

Woodbury Spine

Evan O'Brien, MD

*American Board of Spine Surgery
American Board of Orthopaedic Surgery*

Nick Kaffl, PA-C
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*American Board of Pain Management
American Board of Physical Medicine & Rehabilitation*

Millennium Surgical Center
Underwood Memorial Hospital

Patient Registration Form

Patient Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Date of Birth: _____

Social Sec Number: _____ Female: _____ Male: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Employer's Telephone: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Insurance Information -- Please give cards to the receptionist for copying

Primary Insurance: _____

Phone _____ Fax _____

Insured's Name _____ Date of Birth: _____

ID Number _____ Group Number _____

Secondary Insurance: _____

Phone _____ Fax _____

Insured's Name _____ Date of Birth: _____

ID Number _____ Group Number _____

Woodbury Spine

Patient Name: _____ Date: _____

If you had an accident please complete this section

Date of Accident: _____ How did it happen? ___ Auto ___ Work ___ Other

Involvement in accident if auto: ___ Driver ___ Passenger ___ Pedestrian ___ Cyclist

Attorney's Name: _____

Address: _____

Phone: _____

Insurance Company (Worker's Comp or Auto): _____

Address: _____

Phone: _____

Claim Number: _____

Adjuster: _____

Woodbury Spine

Treating Physician Information

Patient Name: _____ Date: _____

Referring Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Primary Care Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Cardiologist

Name: _____

Address: _____

Phone: _____ Fax: _____

Other Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Other Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Woodbury Spine

Patient Name: _____ Date: _____

1. Consent for Medical and Surgical Treatment: I voluntarily consent to all medical care and services performed by my physician and all other health care providers at *Woodbury Spine*. I also consent to routine services, diagnostic procedures, medical treatment, and other services as deemed necessary by the health care providers treating me. I understand that I have a right to consent or to refuse to consent to any proposed treatment and to discuss it with my health care provider. _____ Initials

2. Payment Agreement: I acknowledge full financial responsibility for services rendered by *Woodbury Spine*. I authorize direct payment of medical benefits to Evan D. O'Brien, M.D., P.C. (dba *Woodbury Spine*), for services rendered by *Woodbury Spine*. I agree to pay any balance due in full no later than 30 days of the statement, unless other arrangements have been made in advance. _____ Initials

3. Medicare Authorization: I hereby authorize payment of Medicare benefits be made directly to Evan D. O'Brien, M.D., P.C., (*Woodbury Spine*) for any services rendered to me by my physician and health care providers employed by that corporation. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed for the purpose of determining these benefits. I understand that this authorization is in effect until revoked, in writing, by me. _____ Initials

4. Insurance Authorization and Assignment: I hereby authorize the release of any medical information necessary to process insurance claims or any medical information that is needed for payment, treatment, or health care operations. I authorize direct payment of medical benefits to Evan D. O'Brien, M.D., P.C. (*Woodbury Spine*), for services rendered. I further authorize the release and discharge of such protected health information to my insurance company or other health coverage plan as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. I understand that this authorization is in effect until revoked, in writing, by me. _____ Initials

5. Right to Choose: Our practitioners may prescribe certain diagnostic tests necessary to help ensure the best diagnosis and treatment of your symptoms. He/She may suggest health care facilities and/or individuals regarded as qualified for the testing and treatment that is necessary. Please be aware that Dr. O'Brien and Dr. Zhou are part owners in Millennium Surgery Center. They are committed to providing the highest level of care in that facility. If you prefer to use the services of other health care providers and/or medical diagnostic facilities, you may do so. This will in no way affect the care that will be provided to you by our practitioners. _____ Initials

6. A photocopy of these assignments shall be as valid as the original. _____ Initials

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility, insurance authorization and right to choose.

Signature

Date

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COMPREHENSIVE INTAKE FORM

Last Name: _____ First Name: _____ Date: ___/___/___

Date of Birth: ___/___/___ Age: _____ Sex: ___M ___F Height: _____ Weight: _____

Your dominant hand: ___Right ___Left

Phone: _____ Cell phone #: _____ Email: _____

Allergy: Drug (list): _____

Contrast dye: _____

Latex: _____

Other: _____

Family physician: _____ Phone: _____

Address: _____ Fax: _____

Referring physician: _____ Phone: _____

Address: _____ Fax: _____

Attorney: _____ Phone: _____

Address: _____ Fax: _____

Reason for this consultation: _____

Where is your pain: _____ Head _____ Neck _____ Shoulder _____ Arm _____ Hand

_____ Thoracic _____ Abdomen _____ Low back _____ Hip

_____ Knee _____ Leg _____ Foot

Duration of your pain: _____ Year(s) _____ Month(s) _____ Day(s)

Is your injury: _____ Work related; date: _____

_____ Motor vehicle accident; date: _____

_____ Other injury; date: _____

Prior Studies/date: X-ray _____

CT _____

MRI _____

Bone Scan _____

EMG _____

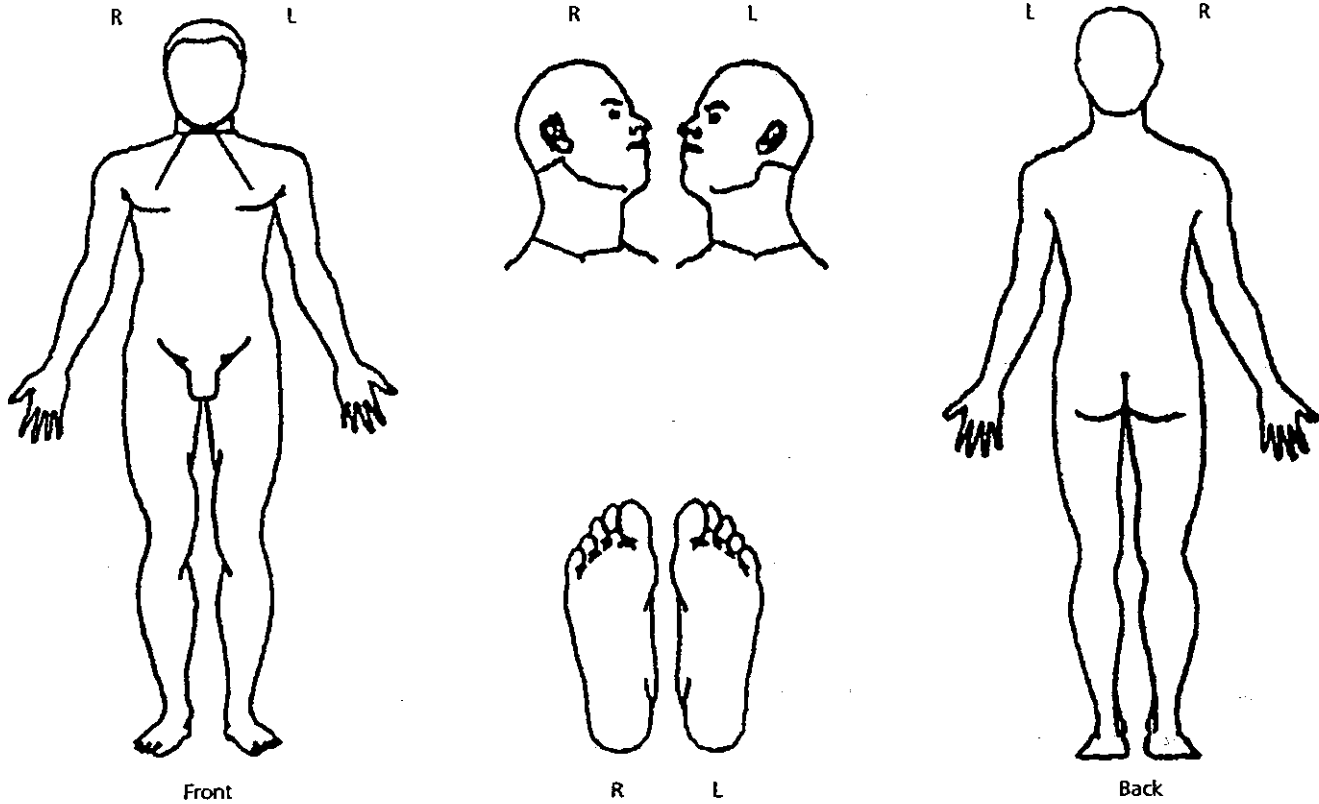
Blood tests _____

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COMPREHENSIVE INTAKE FORM

Patient Name: _____ Date: _____

Shade in painful areas in the diagram below. Please circle the most painful area.



Physician Use Only – Do not write below this line.

Current description of pain

Location

Quality

Intensity

Aggravating

Alleviating

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COMPREHENSIVE INTAKE FORM

Patient Name: _____ Date: _____

Check appropriate boxes that describe your pain. Check only one box within each category.

	None	Mild	Moderate	Severe	
Throbbing	___	___	___	___	Please circle the level of your present pain intensity:
Shooting	___	___	___	___	
Stabbing	___	___	___	___	
Sharp	___	___	___	___	
Cramping	___	___	___	___	
Gnawing	___	___	___	___	
Hot-burning	___	___	___	___	
Aching	___	___	___	___	
Heavy	___	___	___	___	
Tender	___	___	___	___	
Splitting	___	___	___	___	
Tiring-exhausting	___	___	___	___	
Sickening	___	___	___	___	
Fearful	___	___	___	___	
Punishing-cruel	___	___	___	___	
					0 No pain
					1 Mild pain
					2 Discomforting pain
					3 Distressing pain
					4 Horrible pain
					5 Excruciating pain

Please make a slash mark on the line to indicate how you feel:

What is the average level of pain you have every day?
 No pain | _____ | Pain as bad as it could be

What is the least severe pain you have had in the last two weeks?
 No pain | _____ | Pain as bad as it could be

What is the greatest amount of pain you have had in the last two weeks:
 No pain | _____ | Pain as bad as it could be

How much is pain interfering with your activities?
 Not at all | _____ | Completely

What is your mood like now:
 Worst ever felt | _____ | Best ever felt

What is the worst consequence of your pain? (i.e., withdraw from people, lose my temper, overeat, etc.) _____

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COMPREHENSIVE INTAKE FORM

Patient Name: _____ Date: _____

Previous Medications (Please circle all that apply)

___ **Narcotics** (i.e., Demerol, Morphine, Dilaudid, MS Contin, Methadone, Darvon, Percocet, Percodan, Talwin, Vicodin, Codeine, Tylenol 3, Tylox, Fentanyl Patch)

___ **NSAIDS** (i.e., Aspirin, Motrin, Ibuprophen, Dolobid, Toradol, Advil, Naprosyn, Relafen, Orudis)

___ **Sedatives/Relaxants** (i.e., Ativan, Xanax, Valium, Librium, Flexeril, Parafon Forte)

___ **Antidepressants** (i.e., Elavil, Pamelor, Desipramine, Effexor, Desyrel, Prozac, Zoloft, Paxil, Serzone, Remeron)

___ **Anticonvulsants** (i.e., Neuronton, Klonopin, Tegretol, Dilantin)

___ **Neuropathic Pain Medications** (i.e., Baclofen, Maxitil, Hytrin, Phenoxybenzamine, Ultram, Prazocin)

Previous Treatments (Please circle all that apply)

Acupuncture	Traction	TENS Unit	Psychiatrist
Chiropractor	Warm Heat	Physical Therapy	Biofeedback
Massage	Psychologist	Other _____	

ROS (Please circle all that apply)

Fever	Shortness of Breath	Black Bowel Movement	History of Easy Bruising
Weight loss	Wheeze	Nausea	Urinary Frequency
Sweats	Chest Pain	Weakness/Paralysis of Arms & Legs	Difficulty to Urinate
Swelling	Palpitations	Headache	Bowel or Bladder Incontinence
Rash	Abdominal Pain	Lightheadedness	Pregnancy
Cough	Constipation	Dizziness	Sputum Production
Diarrhea	Vision Changes	Other (specify) _____	

___ No relevant positive systems

Sleep # hours/night: _____

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COMPREHENSIVE INTAKE FORM

Patient Name: _____ Date: _____

PMH (Please circle all that apply)

Arrythmia	Liver Disease	Cancer	High Blood Pressure
Kidney Disease	Rheumatologic Disease	Angina/Coronary Artery Disease	
Peptic Ulcer	Diabetes	Heart Attack	Bleeding Disorder
Depression	Emphysema/Asthma	Taking Anticoagulants	Stroke
Migraine Headache	Thyroid Disease	Seizures	Other _____

___ No relevant PMH

Past Surgical History

Date	Surgery	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications

Drug	Dose	# times/day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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COMPREHENSIVE INTAKE FORM

Patient Name: _____ Date: _____

Social History

Do you drink alcohol ___ Yes ___ No

Do you smoke cigarettes ___ Yes ___ No

If yes, specify quantity: _____

If yes, specify # of packs per day _____

Current employment status (Check one) ___ Employed full-time ___ Employed part-time
___ Retired ___ Self-employed ___ Unemployed due to pain ___ Unemployed due to other

Present or most recent occupation _____

Marital History ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

With whom do you live ___ Self ___ Spouse ___ Children ___ Parents ___ Friend ___
Other _____

Family History

Mother Living/Deceased Cause: _____

Father Living/Deceased Cause: _____

Patient Signature

Date

Physician Use Only – Do not write below this line

Illicit drug use

Miscellaneous

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ACKNOWLEDGMENT AND CONSENT

This acknowledgment of notice and consent authorizes Woodbury Spine to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices

Woodbury Spine has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to Contact Our Privacy Officer

Mail: Privacy Officer, Woodbury Spine
1225 N. Broad Street, Suite 3
Woodbury, NJ 08096
Telephone: 856-845-0707
Fax: 856-845-0082

Acknowledgment and Consent

I have received the Notice of Privacy Practices for Woodbury Spine, and authorize the use and disclosure of health information for treatment, payment and health care operations purposes consistent with its Notice of Privacy Practices.

Patient name (or patient's personal representative)

Date

Patient Signature

Name/relationship of personal representative, if applicable