INTERVENTIONAL
PAIN CONSULTANTS

Patient Demographic

Patient Name: _____
First Middle Last Suffix

Date of birth: _____/_____/_____ SSN:_____

Gender: _____ Marital Status:_____ Preferred Language if other than English: _____

Address: _____
Street City, State Zip Code

Home phone: _____ Cell Phone: _____

Email: _____ Emergency Contact: _____

Referral Source (please circle): Self / Physician / Insurance / Patient

If physician please provide their name: _____

Primary care physician name: _____

Office number: _____ Fax number: _____

Primary Insurance Information	**Secondary Insurance Information**
Type: Health Insurance ☐ Worker's Comp ☐ Auto/PIP Accident ☐ Self Pay ☐	Type: Health Insurance ☐ Worker's Comp ☐ Auto/PIP Accident ☐
Subscriber's Name: _____	Subscriber's Name: _____
DOB: _____	DOB: _____
Insurance Company: _____	Insurance Company: _____
Date of accident (if applicable): _____	Date of accident (if applicable): _____
Policy/ID #: _____	Policy/ID #: _____
Claim/Group #: _____	Claim/Group #: _____
Address: _____	Address: _____
Phone #: _____	Phone #: _____
Case Manager: _____	Case Manager: _____
Phone #: _____	Phone #: _____

My signature indicates that the information provided above is true to the best of my knowledge.

Patient Signature: _____ Date: _____

3799 Route 46, Suite 301 Parsippany, NJ 07054
973-335-1440 973-335-1448 Fax

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What is your height?_____ Weight?_____

Is there any possibility that you could be pregnant? ☐ Yes ☐ No

What is the reason for today's visit?_____
_____

When did it start?_____
_____

Please select the number that represents your pain today:

◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Review the words below that are commonly used to describe pain, and indicate the highest severity you have experienced in the past week.

	None	Mild	Moderate	Severe
Throbbing/Aching				
Shooting				
Stabbing/Sharp				
Cramping				
Hot/Burning				
Tender				
Tiring/Exhausting				

What makes the pain worse? ☐Sitting ☐Lying Down ☐Walking ☐Standing ☐Heat ☐Cold

What makes the pain better? ☐Sitting ☐Lying Down ☐Walking ☐Standing ☐Heat ☐Cold

What treatments have you had for this problem and when?

☐Physical Therapy _____ ☐Chiropractic Treatments _____ ☐Medications _____
☐Anti-Inflammatory _____ ☐Nerve Blocks/Injections _____ how many _____

Have you had any diagnostic imaging for this problem and when?

☐MRI_____ ☐CT Scan_____ ☐XRAYS _____ ☐EMG _____ ☐Ultrasound____

Does/Did anyone in your family have a history of chronic pain, disability or illness? If yes please explain.

_____

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Previous Hospitalizations/ Surgeries	Year

Please check off if any current problems in any of the following areas:

□ General Wellness □ Headaches □ Nausea □ Stomach/Digestion □ Lungs/Breathing
□ Ears, Nose, Throat□ Psychiatric □ Neurological □ Skin □ Stroke □ Blood/Lymph
□ Reproductive/Urinary □ Thyroid Endocrine □ Trouble Sleeping □ Memory □ Dizziness
□ Ringing in Ears □ Muscles/Joint/Bones □ Eyes □ Fatigue □ Chest Pain □ Heart Problems
□ Cancer □ Diabetes □ Blood Pressure □ Kidney Problems □ Convulsions □ Hypertension
□ Thyroid □ Asthma □ Liver Problems □ Stroke/ TIA

If any of above are checked, please explain: _____
_____

Use of alcohol: □ Never □ Daily □ Moderate □ Rarely
Use of tobacco: □ Never □ Daily ____ # of packs □ Previously but Quit
Use of drugs: □ Never Type/Frequency _____
Work/ School Status: □ Full Time □ Part Time □ Unemployed □Retired □ Workers Comp
Current Job:_____ Job Title: _____

Is your pain from a work related injury? □ Yes □ No **Returning to work?** □ Yes □ No

Job Requirements (check all that apply)

□ Work at a constant rate □ Work outdoors □ Indoors and Outdoors
□ Use hand tools □ Use of power tools □ Operate Computer
□ Climb stairs □ Climb ladder □ Bend □ Grasp □ Reach
□ Pull ___lbs □ Push ___ lbs □ Carry ___lbs □ Lift ___lbs
□ Stand □ Sit □ Walk

Are you receiving any of the following?

□ Workers Compensation □ No Fault Auto Wage Reimbursement □ Long Term Disability
□ Short Term Disability □ Social Security Disability □ Retired/Pension
□ Litigation □ Other

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Medication List

Please list all current prescription and non-prescription medications or supplements or check the following options.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)

☐ Not currently taking any medications

Medication Name	Dosage	# of times dosage taken per day

Preferred pharmacy: _____

Name City Phone number

Allergies

Please list all known allergies or check the following options, whichever applies

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)

☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

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Practice Policies

Thank you for choosing Interventional Pain Consultants. We are committed to the treatment of your pain and in order to provide your care, we require your compliance with our policies. Your clear understanding of our policies is important to our professional relationship.

We will bill your primary insurance company directly if a copy of both sides of your insurance card is provided at the time of service as well as required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at the time of service. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. If payment is not received from your insurance company in 60 days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

If your insurance requires a referral, it is your responsibility to obtain the necessary referral for your visit or procedure and have a copy of this referral sent to our office prior to your visit or procedure. If you do not have a referral from your primary care physician at the time of a visit, you will be given the option to reschedule your appointment.

Authorization to Release Information and Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Blue Shield, HMO's and commercial insurance to Interventional Pain Consultants and to Morris Anesthesia Group if anesthesia is administered for procedures at a surgery center or hospital. I understand that I am fully responsible for all charges whether or not they are covered by said insurance. I hereby authorize assignee to release any information necessary to secure payment on my behalf.

Consent of Treatment

I understand that the practice of medicine is not an exact science, many things are not predictable, and no guarantees or promises can be made to me by the doctors or assistants. I understand that I maintain the option to terminate my consent to treatment at any time, but such termination must be in writing.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

To ensure you are seen in a timely manner, please remember to book your next appointment prior to leaving the office.

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Cancellation / No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a seventy five ($75.00) fee; this will not be covered by your insurance company.

Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. **If a surgery is not cancelled at least 48 hours in advance you will be charged a one hundred and fifty ($150.00) fee; this will not be covered by your insurance company.**

Disability Forms, Reports, Etc.

Request for completion of disability forms, reports or other paperwork will require a minimum fee of $15.00, paid in advance, related to the amount of preparation involved. If you have not seen your physician recently, you may be required to see your physician before the form can be completed. Please allow five business days for completion.

Medication Policy

It is important to your health that you follow the directions carefully on all medications that we prescribe. In addition, we must be informed of all other medications, prescription, over-the-counter and supplements that you are taking. We will not refill controlled medications in advance of their refill date, nor will we mail prescriptions. They must be given in person to you at the time of your appointment. If there is an unavoidable reason that you cannot make an appointment, we require a 3-day notice for a medication refill. Patients receiving chronic medication management will be required to sign a separate narcotic agreement.

My signature indicates that I have read, understood, and agree with the above statements, terms, and conditions.

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Patient or Representative Signature: _____

Date: _____

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Authorization for Release of Information to Family Members

Name of Patient: _____

Date of Birth _____/_____/_____

Interventional Pain Consultants is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. You have the right to revoke this consent, in writing, at any time except where we have already made disclosures in reliance on your prior consent.

I authorize IPC to release my records and any information requested to the following individuals.

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____
4. _____ Relation to patient: _____
5. _____ Relation to patient: _____

Authorization Regarding Messages (please check all that apply)

☐ I authorize you to leave a detailed message on my home or cell number regarding appointments

☐ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

☐ I authorize you to leave a message with anyone who answers the phone

☐ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature

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Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

I request and authorize Interventional Pain Consultants to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Fax #: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All Healthcare Information

☐ Other: _____

Reason for request: _____

_____ _____

Patient Signature Date

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