Woodbury Spine

Evan O'Brien, MD, PC
American Board of Spine Surgery
American Board of Orthopaedic Surgery
Nick Kaffl, PA-C
Chris Hennessey, PA-C
Millennium Surgical Center
Inspira Medical Center Woodbury

Dear Patient,

Welcome to Woodbury Spine!

You are scheduled for a visit in our office on _____. Please complete the attached paperwork and bring it with you along with any films or cds relating to your visit, current insurance cards, and a valid photo ID (such as a driver's license). Please arrive at least 15 minutes prior to your scheduled appointment to complete all necessary paperwork.

Our office is located at 1225 N. Broad Street, Suite 3, in Woodbury, NJ. We are located at the back of the building.

We will be happy to answer any questions you may have, and can be reached at 856-845-0707.

Thank you.

Patient Registration Form

Patient Name:_____ Date:_____

Address:_____

_____

Home Phone:_____ Cell:_____

Work Phone:_____ Date of Birth:_____

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_____

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: _____

Authorization and Consent

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 the providers at ***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. If payment is sent directly to me from the insurance company, I agree to turn over the payment and related paperwork immediately. If I do not turn over those funds received I will be responsible for the entire charge plus any fees related to collection efforts. I certify that the health insurance information that I provided is accurate as of the date set forth below and that I am responsible for keeping it updated. _____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

Patient Name:_____ Date: _____

5. Appointment as Legal Authorized Representative: I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Evan D. O'Brien, M.D., P.C., and the legal representative of the practice and I appoint them as my authorized representative with the power to: file medical claims with the health plan; file appeals and grievances with the health plan; institute any necessary litigation and/or complaints against my health plan; and discuss or divulge any of my personal health information or that of my dependents with the third party including the health plan. _____ Initials

6. Consent to Access Medication History: I authorize Woodbury Spine to access information about my medication history as part of my medical treatment. _____ Initials

7. 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 is a part owner of Millennium Surgery Center. He is 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

8. Release of Records: I hereby authorize the release of my medical records necessary for medical care. I also authorize the release of medical records and films from any other facility or physician as needed for my medical care. _____ Initials

9. 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.

_____ _____

Patient Signature Date

Review of Systems

Name: _____ Date: _____

Have you been experiencing any of the following symptoms and/or conditions in the last 6 months?

		YES	NO			YES	NO
General				Cardiovasular			
	Weight Change	☐	☐		Heart Trouble	☐	☐
	Weakness	☐	☐		High Blood Pressure	☐	☐
	Fatigue	☐	☐		Murmurs	☐	☐
	Fever	☐	☐		Chest Pain	☐	☐
	Sweats	☐	☐		Palpitations	☐	☐
	Chills	☐	☐		Shortness of Breath	☐	☐
Eyes					Edema	☐	☐
	Change in Vision	☐	☐		Leg Cramps	☐	☐
	Pain	☐	☐		Previous Blood Clots	☐	☐
	Redness	☐	☐	Gastrointestinal			
	Double Vision	☐	☐		Trouble Swallowing	☐	☐
	Blurred Vision	☐	☐		Heartburn	☐	☐
	Spots	☐	☐		Nausea	☐	☐
	Glaucoma	☐	☐		Vomiting	☐	☐
	Cataracts	☐	☐		Indigestion	☐	☐
Ent					Rectal Bleeding	☐	☐
	Periodontal disease	☐	☐		Black/Tarry Stools	☐	☐
	Dentures	☐	☐		Constipation	☐	☐
	Change in Hearing	☐	☐		Diarrhea	☐	☐
	Ringing in Ears	☐	☐	Genitourinary			
	Vertigo	☐	☐		Increased Urination	☐	☐
	Earaches	☐	☐		Painful Urination	☐	☐
	Infections	☐	☐		Difficulty Urinating	☐	☐
	Frequent Colds	☐	☐		Blood in Urine	☐	☐
	Nosebleeds	☐	☐		Urgency	☐	☐
	Frequent Sore Throats	☐	☐		Incontinence	☐	☐
	Hoarseness			Musculoskeletal			
Skin/breast		☐	☐		Muscle Pain	☐	☐
	Rashes	☐	☐		Joint Pain	☐	☐
	Lumps	☐	☐		Stiffness	☐	☐
	Itching	☐	☐		Arthritis	☐	☐
	Dry Skin	☐	☐		Gout	☐	☐
	Color Change				Backache	☐	☐
Respiratory		☐	☐	Neurological			
	Cough	☐	☐		Fainting	☐	☐
	Sputum	☐	☐		Blackouts	☐	☐
	Coughing Blood	☐	☐		Seizures	☐	☐
	Wheezing	☐	☐		Weakness	☐	☐
	Asthma	☐	☐		Paralysis	☐	☐
	Bronchitis	☐	☐		Numbness	☐	☐
	Emphysema	☐	☐		Tingling	☐	☐
	Pneumonia	☐	☐		Tremors	☐	☐
	Tuberculosis	☐	☐		Headaches	☐	☐

Review of Systems

Name: _____ Date: _____

Psychiatric		YES	NO	Hematologic		YES	NO
	Nervousness	☐	☐		Anemia	☐	☐
	Tension	☐	☐		Easy Bruising	☐	☐
	Depression	☐	☐		Easy Bleeding	☐	☐
	Memory Trouble	☐	☐		Previous Blood Transfusions	☐	☐
Endocrine				**Allergic**			
	Thyroid Trouble	☐	☐		**Please List All Allergies:**		
	Heat Intolerance	☐	☐		1. _____		
	Cold Intolerance	☐	☐				
	Excessive Sweating	☐	☐		2. _____		
	Diabetes	☐	☐				
	Excessive Thirst	☐	☐		3. _____		

Family physician: _____ Tel: _____ Fax: _____

Cardiologist: _____ Tel: _____ Fax: _____

Other Physician: _____ Tel: _____ Fax: _____

Attorney: _____ Tel: _____ Fax: _____

BELOW IS FOR OFFICE USE ONLY

Initially Reviewed Date: _____ Comments on positive responses:

_____

_____

_____

_____

_____

Physician/Practitioner Signature: _____

COMPREHENSIVE INTAKE FORM

Patient Name _____ Date _____

Date of Birth _____ Age ____ Sex ____M ____F Height ____ Weight _____

Phone _____ Cell phone _____ Email _____

Your dominant hand ___Right ___ Left

Family physician_____

Address _____

Phone _____ Fax _____

Referring physician _____

Address _____

Phone _____ Fax _____

Cardiologist _____

Address _____

Phone _____ Fax _____

Other Physician _____

Address _____

Phone _____ Fax _____

Attorney _____

Address _____

Phone _____ Fax _____

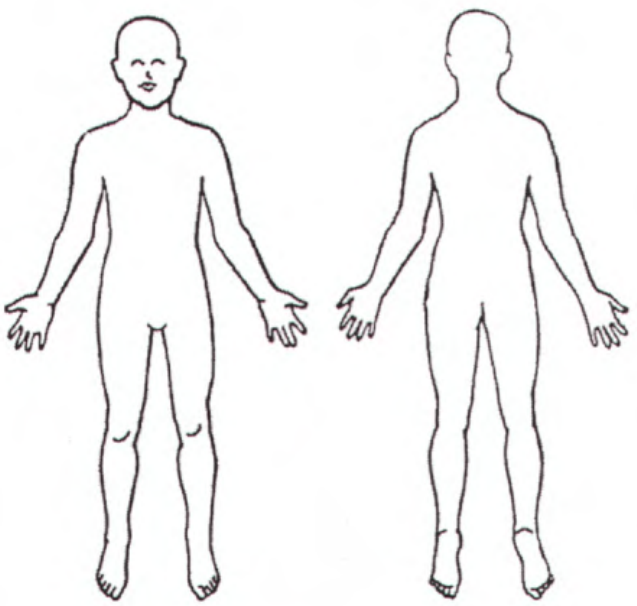
Reason for this consultation _____

How long have you been suffering from these symptoms? _____

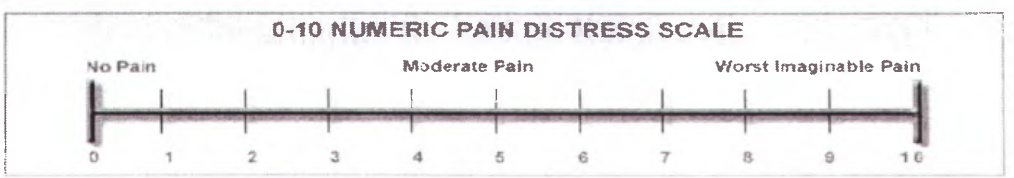
COMPREHENSIVE INTAKE FORM

Patient Name _____ Date _____

Shade in painful areas in the diagram below. Please circle the most painful area. Please indicate type of pain: Aching = XXX Stabbing = --- Burning = ooo



Indicate degree of pain below.



COMPREHENSIVE INTAKE FORM

Patient Name _____ Date _____

Is your injury _____ Work related; date _____

_____ Motor vehicle accident; date _____

_____ Other injury; date _____

Previous Medications (Please circle all that apply)

___ Nacotics (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, Klonipin, Tegretol, Dilantin)

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

_____

Previous Treatments (Please circle all that apply)

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

Prior injections (when, type, provider)_____

_____

COMPREHENSIVE INTAKE FORM

Patient Name _____ Date _____

Prior spine/neck surgeries (when, type, surgeon) _____

_____

_____

Please state the first date you were unable to work because of this condition _____

Job title _____

Does your job require heavy labor? _____ Lifting heavy weights? _____

Current employment status (Check one) ___ Employed full-time ___ Employed part-time

___ Retired ___ Self-employed ___ Unemployed due to pain ___ Unemployed due to other

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

COMPREHENSIVE INTAKE FORM

Patient Name _____ Date _____

Past Surgical History

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

_____

Social History

Do you drink alcohol ____ Yes ____ No

If yes, specify quantity: _____

Any history of tobacco use ____ Yes ____ No

If yes, specify # of pack/day, # years_____

Illicit drug use: _____

Highest level of education completed: _____

Marital History ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

With whom do you live____ Self ____ Spouse ____ Children ____ Parents ____Friend

Other _____

Family History

Mother Living/Deceased Cause: _____

COMPREHENSIVE INTAKE FORM

Patient Name _____ Date _____

Father Living/Deceased Cause: _____

Allergy: Drug (list)_____
Contrast dye _____
Latex _____
Other _____

_____ _____
Patient Signature Date

Medication List

Patient Name: _____ Date: _____

Pharmacy Name: _____ Phone: _____

Medication	Strength	Dosing	Prescribing Doctor