue and obtain payment from the above named Insurance carrier. This assignment shall include but is limited to all rights available to me pursuant to the Personal Injury Protection Statues of the State of New Jersey and New York. I, assign to the medical provider, all my rights and benefits under the Insurance contract for payment for services rendered to me. However, upon consent of both parties, shall be revocable. I, the patient, do hereby understand and acknowledge that if I willingly refuse to comply with reasonable requests of the Insurance carrier, payment of my medical bills may be denied and will be held responsible for same. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account or have same deducted from any settlement made on my behalf.

I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other Insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) five days of the receipt of same. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills,unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier. To prevent the Insurance carrier and/or the vendor designed by the Insurance carrier from refusing to accept my Assignment or submitting challenge to my Assignment as being Invalid. I execute this Special Power of Attorney to appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name. I understand and acknowledge that the attorney chosen by the medical provider is to represent me individually on any claim for outstanding treatment with the medical provider in any appropriate forum.

This Assignment serves as a limited retained agreement between me and the chosen attorney by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. I have been advised that if any arbitration and/or lawsuit is filed in my name individually, failure to include an outstanding medical providers bills whom I have not executed an Assignment of Benefits with could make me liable for payment to the provider. In consideration, this medical provider has agreed to accept as payment in full the amount awarded and/or settled and will not seek additional payment from me. This does not preclude the medical provider from seeking additional payment from other Insurance carriers.

SIGNED:_____ PATIENT NAME: _____
DATE:_____WITNESS:_____

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Agreement on Controlled Substances Therapy for Chronic Pain Treatment

The purpose of this agreement is to create an understanding regarding controlled substances that may benefit your chronic pain symptoms. The goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications. Medications such as opioids, benzodiazepine tranquilizers, barbiturate sedatives, and muscle relaxants such, that may be useful in managing pain, can be problematic in several ways. These medications have "street value" and potential for abuse. Although these medications may be prescribed with the goal of improving your comfort and functionality, their medical use is also associated with the risk of serious adverse effects such as development of an addiction disorder or a relapse in a person with a prior addiction history. The goal is to have you take the lowest possible dose of medication that is reasonably effective in managing your pain and improving your function, and when possible, have it tapered and eventually discontinued. Because these medications have the potential for abuse or diversion, strict accountability is necessary for both medical safety and legal reasons. Therefore, the following policies are agreed to by you, the patient, to help me keep you safe and to provide you with good care.

1. You must get a prescription for all controlled substances from one physician. Multiple sources can lead to untoward medication interactions or poor coordination of treatment.

2. You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed.

3. You must inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.

4. You must give the prescribing physician permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability and coordinating your care.

5. You may not share, sell or otherwise permit others to have access to these medications. You must take all medications exactly as prescribed, unless you develop side effects. If you develop side effects, you must consult with your doctor or local emergency providers.

6. You must not stop these medications abruptly or without consulting the prescribing physician, as an abstinence/withdrawal syndrome may develop.

7. You must agree that your urine may be tested for controlled substances during your treatment. You must cooperate in such testing, and you must agree that the presence of unauthorized substances, illicit substances or absence of prescribed medications may prompt possible tapering and discontinuation of the controlled substances immediately or in the future.

8. You will not give your prescriptions to anyone else. These substances may be sought by other individuals with chemical dependency and should be closely safeguarded. You will take the highest degree of care with your medications and prescriptions. You will not leave them where others might have access to them.

9. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery. If you are the slightest bit impaired, you must refrain from these activities.

10. You must discuss the long-term use of controlled substances with your physician. Prolonged opioid use can be associated with serious health risks. You need to understand these risks.

11. You must agree that medications will not be replaced if they are lost, and that early refills will not be given, unless an exception is made by the provider.

12. You agree that failure to adhere to these policies may result in tapering and cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

Patient Signature:_____Date:_____

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FINANCIAL DISCLOSURE

On behalf of Garden State Pain Control kindly accept this disclosure in accordance with ("Out - of-network Consumer Protection, Transparency, Cost Containment and Accountability Act") as it applies to health care providers and physicians.

Saurabh Dang, M.D. is a paid consultant for:
- Medtronic
- Nuvectra
- St. Jude / Abbott
- Flowonix
- Boston Scientific
- Omnia Medical

Dipan Patel, M.D. is a paid consultant for:
- Relievant
- Nuvectra
- Boston Scientific
- St. Jude / Abbott

All Companies are medical device manufacturers of implantable devices. These devices are implanted for pain reduction by reducing or altering the pain signals as they travel to the brain.

The patient has the option of choosing any other manufacturer's devices if they wish so.

AFFLIATED PROVIDER STATEMENT

Please be advised that Garden State Pain Control makes no representations or assertions regarding whether these secondary health care providers accept certain health insurances. You may be responsible for costs associated with treatment or services rendered by these providers in addition, and not limited to, all applicable co-pay, deductible, and co-insurance. If you have further questions regarding a health care provider listed below that may be involved with your care here at Garden State Pain Control, please contact the provider or your health insurance provider directly for more information.

Surtox Laboratory
Elmwood Park, Ph: 201-791-7293
www.suretoxlab.com

Spectrum Diagnostics
NJ Old Bridge, NJ
Ph: 732-792-3609
www.spectrumdiagnostics.com

Please note by signing this document, you acknowledge that you have reviewed this document and have received all of the required disclosures listed above and that you hereby waive any challenge to the notice requirements contained within the "Out of network Consumer Protection, Transparency, Cost Containment and Accountability Act" and wish to proceed with your treatment/ health services / health care at Garden State Pain.

UNDERSTOOD AND AGREED:
Patient Signature:_____
Printed Name:_____Date:_____

RESET

Horizon Blue Cross Blue Shield of New Jersey

Consent for Referral to a Nonparticipating Provider

This form is used when a participating doctor or other participating health care professional refers a member (enrolled in a Horizon BCBSNJ plan that includes out-of-network benefits) to a non-participating doctor, facility or other health care provider. By signing this form you attest that you have had a discussion with your doctor/other health care professional, that you agree to receive services from the non-participating provider noted below.

This form is NOT for the use of members enrolled in Horizon BCBSNJ plans that have no out-of-network benefits (e.g., Horizon HMO, Horizon EPO, OMNIA Health Plans, Medicare Advantage HMO, etc.).

This section to be completed by the referring doctor/other health care professional:

This form must be completed and signed by the member **AT THE TIME A REFERRAL IS MADE** to an out-of-network doctor, facility or other health care professional. The signed original form must be retained in the patient's medical record. A copy of this signed form must be made available to the member upon request.

Member Name	
Member ID#	
Referring Doctor's Name / NPI	
Name of Non-Participating Provider	
Type of service to be rendered (e.g. Lab, Dialysis)	
Reason for involving a Non-Participating Provider	

I, the referring doctor/other health care professional:

☐ DO ☐ DO NOT have a financial interest in the referred-to nonparticipating provider (noted above).

☐ DO ☐ DO NOT receive compensation from the referred-to provider (noted above).

As an example, the table below compares the member liability for a claim for an Ambulatory Surgery Center (ASC) service processed at the in-network and out-of-network level of benefits. Claims for a nonparticipating facility are processed at the out-of-network benefit level, increasing out-of-pocket expenses. *This example is for illustrative purposes only. Your benefits may vary.*

ASC Example	Total Billed Charges	Horizon BCBSNJ Allowed Amount	Coinsurance/Copayment	Horizon BCBSNJ Payment	Member Liability
Out-of-network	$5,000.00	$1,500.00	$300.00 (assuming an 80% out-of-network benefit)	$1,200.00	$3,800.00
In-network	$5,000.00	$1,500.00	$35.00 copayment (no coinsurance in network)	$1,465.00	$35.00

I, the member (or the parent, guardian or designated personal representative of the member):

- Understand that the doctor, facility or other health care provider noted will be involved in my care and does not participate with my Horizon BCBSNJ health insurance plan. **I was offered, but declined, the opportunity to select a participating provider to render the health care services noted.**
- Understand that my out-of-network benefits will apply to services performed by this nonparticipating provider and that I will be responsible for all out-of-network cost-sharing amounts including applicable copayments, deductible and/or coinsurance liability, as well as the difference between Horizon BCBSNJ's allowed amount for the eligible services and the nonparticipating provider's total billed charges.
- If services were to be rendered by a participating provider that my in-network benefits would apply and that a participating provider may not bill any amounts in excess of Horizon BCBSNJ's allowed amount.

_____ _____

Signature of Member, Parent (if the member is under age 18) or Legal Guardian Date

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RELEASE OF INFORMATION

I,_____, authorize and release the disclosure of all my health information By: GARDEN STATE PAIN CONTROL

To: □Primary Care Physician □Attorney/Adjuster □Referring Doctor □Physical Therapist □Other:_____

For: □Continuing Care, □Personal, □Transfer of Care, □Disability Determination, □Legal, □Worker Comp, □Insurance, □Other:_____

List whom you would like to SHARE your MEDICAL HEALTH Information with:
NAME:_____
RELATIONSHIP TO PATIENT:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
PHONE NUMBER:_____

I hereby request a copy of the following patient's medical record:

FULL NAME OF PATIENT:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
PHONE NUMBER:_____DATE OF BIRTH_____
INFORMATION TO BE RELEASED:

This authorization includes release of information concerning treatment of psychiatric/ psychological conditions, drug and/or alcohol related conditions , and HIV or AIDS related conditions, X-Ray/ medical imaging reports, emergency department records, operative reports, history and physical, laboratory results, discharge summary and entire record to Garden State Pain Control Center.

I understand that I may revoke this authorization at any time except to the extent that information has already been released in response to this authorization.

I understand that I may revoke this authorization by making the request in writing and giving it to an office staff member.

I understand that information disclosed in response to this authorization may be disclosed by the recipient and therefore is no longer protected.

I understand that my treatment may not be conditioned on the signing of this authorization.

Please note that once the records leave the premises of Garden State Pain Control via mail or email GSP is no longer liable for the requested medical records

SIGNATURE:_____DATE:_____
RELATIONSHIP IF OTHER THAN PATIENT:_____
EXPIRATION DATE OR EVENT:_____

Garden State Pain Control Center

Interventional Pain Medicine – Orthopaedic Surgery – Sports Medicine
Regenerative Medicine - Vein Therapy - Electrodiagnostic Testing
Phone: 973-777-5444 Fax: 973-777-0304

Pain Medicine

Neil Sinha, MD

Dev Sinha, MD

Saurabh K. Dang, MD

Dipan G. Patel, MD

Jahnna H. Levy, DO

Andrew So, MD

Tyler Duggan, PA-C

Orthopaedic Surgery

Deepan N. Patel, MD

Jake Pawela, PA-C

Locations

1117 Route 46 East
Suite 301
Clifton, NJ 07013

25 S. Main St
Suite 12
Edison, NJ 08837

631 Grand St
Suite 2-100
Jersey City, NJ 07304

226 Middle Rd
Suite #4
Hazlet, NJ 07730

MVA/WC SUPPLEMENTAL

LAST NAME:_____FIRST NAME:_____
DATE OF BIRTH:_____SSN#:_____PHONE#:_____
DATE OF ACCIDENT/INCIDENT:_____ EMAIL:_____
ADDRESS:_____CITY:_____STATE:_____ ZIP CODE:_____
SEX:_____MARITAL STATUS:_____
INSURANCE:NAME:_____
POLICY#:_____ADDRESS:_____
CITY:_____STATE:_____ZIP CODE:_____
ADJUSTER NAME:_____PHONE#:_____
ATTORNEY NAME:_____PHONE#:_____
EMPLOYER NAME:_____PHONE#:_____
ADDRESS:_____ CITY:_____STATE:_____ZIP CODE:_____

ACCIDENT DETAILS:

Where did the accident occur?:_____
Were you in the (circle one): DRIVER / PASSENGER SEAT-FRONT / BACK
Were you wearing your seatbelt? YES / NO
Did the airbags deploy? YES / NO
Did you go to the hospital? YES / NO
Have you had any previous car accidents? YES / NO

What treatment have you had?:_____
CHIROPRACTIC THERAPY:_____
PHYSICAL THERAPY:_____
MEDICATION MANAGEMENT:_____
MRI's:_____

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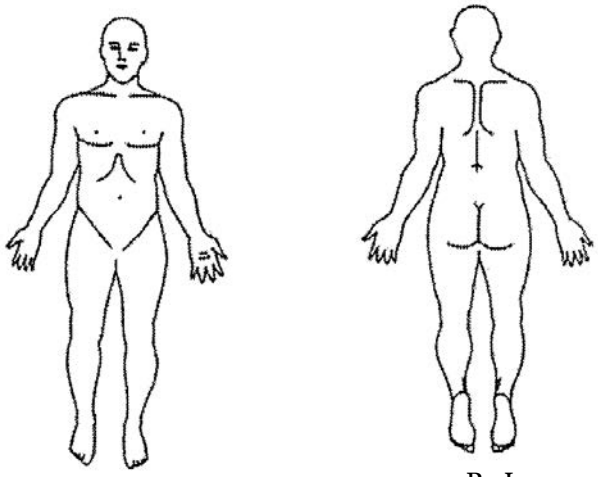
Office use only *
Provider_____
Time of Appt:_____
Vitals _____

Patient Name _____DOB _____ Date_____
Referring Physician _____Primary Care Physician _____
Chief Complaint (main problem seeking treatment) _____

On the Diagram, shade in or circle the area where you feel pain:



R L R L

Pain level today : (0 = no pain 10 = unbearable pain)
1 2 3 4 5 6 7 8 9 10

Preferred Pharmacy Name/Address:_____
Preferred Pharmacy Phone:_____

Are you pregnant or possibly pregnant?
Yes No N/A

Date of injury _____What injury occurred? _____

Motor vehicle accident YES / NO
Date of Accident _____Were you wearing a seatbelt: Yes / No
Position during the accident:_____
(Circle one) Driver / Passenger in front seat / Passenger in back seat

Your Pain Occurs: constant / intermittent /worse after activity /worse at the end of the day

Describe your pain: aching /burning /cramp-like /dull /in a glove distribution /in a stocking distribution /pins & needles /sharp/ shooting /stabbing

Your pain has been occurring for: _____ days /weeks /months/ years
What relives your pain:_____