OFFICE USE ONLY
☐ New PT
☐ Yearly Check

PATIENT REGISTRATION

LAST NAME: _____ FIRST NAME: _____ MI:____

DATE OF BIRTH: ____ _____ _____ (mm/dd/yyyy) SEX:_____SOCIAL SECURITY #:_____

ADDRESS:_____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EXT:_____ EMAIL:_____

PRIMARY CONTACT METHOD: HOME CELL WORK EMAIL

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED☐ DOMESTIC PARTNER

Please circle one:

RACE: AMERICAN, INDIAN OR ALASKA NATIVE, ASIAN, BLACK OR AFRICAN AMERICAN, HISPANIC OR LATINO, NATIVE HAWAIIAN OR PACIFIC ISLANDER, WHITE, DECLINE TO ANSWER
Please circle one:

ETHNICITY: HISPANIC OR LATINO, NOT HISPANIC OR LATINO, DECLINE TO ANSWER

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME:_____ CONTACT LAST NAME:_____

CONTACT PHONE #:_____ RELATIONSHIP TO PATIENT:_____

PRIMARY CARE PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME:_____

Address: _____Phone: _____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHARMACY PHONE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

DO YOU HAVE AN ADVANCED DIRECTIVE? YES ☐ **NO** ☐ If yes, where is it filed:_____

IS THIS AN ACCIDENT? DATE OF INJURY IS THIS WORKER'S COMP OR AUTO RELATED

☐ YES ☐ NO _____ _____

Who Referred you? ☐ Physician ☐ Family ☐ Friend ☐ Phone Book ☐ Insurance Co. ☐ Other

_____

Patient Name: _____ Date of Birth: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: _____ **Date:** _____

EMG CANCELLATION/NO SHOW POLICY

We require a minimum 48 prior hour notice for EMG cancellations* (inclement weather or other extenuating circumstances will be granted on an individual basis). There will be a fee for all cancellations with less than 48 hours' notice.

If you do not show-up for your appointment you will be assessed a $75 fee for the first time and the full visit fee for subsequent no-shows.

Please understand that many times we have patients in pain waiting for treatment,
in order to preserve our ability to see these emergency patients without a protracted wait, we will need to ask all patients to give us notice if they need to change their appointment schedule in advance. Thank you for your understanding.

PLEASE BE AWARE IF AUTO OR WORKMANS COMP IS YOUR PRIMARY INSURANCE THIS TEST NEEDS TO BE APPROVED AND YOU WILL BE CONTACT ONCE APPROVED.

Patient's Printed Name: _____

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

☐ Information has been entered on patient portal

ARE YOU TAKING ANY KIND OF MEDICATION NOW? ☐ No ☐ Yes If yes, please list below.

Medication Name	Dosage

☐ Information has been entered on patient portal

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ No ☐ Yes If yes please list below.

Medication Name	Type of Reaction

FAMILY HISTORY

Mother ☐ Alive ☐ Deceased

Father ☐ Alive ☐ Deceased

Anemia	☐ Father	☐ Mother	**Epilepsy**	☐ Father	☐ Mother
Anxiety	☐ Father	☐ Mother	**GERD**	☐ Father	☐ Mother
Arthritis	☐ Father	☐ Mother	**Glaucoma**	☐ Father	☐ Mother
Asthma	☐ Father	☐ Mother	**Gout**	☐ Father	☐ Mother
BPH	☐ Father	☐ Mother	**HIV/Aids**	☐ Father	☐ Mother
Back Problem	☐ Father	☐ Mother	**Headache**	☐ Father	☐ Mother
Breast Cancer	☐ Father	☐ Mother	**Hepatitis**	☐ Father	☐ Mother
CAD	☐ Father	☐ Mother	**Hypertension**	☐ Father	☐ Mother
CHF	☐ Father	☐ Mother	**MI**	☐ Father	☐ Mother
COPD	☐ Father	☐ Mother	**Migraine**	☐ Father	☐ Mother
Cancer	☐ Father	☐ Mother	**Pneumonia**	☐ Father	☐ Mother
Cholesterol High	☐ Father	☐ Mother	**Renal Stone**	☐ Father	☐ Mother
Dementia	☐ Father	☐ Mother	**Stroke**	☐ Father	☐ Mother
Depression	☐ Father	☐ Mother	**TB**	☐ Father	☐ Mother
Dermatitis	☐ Father	☐ Mother	**Thyroid Dz**	☐ Father	☐ Mother
Diabetes	☐ Father	☐ Mother	**Ulcer (GI)**	☐ Father	☐ Mother

Patient Name: _____ **Date of Birth:** _____

NON-MEDICATION ALLERGIES **NO KNOWN ALLERGIES**

Are you allergic to any food: Specify: _____Type of Reaction: _____

Do you have any non-food allergies such as latex, tape, metal? ☐ No ☐ Yes

If yes, specify: _____Type of Reaction: _____

Are you allergic to contrast dye? ☐ No ☐ Yes Iodine/Betadine? ☐ No ☐ Yes

IMMUNIZATIONS

☐ Information has been entered on patient portal

Are all your immunizations current? ☐ No ☐ Yes ☐ Don't Know

PAST MEDICAL HISTORY – Problems you have been ***diagnosed with***:

Do you have a pacemaker: ☐ No ☐ Yes

Anemia	☐ No ☐ Yes	**Glaucoma**	☐ No ☐ Yes
Anxiety	☐ No ☐ Yes	**Gout**	☐ No ☐ Yes
Arthritis	☐ No ☐ Yes	**HIV/Aids**	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	**Headache**	☐ No ☐ Yes
Back Problem	☐ No ☐ Yes	**Hepatitis**	☐ No ☐ Yes Type:_____
CAD	☐ No ☐ Yes	**Hypertension**	☐ No ☐ Yes
CHF	☐ No ☐ Yes	**MI**	☐ No ☐ Yes
COPD	☐ No ☐ Yes	**Migraine**	☐ No ☐ Yes
Cancer	☐ No ☐ Yes Type:_____	**Pneumonia**	☐ No ☐ Yes
Cholesterol High	☐ No ☐ Yes	**Renal Stone**	☐ No ☐ Yes
Dementia	☐ No ☐ Yes	**Stroke**	☐ No ☐ Yes
Depression	☐ No ☐ Yes	**TB**	☐ No ☐ Yes
Dermatitis	☐ No ☐ Yes	**Thyroid Disease**	☐ No ☐ Yes
Epilepsy	☐ No ☐ Yes	**Ulcer (GI)**	☐ No ☐ Yes
GERD	☐ No ☐ Yes		

Other: _____

SOCIAL HISTORY

Tobacco Use: ☐ None ☐ Cigarette ☐ Cigars ☐ Pipe ☐ Chewing or Dipping

_____ Packs per day. How long have you been smoking? _____

Alcohol Use: Please Circle all that apply BEER WINE HARD LIQUOR?

☐ None ☐ Social ☐ Occasional ☐ Light ☐ Heavily

Patient Name: _____ Date of Birth: _____

SURGERIES AND HOSPITALIZATIONS

Have you ever had surgery before? ☐ No ☐ Yes If yes, please list all surgeries and approximate dates they occurred:

_____

_____

Have you had any problems with anesthesia (being numbed or put to sleep)? No ☐ Yes ☐

If yes please list what type of problems:

_____

VISIT INFORMATION

Why are you here?

- ☐ Back pain (Upper/Lower) ☐ neck pain ☐ shoulder(s) ☐ knee(s) ☐ foot(feet)
- ☐ other: _____

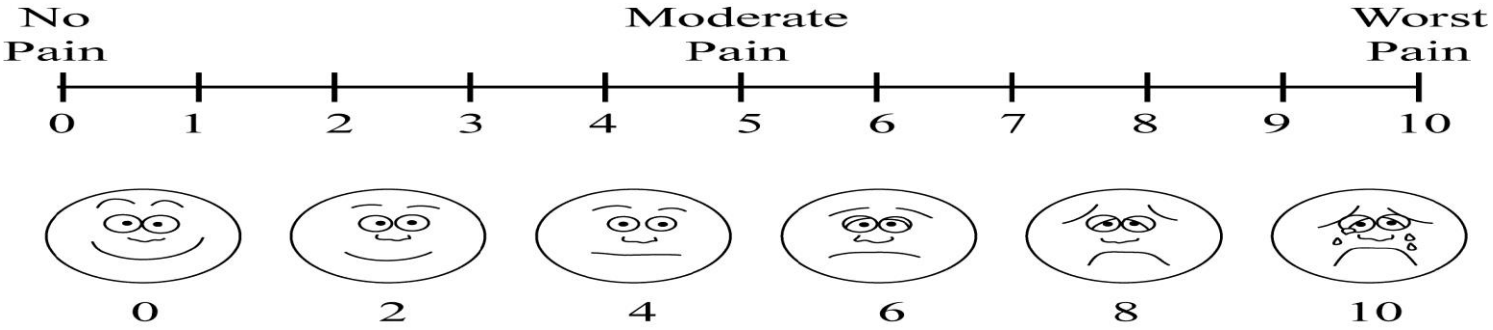
Is this related to an injury or has it progressed over time?

_____

Do you have any numbness, tingling or pain in hands, arms, legs or feet? Right side Left side Bilaterally

_____

What is your pain level?



Did you seek treatment prior to this visit?

_____

Previous treatment for this issue

Physical Therapy Over The Counter Medication Home Exercises Injections Chiropractor
Acupuncture Massage Blood work EKG Stress Testing Echocardiogram

Pain Management: with whom?: _____

Previous Testing within the last year for this issue:

MRI CT SCAN XRAY EMG OTHER_____

Where this testing was completed? _____

PATIENT NAME: _____ **DATE OF BIRTH**: _____

Date: _____

Assignment of Benefits Form

Name of Insured (Print):

_____

Social Security Number:

_____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical records or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, Ani Medical Group and/or Orthopaedic and Spine Institute of NJ, my insurance carrier, or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company, or other entity if requested. The original authorization will be kept of file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in health care coverage.

In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products or services received.

Ani Medical Group

Orthopaedic and Spine Institute of NJ

1 Bethany Rd., Bldg 2

Hazlet, NJ 07730

Name of person signing below (print):

_____

Relationship to Insured:

_____

Signature of Insured or Parent/Guardian:

_____

Ani Medical Group & Orthopedic and Spine

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Home Phone:_____ Cell Phone: _____

Work Phone: _____

I authorize the above Care Center to leave messages with medical information on voicemail/answering machine at: (circle all that apply)

Home Cell Phone Work Re-

strictions/Instructions: _____

There may be times when it is necessary for an individual directly involved in your care to call the office to inquire about your personal health information. Please take a few moments to complete this section.

I authorize Ani Medical Group and/or Orthopaedic and Spine Institute of NJ to disclose my health information that is directly related to my current treatment to the individual(s) listed below for the purpose of their role in my treatment or payment for the health services that I have received.

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name:_____ Relationship: _____ DOB:_____

Name:_____ Relationship: _____ DOB:_____

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name:_____ Relationship: _____ DOB:_____

Name:_____ Relationship: _____ DOB: _____

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office at (care centers address). My revocation will be effective once received by (care center).
2. The information provided under the release may be subject to re-disclosure by the recipient under circumstances no longer protected by HIPAA Privacy Rules.
3. My authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity.
4. A copy of this authorization may be used with the same effectiveness as the original.

This authorization shall supersede any prior written authorization I have made regarding the use, release and disclosure of my medical information. This authorization will expire 2 years from the date it is signed.

_____ _____ _____

Name of Patient DOB Signature Date

OR Authorized representative name:

MEDICATION RELEASE FORM

Ani Medical Group/Orthopaedic and Spine Institute of NJ have a strict policy as to who is able to pick up prescription(s) for any patient. Only person(s) listed on this form will be permitted to pick up a prescription on your behalf. NO MINOR will be permitted release of a prescription(s)

I authorize the following individual(s) to pick up prescriptions on my behalf

Name:_____ Relationship: _____ DOB:_____

Name:_____ Relationship: _____ DOB:_____

Name:_____ Relationship: _____ DOB:_____

Name:_____ Relationship: _____ DOB:_____

Name:_____ Relationship: _____ DOB:_____

Name:_____ Relationship: _____ DOB:_____

**** PLEASE NOTE, ANY PERSON(S) PICKING UP A PRESCRIPTION, INCLUDING PATIENT, MUST HAVE A VALID FORM OF IDENTIFICATION. MEDICATIONS WILL NOT BE RELEASED WITHOUT.****

Patient Signature_____ Date_____