ADVANCED PHYSICAL MEDICINE CENTER, L.L.C.
222 Bergen Boulevard-Suite 8 Fairview, NJ 07022 Phone: 201-945-1156 Fax: 201-945-0012

Name_____Date of Birth_____/_____/_____
Address_____
City, State, Zip_____
Home Phone_____Work_____Cell_____
E-Mail_____ *Your e-mail address will not be rented or sold
(CIRCLE ONE) Male Female Marital Status S M D W Name of Spouse_____
Soc. Sec.# _____-_____-_____

Occupation_____
Employer_____
Employer's Address_____
_____

Primary Physician: _____ Phone Number: _____

Were You Referred By:

- ☐ Yourself
- ☐ Friend (Name _____)
- ☐ Primary Physician (Name _____)
- ☐ Newspaper Ad:
  ____North Bergen Reporter
- ☐ Table Top Ad: Garden Pizza
- ☐ Workshop/Speaking Engagement
- ☐ Internet(Website, Facebook, Google): _____

Have you been seen by another physician for this condition? Y or N
If yes, please describe and list dates.

_____

Is today's visit related to an auto accident or any other personal injury? Y or N
If yes, please describe and list dates.

_____

_____ _____
SIGNATURE DATE

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

Did it come on: ☐ Suddenly ☐ Built up over several days ☐ Gradually worse over a long time.

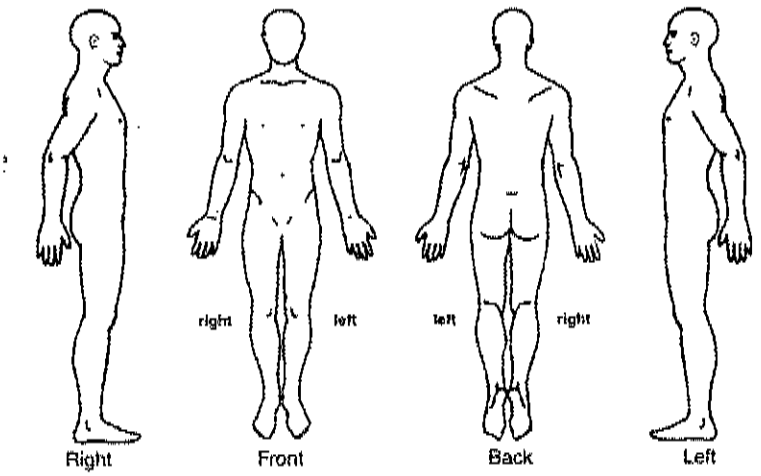
If you were injured was it: ☐ At Work ☐ At Home ☐ Due to Auto Accident ☐ Other Injury

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT. **Circle** the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time and how frequent.

AREA 1 pain is (1-10) ___ Constant or Intermittent
At _____% of my day

AREA 2 pain is (1-10) ___ Constant or Intermittent
At _____% of my day.

AREA 3 pain is (1-10) ___ Constant or Intermittent
At _____% of my day



Please help us understand your pain: **Circle the words** for each area that best describes your pain and activity during your day.

Area 1 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 2 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 3 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am : Ambulatory without assistance Need to use: Support Brace _____ Walker Cane Crutches Wheelchair

Please help us better understand **your personal circumstances** and assist us in providing you customized treatment and care.

I Am Now: ☐ Working Full Time Part Time ☐ Homemaker ☐ Full Time Student ☐ Unemployed ☐ Retired

Occupation: _____

☐ On sick leave ☐ On Temp disability ☐ On Full Disability My last day worked was _____

Age _____ Single Married Separated Filing for Divorce Divorced

Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.

I Now ◯ Smoke ___ Packs per day Stopped _____ ◯ Use Alcohol Type and Amt _____

◯ Consume Caffeine: Type/ Amt _____ ◯ Use recreational drugs _____

I am now or have in the past been : ◯ Addicted to drugs alcohol ◯ Treated for alcohol or drug addiction

WOMEN ONLY Can you become pregnant? YES NO Date of last period _____ Normal Yes No

If not, why? _____ Date of last Mammogram _____ Normal Yes No

Are you now or could you be pregnant ? ? YES NO Pap Smear _____ Normal Yes No

Pertinent History/ Please advise us of any special circumstances, previous tests, therapy or conditions.

Are you allergic to any medications? NO YES (If yes, please list all that you are allergic to below)

If you previously had any of the following procedures, please list the date and place they were performed.

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE RECENT PAST.

Severe headaches / Chest pain / Angina / Kidney Stones / Digestive problems / Hypertension / Renal disease Gout / Stroke / Heart murmur / Diabetes / Arthritis / Epilepsy / Arrhythmia / Endocrine disease / HIV / AIDS Fatigue / Congenital heart disease / Urinary, genital problems / Dizziness / Fainting / Anemia / Reumatic fever / Scarlet fever / Prostate problems / Ulcers / Gall Stones / Sexual dysfunction / Venereal disease / Pancreatitis Shortness of breath / Menstrual dysfunction / Mental Illness / Asthma / Liver disease / Alcohol or Drug problems.

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. *(Prescription and over the counter)*	
Name of medication and Strength	**# of doses / day**

HOSPITALIZATION and SURGERY
PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)

FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

	condition	who?		condition	who?
	Heart Disease			Epilepsy	
	Hypertension			Glaucoma	
	Stroke			Bleeding disorders	
	Cancer			Kidney disease	
	Diabetes			Thyroid disease	

Do you require special care or have any concerns that might affect your treatment or recovery? NO YES (If yes please describe)

Thank you for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To verify that the information is correct as given to us by you, please affix your signature in the area (x) provided below.

Patient Signature: X	*Primary Intake History #6011*

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HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize Advanced Physical Medicine Ctr (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date

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Assignment of Rights

I, _____, hereby assign and transfer any and all rights that I may have in and to any claim for benefits from _____ pursuant to Policy # _____, related to all medical treatment now rendered or to be rendered by Advanced Physical Medicine Center, LLC.

I further authorize Advanced Physical Medicine Center to proceed, on my behalf, to collect any and all unpaid benefits or proceeds to which I may be entitled and to apply the same toward any unpaid medical expenses arising out of my treatment.

I further promise to fully cooperate with Advanced Physical Medicine and their attorneys and/or representatives in their efforts to collect any benefits or proceeds for medical expenses incurred to Advanced Physical Medicine Center, LLC, including timely filing of claims and/or denial of services rendered. I understand and agree that Advanced Physical Medicine Center and their attorneys and/or their representatives shall have full access to my medical records and bills.

Signature: _____ Date: _____

Out-of-Network Insurance Disclosure

I am aware that the Advanced Physical Medicine Center and all doctors and therapists are out-of-network. As a result, I may be responsible for any outstanding deductibles and co-payments.

Policy for Updating Medical Coverage Information

I, the patient, will be responsible to notify the office of any changes that may occur in regards to my medical coverage during ongoing treatment. This may include an auto accident, a work related injury, termination, a change of insurance company and/or policies. If I do NOT comply with this policy, I will be liable for any and all outstanding bills.

Signature: _____ Date: _____

Witness: _____ Date: _____