Princeton **Pain** & **Spine** Institute P.C.

Fellowship Trained in Interventional Pain Management and Sports Medicine

123 Franklin Corner Road . Suite 104 . Lawrenceville, NJ 08648

Office: (609) 512- 1690 Fax: (609) 512-1674

Patient Registration: WorkersComp

Date:

Patient Information

Last Name: _____ Social Security: _____

Maiden Name: _____ Birth Date: _____

First Name: _____ Middle Name: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Okay to leave message? ☐Yes ☐No

Cell Phone Number: _____ Okay to leave message? ☐Yes ☐No

Email Address: _____ Okay to leave message? ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other: _____

Patients Employer Information

Patient's Employer: _____ ☐Full-Time ☐Part-Time

Employer's Phone: _____

Employer's Address: _____ Suite: _____

City: _____ State: _____ Zip: _____

Unemployed: ☐Yes ☐No Disability: ☐Yes ☐No

Insurance Information- *Primary, Secondary, or other*

Do you have health insurance? ☐Yes • **Please give Insurance Card(s) to the Receptionist** ☐No

Primary Insurance Company Name: _____

Please indicate the policyholder for the Primary Insurance: ☐Self ☐Parent ☐Spouse ☐Other: _____

Secondary Insurance Company Name: _____

Please indicate the policyholder for the Primary Insurance: ☐Self ☐Parent ☐Spouse ☐Other: _____

Spouse or Parent's Information- *If patient is covered by spouse or patient*

Spouse / Parent's Name: _____ Spouse / Parent's Birth Date: _____

Spouse / Parent's SSN: _____ Employer's Phone: _____

Spouse / Parent's Employer's Address: _____

City: _____ State: _____ Zip: _____

Emergency Information

In case of emergency, please list the nearest living relative/friend (other than your spouse/parent) we may contact:

Name: _____

Phone: _____

Relationship: _____

Preferred Pharmacy

Unless otherwise specified, we will fax prescriptions to the following pharmacy:

Name: _____

Location: _____

Phone: _____

Fax: _____

*Fill out only if you are **Workers Comp** *

Worker's Comp.

Date of Injury: _____

Where Injury Occurred: _____

How did the injury occur?_____

Were you taken to the Hospital/Emergency Room? _____

What is the name of the Hospital/Emergency Room?_____

Were you admitted to the Hospital?_____

What treatments have you had?_____

Have you had any radiology services done? ☐CT Scan ☐MRI ☐X-Rays

Case Manager's (Adjuster's) Name:_____

Case Manager's (Adjuster's) Number: _____

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Date:_____

First Name | Last Name | Date of Birth | Age

Referring Physician | Phone Number

Primary Physician | Phone Number

Reason for the visit today: _____

Are you pregnant? ☐YES ☐NO **Do you suspect you are pregnant?** ☐YES ☐NO

Previous Treatment: ☐PT ☐Chiropractic ☐Injections ☐NSAID Treatment ☐Pain Medication

Medical History: *Include any diseases, conditions, or incidents, chronic or temporary (Diabetes, heart attack etc...)*

Current Medications (May Attach a List):

Name	Dose	# Per Day	What do you take this medication for?

☐Plavix ☐Clopidogrel ☐Pradaxa ☐Xarelto ☐Trental ☐Coumadin ☐Fish Oil

Food/Medication Allergies (May Attach list):

Substance	Reaction

☐Contrast Dye ☐Iodine ☐Shellfish

Date: _____

First Name | Last Name | Date of Birth | Age

Surgical History:

Type of Surgery/Procedure	Dates

☐ Pacemaker ☐ Defibrillator ☐ Number of Stents _____ Date: _____

Review of Systems:

Neurological:

Seizures	☐ Yes	☐ No
Strokes	☐ Yes	☐ No

Cardiovascular:

Chest Pain	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Anticoagulants	☐ Yes	☐ No
Murmur	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No

Ear, Nose, and Throat:

Nose Bleeds	☐ Yes	☐ No
Difficulty Swallowing	☐ Yes	☐ No
Cataracts/Glaucoma	☐ Yes	☐ No

Diabetes: Blood Sugar Values_____

Insulin Use	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No

Gastrointestinal:

Ulcers	☐ Yes	☐ No
Reflux Disease	☐ Yes	☐ No

Respiratory:

Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Tobacco Use	☐ Yes	☐ No
COPD	☐ Yes	☐ No

Bowel/Bladder:

Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Psychosocial:

Depression	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No

Family History:

Condition	Mother(✓)	Father(✓)	Brother(✓)	Sister(✓)	Grandmother(✓)	Grandfather(✓)	Fatal (Yes/No)
Diabetes							
High Blood Pressure							
Liver Disease							
Thyroid Disease							
Cancer(s)							
Heart Disease							
Stroke							

Date: _____

First Name | Last Name | Date of Birth | Age

Social History:

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

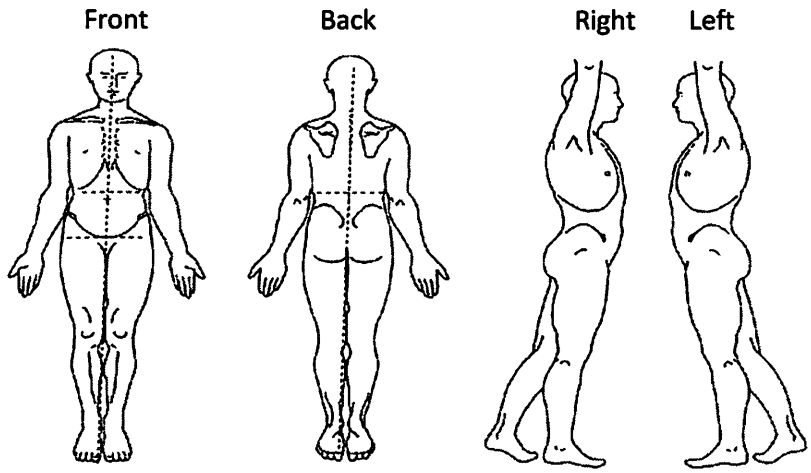
Number of Children: _____

Highest Level of Schooling: ☐Eighth Grade ☐High School ☐Some College ☐College ☐Trade School ☐Masters ☐Doctoral ☐GED Diploma

☐Tobacco: Cigarettes/Day_____ Packs/Day_____ ☐Alcohol ☐Illicit Drug Use

Pain Assessment:

Please mark on the diagram the location of the pain



Current Pain Level: /10

1 2 3 4 5 6 7 8 9 10

Worst Pain Level: /10

1 2 3 4 5 6 7 8 9 10

Check all that apply:

☐Aching ☐Burning
☐Cramps ☐Dull
☐Numbness ☐Sharp
☐Shooting ☐Stabbing
☐Stiffness ☐Swelling
☐Throbbing ☐Tingling
☐Other: (Please describe)

First and Last Initials: _____

When did the pain begin? _____ Any flare-ups since then? If so, when? _____

Auto Accident ☐Yes ☐No Date: _____

Work Injury ☐Yes ☐No Date: _____

What brought the pain on?

The pain (is constant / comes and goes). If the pain comes and goes, how often does the pain occur? And for how long?

Does it interfere with (Work / Sleep / Daily Routine / Recreation / Other: _____)

Date: _____

First Name | Last Name | Date of Birth | Age

Activities that are painful to perform: ☐Sitting ☐Standing ☐Bending ☐Other: _____

☐None

When and what makes it better? _____

When and what makes it worse? _____

Any prior injuries to the area of pain? _____

Have you seen another healthcare practitioner for the pain/condition? (Yes/No)

If Yes, who? _____

Please Provide the Following Information:

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Patient Name: _____ Date: _____

Patient Signature: _____

Physician's Notes:

Physical Exam:

Height: _____ Weight: _____ Age: _____ Vitals: _____ P _____ R _____ T_____

Clinical Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Imaging Studies: ☐CT scan ☐MRI ☐EMG ☐Bone Scan ☐X-Ray ☐Physical Therapy

☐ESZ ☐R ☐Facets ☐B/L ☐Surgical Consult ☐Other_____

☐L ☐R

☐L

Physician's Signature: _____ **Date:** _____

Authorization for release of information

I authorize Princeton Pain and Spine Institute, P.C to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify Princeton Pain and Spine Institute, P.C in writing of any information I do not want released.

X _____

SIGNATURE DATE

Assignment of benefits

I authorize the assignment of benefits payable to Princeton Pain and Spine Institute, P.C and/or its designee for physician services and supplies by government and/or any other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

Authorization for additional fees

In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur.

Authorization for treatment

I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

X _____

SIGNATURE DATE

Princeton Pain and Spine Institute, P.C.

Dinash K. Yanamadula MD

(Board Certified in Physical Medicine and Rehabilitation & Pain Management)

NARCOTIC AGREEMENT

Prior to receiving any controlled substances from our practice, you must be aware of the risks, benefits, and other potential options available to you. You must read and agree to abide to the following:

- I understand that controlled substances may be addictive. My physician has explained the risks, benefits, and alternatives to the use of controlled substances.
- Telephone calls-No prescriptions will be refilled after regular business hours. Regular business hours are Monday thru Friday 9:00 am to 4:00 pm.
- Please allow 24-48 hours for medication refills to be taken care of.
- Lost/Stolen medications or prescriptions will not be replaced unless a police report has been filed and a copy has been provided to the practice.
- Driving or operating heavy machinery is strictly prohibited while taking controlled substances.
- Random drug screening-As part of this agreement, you consent to random urine or blood screening. This is done in order to ensure that you are using the medication appropriately as well as to rule out the use of illegal substances.
- I agree not to obtain any controlled substance from any other physicians and or other sources.
- Pregnancy/Lactation-I am currently not pregnant nor do I intend to become pregnant. Should I become pregnant or choose to try to become pregnant, I will immediately notify my physician. Use of controlled substances while pregnant may cause fetal abnormalities.
- Use of alcohol is prohibited while taking controlled substances.
- I agree to use only one pharmacy. It is my responsibility to notify the physician if I choose to change my pharmacy.
- Follow-Up visits-I understand that periodic visits will be required for the purpose of determining the effectiveness of my treatment and my compliance with the above contract.

I understand that should my physician feel that I have violated any of the terms of the above contract, my physician will terminate the prescribing relationship.

_____ _____

(Signature of Patient) **(Date)**

_____

(Print Name)

Princeton Pain and Spine Institute, P.C
Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

1. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request

2. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.
Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.
Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

3. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you $0.25 for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we, or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified expectations.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Princeton Pain and Spine Institute, PC
Dinash K. Yanamadula, MD
123 Franklin Corner Rd.
Suite 104
Lawrenceville, NJ 08648
Phone: 609-512-1690 Fax: 609-512-1674

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Princeton Pain and Spine Institute, P.C
Dinash K. Yanamadula, MD

I have received Notice of HIPAA Privacy Policy from Dr Dinash K. Yanamadula, M.D at Princeton Pain and Spine Institute, P.C located at 123 Franklin Corner Rd. Suite 104, Lawrenceville NJ 08648.

Patient's Name (printed):_____

Patient's Signature: _____

Date: _____