NJ Pain, Spine & Sports Associates

2090 Route 27, Suite 103
North Brunswick, NJ 08902
Tel: (732) 565-3777

288 North Broad Street, Suite 1A
Elizabeth, NJ 07208-3711 Fax
Fax: (609)228-7269

100 Village Ct., Suite 102
Hazlet, NJ 07730
Tel: (732) 800-7246

PATIENT INFORMATION

Last Name: ________________________ First Name: ________________________ MI: _____

Address: ________________________ City: ________________ State: _____ Zip: _________

SS #: ________________ Birth Date: __________ Sex: ________ Marital Status: ________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email: ________________________________ Student: ☐ Full Time ☐ Part Time ☐ Not Student

Employer: ________________ Employment: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Self Employed

How did you hear about us? ____

Referring MD: ________________________ Referring MD Phone: ________________________

Primary Care Physician: ________________________________ PCP Phone: ______________

Preferred Language: English ________ Spanish__________

SPOUSE INFORMATION / RESPONSIBLE PARTY

Name: ________________________________ Relationship to Patient: ________________

Address: ________________________ City: ________________ State: ____ Zip: ________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Date of Birth: ________________ SS#: ________________________

ATTORNEY INFORMATION

ATTORNEY NAME: ________________________ **PHONE #:** ________________

ADDRESS: ____

I acknowledge and understand that a $40 fee for NO SHOW / NO CALL will be billed to my account.

________________________________ ________________
Signature **Date**

____
Witness Name/Signature

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INSURANCE INFORMATION

Patient Name: ___________________________________ DOB: ______________________ Today's Date: __________________

Coverage Type: ☐ Primary

Insurance Company: _______________________________________ Subscriber Name: _____________________________________

Subscriber Relationship to Patient: ____________________________ Subscriber DOB: ______________________________________

Insurance ID #: ____ Effective Date/ DOL: _________________________________

Coverage Type: ☐ Secondary

Insurance Company: _______________________________________ Subscriber Name: _____________________________________

Subscriber Relationship to Patient: ____________________________ Subscriber DOB: ______________________________________

Insurance ID #: ____ Effective Date/ DOL: __________________________________

Patient Affirmation

I certify that above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether covered by insurance. I authorize treatment by the physician at NJPSSA

____ ______________________________

Signature Date

____

Witness Name/Signature

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ASSIGNMENT OF BENEFITS

Patient Name: ____ Date of Loss (if applicable): ________________________

Patient Address: ____

1. I ________________________________, the undersigned, hereafter referred to as "the patient" do hereby assign all of my right and interests to Faheem Abbasi LLC, DBA NJ Pain, Spine & Sports Associates, hereafter referred to as the "the medical provider" to pursue and obtain payment on my behalf. This assignment shall include but is not limited to, all rights available to me pursuant to the guidelines under the State of New Jersey.
2. I assign to the medical provider all my right and benefits under the insurance contract for payment for services rendered to me. However, upon consent of both parties, same shall be revocable.
3. I hereby authorize and request that payment of benefits by my primary insurance company and my secondary insurance be made directly to the medical provider for services furnished to me or my dependent. I understand that my insurance company(s) may only cover a portion of the total bill. I further understand that I may be responsible for all charges including but not limited to copay and deductibles not covered by my insurance carrier(s).
4. If the insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider with (5) days of receipt of same.
5. I authorize the medical provider to disclose all written document to the above-named insurance company(s) and/or its designated representatives at the determination of the medical provider. Such disclosure shall be for reimbursement purposes for those services received. I hereby release the medical provider, its officers, agents, employees, and clinical staff associated with my case from the liability that may arise because of disclosure of information to the above name insurance company(s) or their designated representatives.
6. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied, and I will be held responsible for same.
7. I, the patient authorizes my bodily injury attorney to pay directly to the medical provider any monies due on my account or have same deducted from my settlement made on my behalf. I authorize medical provider to obtain a letter of protection to cover my portion of medical monies owed. In the case I receive no reward when my case settles, I understand I will be responsible for any services rendered to me due to that accident.
8. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above providers' medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier through the arbitration process in place by the state of New Jersey or the state under which my policy was purchased.
9. I the patient understand the medical provider will file appeals on my behalf for any denied services. I will comply with any requests made by the medical provider or carrier regarding these appeals.
10. I understand as the patient I am required to notify the medical provider of any change in my insurance coverage. This assignment of benefits will apply to any new insurance carriers introduced during my treatment. If failure to provide the correct insurance information results in non-payment I understand I will be responsible for services.
11. I the patient understand if I do not pay any monies assigned to my responsibility my account may be forwarded to collection. Furthermore, I understand if my account is forwarded to collection, I may be responsible for an additional 30% of the charges owed.
12. This assignment of benefits is applicable to all locations of the medical provider.

PatientSignature____Date __________________________________

Patient or Guardian's Name ____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date: ______________________

Date of Birth: ______________________ Phone Number: ______________________

To release healthcare information of the patient named above to:

Name: NJ Pain, Spine & Sports Associates

Address: 2090 Route 27, Suite 103

City: North Brunswick State: NJ Zip Code: 08902

This request and authorization apply to:

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

____

☐ All healthcare information

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

______________________ ______________________ ______________________

Patient Name (PRINT) **Patient Guardian Signature** Date

____

Witness Signature

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NOTICE OF PRIVACY PRACTICE RECEIPT

I acknowledge that I was offered the Notice of Privacy Practices of the medical practice named at the top of the Page.

Print name of patient: ____ Date: ____________________________

Signature of patient: ____ SSN: _____________________________

For personal representative of the patient (if applicable):

Print name of personal representative: ____ Date: _____________________

Signature of personal representative: _______________________________________ Relation to patient: _______________

For practice use only:

Signature of practice employee: ____ Date: __________________________

The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions. Please provide the following information:

Appointment Reminder/Test Results (laboratory, x-rays, etc.):

If we need to contact you regarding an appointment or lab results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours. Please check all items below that apply to you.

May we send an appointment reminder card to your home address? ☐ Yes ☐ No

May we call to remind you of an appointment or regarding test results? ☐ Yes ☐ No

Please call me at the following number(s):

Home Phone: ____ Cell Phone: ____

Work Phone: ____ Email address: ____

If we get an answering machine/voicemail, may we leave a message? ☐ Yes ☐ No

If we get a family member, may we leave a message? ☐ Yes ☐ No

Policy for discussing your medical information with family members:

Our office will never discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

- ☐ Spouse ____
- ☐ Parent(s) ____
- ☐ Child(ren) ____
- ☐ Sibling(s) ____
- ☐ Other(s) ____

____

Witness Name/Signature

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APPOINTMENT REMINDER BY TEXT CONSENT FORM

I, ____, authorize New Jersey Pain, Spine & Sports Associates to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply.

__________________________	__________________________	__________________________
PATIENT NAME	**MOBILE#**	**MOBILE CARRIER**

Patient Signature: ____ **Date:** ________________________

OR

Parent/Legal Guardian Signature: ______________________________ **Date:** ________________________

____ ________________________

Witness Name/Signature **Date**

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MEDICAL HISTORY FORM

Patient Name: ____ Today's Date: ____________________________

Have you ever had or been told you have (check all that apply)?

Cardiovascular:
- ☐ Chest pain or Angina
- ☐ Heart Disease
- ☐ MI, Heart Attack, blocked artery
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Peripheral vascular disease
- ☐ Abnormal Heartbeat
- ☐ Pacemaker
- ☐ Angioplasty or Heart Cath
- ☐ Rheumatic Fever
- ☐ Damaged Heart Valve

Respiratory:
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ TB
- ☐ Smoking: Now Past Packs per day ______

Neurological:
- ☐ Epilepsy Seizure
- ☐ Fainting spells or Dizziness
- ☐ Stroke ____________________
- ☐ Headaches / Migraines

Gastrointestinal:
- ☐ Ulcer, Heartburn, Reflux
- ☐ Diverticulitis or Colitis
- ☐ Other ____________________

Cancer: ____________________

Metabolic:
- ☐ Diabetes ______________________
- ☐ Thyroid Disease
- ☐ Adrenal Gland Problem
- ☐ Steroid use ___________________

Liver/Kidney/Blood:
- ☐ Kidney disease
- ☐ Shunt, Graft, Fistula
- ☐ Dialysis
- ☐ Liver disease
- ☐ Gallbladder
- ☐ Hepatitis (Type ______________)
- ☐ Anemia
- ☐ Easy bruising or Bleeding

Other:
- ☐ Chronic numbness or Pain
- ☐ Depression or Anxiety
- ☐ Other nervous problem: __________
- ☐ Anticcegulants (Blood thinner)
- ☐ Back injury / Nerve damage
- ☐ Skin condition
- ☐ Arthritis, Rheumatism
- ☐ Dentures ☐ Partial Plate
- ☐ Glasses ☐ Hearing Aid

ROS: Please check the box if you currently have any of the following
- ☐ Shortness of Breath
- ☐ Swelling or Rash
- ☐ Abdominal pain
- ☐ Cough, Sputum Production, Wheeze
- ☐ Headache(s) How often? ___________________________________
- ☐ fever, weight Loss, Sweat
- ☐ Chest pain, Palpitations
- ☐ Change in bowel habits, nausea
- ☐ Pregnant or possibly pregnant
- ☐ Weakness or paralysis of arms or legs
- ☐ Dizziness, Vision Changes, lightheadedness
- ☐ Easy bruising, bleeding, using blood thinner
- ☐ Change in bladder habits (frequency, pain)

Social/ Family History:

Mother: living / deceased Cause____

Father: living / deceased Cause____

Usual Diet: ________________________________ Alcohol: drinks per day _____ Other Drug use: ____________________

Is your injury related to an accident? _____________ if yes, please answer question 1-7 otherwise move on to question number 8.

1. What Kind of Vehicle Was Involved in Accident? ☐ Truck ☐ Car ☐ Motorcycle ☐ Other
2. Were You a ☐ Driver ☐ Passenger ☐ Pedestrian?
3. If a Passenger, Please Indicate Your Location in the Car ____
4. Was Your Vehicle Moving When the Accident Occurred? ☐ Yes ☐ No Mph? __________________________
5. Did Your Vehicle Hit Other Vehicle(s)? ☐ Yes ☐ No Where? _________________________
6. Did Other Vehicle(s) Hit Your Vehicle? ☐ Yes ☐ No Where? _________________________
7. Describe Accident Including Causes and Surrounding Circumstances

____
____
____

Patient Signature: ____ Date: ___________________________

Reviewed by MD: ____ Date: ___________________________

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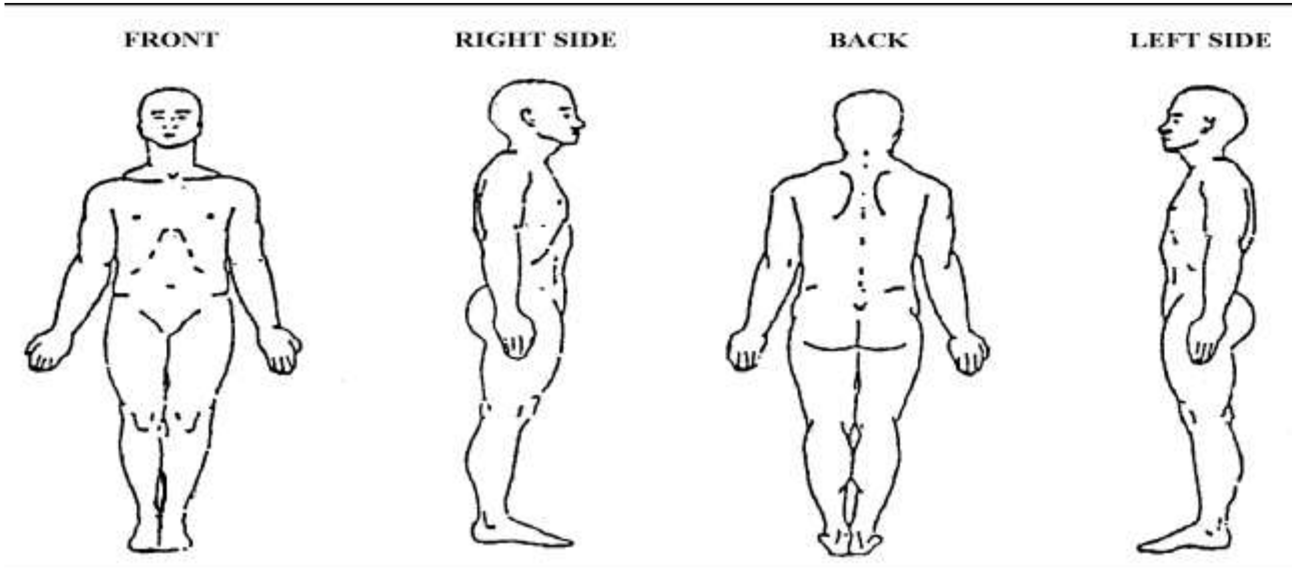
MEDICAL HISTORY FORM (Continued)

8. Please mark the area(s) in the diagram below where you are having pain:



9. Where is your pain located? ______________________________
10. Does your pain radiate anywhere? ____ Yes ____ No Where? ______________________________
11. When did it start? ______________________________
12. How long have you had the pain? ______________________________
13. Did it start: ____ Gradually ____ Suddenly ____ Not sure
14. How often does the pain occur? ☐ Continuously ☐ Several times a day ☐ Intermittent ☐ Occasionally ☐ Less than daily
15. Has the pain intensity changed since it began? ☐ Getting better ☐ Getting worse ☐ No change
16. How did it start? ______________________________
17. What makes the pain better?
    ☐ Standing ☐ Sitting ☐ Walking ☐ Laying Down ☐ Bending Forward ☐ Arching Backward
    ☐ Coughing/Sneezing ☐ Using Bathroom ☐ Other ______________________________
18. What makes the pain worse?
    ☐ Standing ☐ Sitting ☐ Walking ☐ Laying Down ☐ Bending Forward ☐ Arching Backward
    ☐ Coughing/Sneezing ☐ Using Bathroom ☐ Other ______________________________
19. Check all those that describe your pain:
    ☐ Aching ☐ Burning ☐ Cramping ☐ Tingling ☐ Throbbing ☐ Sharp ☐ Shooting
    ☐ Stabbing ☐ Numb ☐ Heavy ☐ Tender ☐ Splitting ☐ Tiring ☐ Exhausting
    ☐ Sickening ☐ Fearful ☐ Punishing ☐ Cruel
20. What is your current level of pain on a scale from 0 to 10, with 0 being no pain and 10 being severe? ____________
21. What tests have been done?
22. ☐ MRI ☐ CT ☐ X-ray ☐ EMG ☐ Other ______________________________
23. What treatment have you tried for your pain?
    ___ Exercise ___ Massage ___ Chiropractor ___ Acupuncture ___ Brace ___Physical Therapy
    ___ Warm pack ___ Ice pack ___ Nerve block ___ Psychologist ___ Psychiatrist ___ Surgery

Patient Signature: ______________________________ Date: ____________________

Reviewed by MD: ______________________________ Date: ____________________

Review :05/19/2022

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MEDICAL HISTORY FORM (Continued)

Patient Name: ______________________________ Today's Date: ____________________

Previous Medications Tried (Circling all that apply)

NSAIDS
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Advil
- ☐ Motrin
- ☐ Naprosyn

Relaxation
- ☐ Flexeril
- ☐ Valium
- ☐ Xanax
- ☐ Ativan
- ☐ Librium

Sleep Medicines
- ☐ Ambien
- ☐ Restoril
- ☐ Benadryl
- ☐ Halcion

Pain Medication
- ☐ Neurontin
- ☐ Klonopin
- ☐ Dilantin
- ☐ Baclofen
- ☐ Ultram
- ☐ Prozocin
- ☐ Mexitil
- ☐ Prazocin

Antidepressants
- ☐ Elavil
- ☐ Amityptilline
- ☐ Prozac
- ☐ Effexor
- ☐ Zoloft
- ☐ Deseryl
- ☐ Paxil
- ☐ Pamelor
- ☐ Serozone
- ☐ Desipiramine
- ☐ Remeron

Narcotics
- ☐ Vicodin
- ☐ Darvocet
- ☐ Tylenol 3
- ☐ Tylox
- ☐ Codeine
- ☐ Percocet
- ☐ Percodan
- ☐ MS Contin
- ☐ Cxycontin
- ☐ Demerol
- ☐ Morphine
- ☐ Methadone
- ☐ Dilaudid

Please list if you have any **Allergies**:

Allergies	Reaction

Please list all previous **Surgeries**:

Surgeries	Date

Medications you take at home (including pain medicines)

Medicine	Dose	How often	Last dose

Patient Signature: ______________________________ Date: ____________________

Reviewed by MD: ______________________________ Date: ____________________