Welcome To Our Office

NEW PATIENT INFORMATION

DATE _____

PATIENT'S NAME (PLEASE PRINT)	S.S. #	MARITAL STATUS (S M W D SEP)	SEX (M F)	BIRTH DATE	AGE	RELIGION (OPTIONAL)
STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE			ZIP CODE	HOME PHONE #	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)			HOW LONG EMPLOYED	BUS. PHONE # EXT. #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE	
DRUG ALLERGIES, IF ANY						
SPOUSE OR PARENT'S NAME	S.S. #	BIRTH DATE				
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATED IF STUDENT)			HOW LONG EMPLOYED	BUS. PHONE #	
EMPLOYER'S STREET ADDRESS	CITY AND STATE				ZIP CODE	
*SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED	CITY AND STATE			ZIP CODE	HOME PHONE #	

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE	ZIP CODE	HOME PHONE #
BLUE SHIELD (GIVE NAME OF POLICY H) ☐		GROUP #	COVERAGE CODE
OTHER (WRITE IN NAME OF INSURANC) ☐		POLICY #	
OTHER (WRITE IN NAME OF INSURANCE COMPANY) ☐	EFFECTIVE DATE	POLICY #	

SKIP – OFFICE WILL COPY YOUR INSURANCE CARD FOR THIS INFORMATION

MEDICARE # ☐	RAILROAD RETIREMENT # ☐	☐ VISA or ☐ MASTERCARD # EXP. DATE /

MEDICAID ☐	EFFECTIVE DATE	PROGRAM #	COUNTY #	CASE #	ACCOUNT #

INDUSTRIAL ☐	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF INJURY	INDUSTRIAL CLAIM #
ACCIDENT ☐	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	DATE OF ACCIDENT	NAME OF ATTORNEY

WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? ☐ YES ☐ NO	IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.)	DATE X-RAYS TAKEN
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER.		

REFERRED BY	STREET ADDRESS, CITY, STATE	ZIP CODE	PHONE #

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____ HIC Number _____

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to _____ for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or is intermediaries to carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Acknowledgment of Receipt of Privacy Notice - I have been presented with a copy of this provider's Notice of Privacy Policies, detailing how my information my be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and, subject to the following restriction(s) concerning my personal medical information, I agree to the disclosures named in the Notice; _____.

Signature _____ Date _____

NEW PATIENT INFORMATION

SAMUEL D. SCHENKER, M.D.
NEUROLOGIST
DIPLOMATE AMERICAN ACADEMY OF PAIN MANAGEMENT
SPECIALIZING IN MEDICAL AND INTERVENTIONAL NEUROLOGY
437 LAKEHURST ROAD
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MEDICAL HISTORY

Medical history is an essential tool for diagnosing and treating your condition(s). Some of the below questions may seem unrelated. However, every question is important and every detail matters. Please fill out the form completely and return to the front desk. Thank you.

NAME: _____ DATE OF BIRTH: _____
TODAY'S DATE: _____ SOCIAL SECURITY #: _____
REASON FOR TODAY'S VISIT: _____
DATE OF ONSET OF SYMPTOMS: _____
REFERRED TO DR. SCHENKER BY: _____
NAME OF YOUR MEDICAL DOCTOR: _____

INJURIES RELATED TO ACCIDENTS

AUTO: _____ PEDESTRIAN: _____ FALL: _____
DATE OF ACCIDENT: _____ LOSS OF CONSCIOUSNESS: _____
IF AUTO: DRIVER: _____ OR PASSENGER: _____
VEHICLE HIT FROM: FRONT _____ BACK: _____
SIDE: LEFT: _____ RIGHT: _____
ADDITIONAL DETAILS: _____
_____

WHICH PARTS OF YOUR BODY WERE INJURED IN THE ACCIDENT?

HEAD__ NECK __ CHEST __ SHOULDERS __ BACK ___ ARMS ___HANDS___ LEGS __ FEET___
DID YOU GO TO THE HOSPITAL? YES ____ NO_____
ADMISS ON DATE: _____ DISCHARGE DATE: _____
NAME OF HOSPITAL: _____
TESTS PERFORMED: X-RAYS: _____ CT SCAN: _____
RESULTS: X-RAYS:_____ CT SCAN: _____

SYMPTOMS

Please fill in the blanks with a number from 1 to 10 in the appropriate frequency box:
1 being mild pain and 10 being very severe pain.

		DAILY	WEEKLY	MONTHLY
HEADACHES:	BACK OF HEAD	_____	_____	_____
	TOP OF HEAD	_____	_____	_____
	FOREHEAD	_____	_____	_____
	AROUND THE EYES	_____	_____	_____
BLURRED VISION		_____	_____	_____
DIZZINESS / LIGHTHEADEDNESS		_____	_____	_____
RINGING IN EARS		_____	_____	_____
NECK PAIN		_____	_____	_____
SINUS PROBLEMS		_____	_____	_____
BACKACHES:	UPPER BACK	_____	_____	_____
	MIDDLE BACK	_____	_____	_____
	LOWER BACK	_____	_____	_____

PLEASE FILL IN BELOW WITH (R) FOR RIGHT, (L) FOR LEFT OR (B) FOR BOTH SIDES.

	ARMS	HANDS	FINGERS	LEGS	FEET	TOES
NUMBNESS:	_____	_____	_____	_____	_____	_____
TINGLING:	_____	_____	_____	_____	_____	_____
PINS / NEEDLES:	_____	_____	_____	_____	_____	_____

DOES YOUR PAIN RADIATE TO ANY OTHER AREA? YES ____ NO ____
IF YES, DOES IT RADIATE TO THE: BUTTOCKS ____ THIGHS ____ NECK _____ CALVES ____
FEET ____ SHOULDERS ____ ARMS ____ OTHER ____

HAVE YOU BEEN TREATED FOR THESE SYMPTOMS BY ANY OTHER DOCTORS AND/OR CHIROPRACTORS? YES _____ NO _____

PREVIOUS TESTS PERFORMED: X-RAYS _____ CT SCANS _____ MRI _____

MYELOGRAM _____ EMG _____ OTHER _____

WHEN? _____ WHERE? _____

CHECK BELOW ONLY THOSE SYMPTOMS THAT APPLY TO YOU:

_____ ARE YOU UNDER STRESS?

_____ DO YOU HAVE DIFFICULTY THINKING?

_____ DO YOU HAVE DIFFICULTY REMEMBERING?

_____ DO YOU HAVE FATIGUE?

_____ DO YOU HAVE CHANGE IN PERSONALITY?

_____ DO YOU HAVE FAINTING EPISODES? IF SO, HOW MANY? _____

_____ DO YOU HAVE DIFFICULTY WALKING?

_____ DO YOU HAVE DEPRESSION?

_____ DO YOU HAVE DIFFICULTY SLEEPING?

_____ OTHER DIFFICULTIES, PLEASE LIST: _____

PAST MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

_____ HEART PROBLEMS

_____ KIDNEY PROBLEMS

_____ CANCER

_____ DIABETES

_____ HIGH BLOOD PRESSURE

_____ MULTIPLE SCLEROSIS

_____ ANEMIA

_____ ASTHMA

_____ OSTEOARTHRITIS

_____ STROKE

_____ SEIZURES

_____ ENDOCRINE PROBLEMS

_____ THYROID CONDITION

_____ PACEMAKER INSERTION

_____ NERVOUS DISORDERS

_____ ULCER

_____ DIGESTIVE PROBLEMS

_____ MIGRAINES

OTHER _____

PREVIOUS ACCIDENTS _____

FEMALES: ARE YOU PRESENTLY PREGNANT? YES _____ NO _____

ARE YOU PRESENTLY TAKING BIRTH CONTROL PILLS? YES _____ NO _____

SOCIAL HISTORY

HOW MAY CUPS OF COFFEE DO YOU DRINK PER DAY? _____ TEA _____

DO YOU SMOKE TOBACCO? NO_____ YES _____ IF YES, HOW MUCH _____

DO YOU DRINK ALCOHOL? DAILY_____ OCCASIONALLY_____ RARELY _____ NEVER _____

MEDICATIONS

ARE YOU PRESENTLY TAKING ANY OF THESE TYPES OF MEDICATIONS?
IF SO, PLEASE FILL IN THE NAME OF THE DRUG AND THE DOSAGE (IF KNOWN).

SEDATIVES: _____ ASPIRIN: _____

ANTIBIOTICS: _____ MUSCLE RELAXANTS: _____

BLOOD PRESSURE PILLS: _____

HEART MEDICATIONS: _____

OTHER: _____

DRUG ALLERGIES: _____

FAMILY HISTORY

PERTINENT FAMILY HISTORY: _____

_____

EMPLOYMENT

ARE YOU PRESENTLY: RETIRED_____ DISABLED _____ WORKING _____

LAST DATE WORKED: _____

IF DISABLED, IS THIS RELATED TO:

WORKMAN'S COMPENSATION_____ AUTO ACCIDENT _____

THANK YOU VERY MUCH FOR COMPLETING THIS INFORMATION.
IT WILL HELP DR. SCHENKER IN THE TREATMENT OF YOUR PROBLEM.

DOC: MEDHISTORY

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FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (TPO)

I, _____ understand that as part of my healthcare, the Pain Institute of Central Jersey originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among health care professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested, but if it does, it is bound by this agreement. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

With this consent, Pain Institute of Central Jersey may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others. Any materials sent to my home other than regular billing statements, will be marked Personal and Confidential.

By signing this agreement I am consenting to the Pain Institute of Central Jersey to use and disclose my PHI to carry out my TPO.

Patient Name: _____

Patient Signature: _____

Date: _____

DOC: PHITPO

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ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE/NON-COVERED SERVICES

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless our staff has approved payment arrangements in advance or if we are a participating provider with your insurance carrier. It is your responsibility to know whether we are in your policy. We accept cash, checks, Visa and MasterCard. We will be happy to help you process your insurance claim form for your reimbursement. We accept assignment of most insurance benefits, provided your yearly deductible has been met.

Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month. There will be a $50.00 charge for broken appointments and canceled appointments if you have not given this office at least 24 hours advance notification. You will be charged $25.00 for returned checks.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the inforn1ation on this sheet, and I understand the information presented to me. I agree to comply with your office policy, and I will notify you of any changes in my status.

Name: _____

Signature of Patient or Parent (if minor): _____

Date: _____

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NON-COVERED SERVICES

I am aware that my insurance company may not cover the entire payment for the service that I am about to receive today. I take full financial responsibility for any uncovered fees and guarantee payment to Dr. Samuel D. Schenker for any unpaid balances, whether they be partial or full. I am also aware that there will be a 1.5% monthly interest charge added on to any unpaid balances past 60 days.

Name: _____

Signature of Patient or Parent (if minor): _____

Date: _____

DOC: NONCOVEREDSERVICES

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CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Pain Institute of Central Jersey & Neurology or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to- day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Pain Institute of Central Jersey & Neurology may or may not agree to restrict the use of disclosure of your protected health information.

If **Pain Institute of Central Jersey & Neurology** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent **in writing.** Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Pain Institute of Central Jersey & Neurology reserves the right to modify the privacy practices outlined in the notice.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PAGE TWO)

Signature

I have reviewed this consent form and give my permission to **Pain Institute of Central Jersey & Neurology** to use and disclose my health information in accordance with it.

Name of Patient (Print) _____

Signature of Patient _____

Date _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____

CONTROLLED SUBSTANCE REFILL PROGRAM: PATIENT AGREEMENT FORM

Treatment Agreement for Chronic Opioids

We want to ensure that patients and caregivers have clear communication and safe, effective procedures when patients use opioids.

EFFECTIVENESS: For most patients and pain conditions, opioids are effective pain-relieving medications. However, it is possible opioids will not work well for you and your pain.

SAFETY: Most people can take these drugs safely, but some people do experience side effects. (See below.)

SIDE EFFECTS: Most patients do not have serious side effects or drug interactions. Unfortunately, some do experience side effects and must stop the medication(s). Common side effects include constipation, itching, nausea, vomiting, sedation or lightheadedness. Uncommon reactions include swelling in the legs, water on the lungs, trouble breathing (especially if you have emphysema/COPD or are on other narcotics), mental slowing and loss of coordination, lowering of sex drive, decreased testosterone (male sex hormone) and addiction. Note: Pregnant women using opioids could make their newborn child dependent upon opioids. If you are pregnant, you need to alert your health care provider.

DEPENDENCE: Dependence is not the same as addiction. Many people who take opioids daily will become dependent on them. Dependence is when your body adapts to the medication and then experiences withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include moodiness, aches and pains, sweating, diarrhea, abdominal pain and even seizures.

ADDICTION: Addiction is not the same as dependence. While many people become dependent on daily opioids, only a small percentage of these people will become addicted. Addiction is characterized by behaviors such as loss of control of drug use, compulsive use and craving, and continued use despite harm or risk to the person. When people are addicted, they are not taking opioids simply to treat the pain.

GOALS: The goals of chronic pain management are to:

1. Improve your ability to function in your daily life,
2. Lower your pain.

TREATMENT OPTIONS :

1. Medications,
2. Counseling, relaxation training, hypnosis and meditation,
3. Chiropractic care, massage, acupuncture and physical therapy,
4. Surgery and injections.

WHAT YOU NEED TO DO :

1. Realize that opioid therapy is only one part of treatment.
2. Remain active every day and try to increase activity a little bit at a time.
3. Use your medications ONLY as directed by your provider.
4. Work with your provider and follow treatment recommendations in addition to taking prescribed medications.

Dr. _____ and staff have explained the risks and benefits of chronic opioid therapy for my pain.

I, _____, understand that I must comply with the following rules or I will not be given opioids.

I will fill the prescription at one and only one pharmacy.

Pharmacy name _____ Phone _____

I will take the medication, _____, as it was prescribed and only in that way.

continued ➤

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PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE ACKNOWLEDGMENT AND PROMISE

I,_____(print full name), acknowledge and understand that even with the exercise of good medical care, a physician cannot always assure the successful treatment and resolution of my medical problems. Therefore, I understand it is important that any and all recommendations by my physician are followed promptly and completely in order to increase the likelihood of a positive and healthy treatment/outcome.

I acknowledge and understand that if my physician prescribes medicine, it is my sole responsibility to fill the prescription promptly and to take the medicine as directed to completion.

I also understand that if my physician refers me to see another doctor or for a test, such as a blood test, an MRI, a CT scan or other diagnostic study, this recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is my sole responsibility to see the consulting physician or to obtain the recommended test as promptly as possible. I recognize that it is not possible for my physician or his office to follow up to ensure that I have followed his recommendations. Therefore, I understand that if I fail to promptly see the recommended specialist or obtain the testing for which I was referred, this may compromise my current health or increase future health risks as the result of the failure to follow the advice of my doctors.

Signature of Patient or Guardian _____ Date _____