

WELCOME TO OUR OFFICE!

Date of orig				
Brief history	ofhow	injury	occurre	d:
	•			
In order for following in	your ins formatio	urance on to th	claim to e best o	be processed correctly, it is necessary for you to provide the f your ability.
Are you bein	ng treate	ed today	for an	injury resulting from an accident at work?
Circle:	Yes	or	N_O	(This includes driving during work hours)
Are you beir	ng treate	d today	for an	injury resulting from an automobile accident?
Circle:	Yes	or	No.	a martino no n
Are you beir	g treate	d today	for an	injury resulting from a slip and fall outside of your home?
Circle:	Yes	or	No	and any and fair outside of your nome?
Did this hap	pen at h	ome?	Yes or	No If so, where?
Please state	what are	ea of th	e body y	was injured:
Please state	the plac	e in wh	ich the i	injury occurred:
Please state	if you a	re seein	g an atte	orney for this injury:
Did you seel	c emerg	ency tra	eatment	? Yes or No If so, where?
	Ü	, J	- aunioni	res of No II so, where?
If this was a	WC N	/TX7.4	u Cli /E	י אוד
letter. If we pull the payr	approva send thi nent ba	il, for ti s claim ck whe	eatment only to they do	Fall injury, our office needs to bill that insurance first. t from the insurance company and/or a settlement or denial your medical insurance, they may pay the claim first but ther etermine the type of injury was one of the listed above. If this the payment of that bill.
Please print	name: _			
Patient's sig	nature:			
Date:				

CRAIGH. ROSEN, M.D. Orthopedic Surgery

Name:		Date:					
Address:							Age:
SS#						Ja	
PAST MEDICAL HISTO	<u>RY</u> : (Check those that app	oly)				
☐ Hypertension ☐ Heart Disease - Pacemaker - Heart Attack - Stents - Arrhythmia - Valve ☐ Fractures		Diabetes [High Cholesterol [Asthma [Emphysema(COPD) [Pneumonia [Rheumatoid Arthritis Reflux, Peptic Ulcers Phlebitis/DVT/Blood C Cancer			Kidney Disease TB Gout Psoriasis Stroke
PAST SURGICAL HIST			ne				
		•					
MEDICATION ALLER		:					
SOCIAL HISTORY: Drugs: Sports/Hobbies/Night & Last Grade Completed in	Weeke	nd Activities: (time	wit1	ing:packs/day n each)		Alco	hol#/day
Living Situation: With So	meon	e?		Number of	Floors/;	Stairs	3 :
FAMILY HISTORY: A							
HOSPITALIZATIONS	;						
WORK STATUS: Occu	pation	1:		· Cur	rantly, Y	X/orl	ing? Vor on No
Time (and date) Lost Fro	m Wo	rk:					

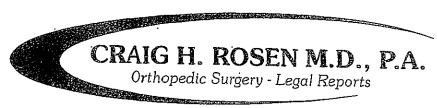
CRAIG H. ROSEN, M.D. Orthopedic Surgery

Name:

	Explain any YES ans	wers	n me sp	ace provided.	Unanswe	red questions are o	onsid	ered a N
	utional Systems				Integume	entary		
	Fever	Y	N		-	Skin Rash	Y	N
	Chills	Y	N			Lesions, Spots		N
	Headaches	Y	N			Persistent Itch		N
	Other					Other	-	11
res			- 		Musculo			
	Blurred Vision	Y	N			oint Pain	Y	N
	Double Vision		N				·Ŷ	N
	Pain, white of eye-Jaundice		N			Back Pain	Ŷ	N
	Other					Other	7	14
lergi	c/Immunologic	* * -				-/Throat/Mouth		
	Hay Fever	Y	N	•		Bar Infection	Y	ኤተ
	Drug Allergies	Y	N			Sore Throat	Y	N
	Drug Allergies Other	•				Sinus Problems		N
<u>irol</u>	ogical .							N
	Tremors	Y	N		Gonitar	Other		
	Dizzy Spells	Ŷ	N		Genitour		~~	~ ~
	Numbness/Tingling		N			Urine Retention	Y	N
	Circle: Upper or Lower	Extre	mities			Painful Urination	Y	N
<u>docr</u>	ine					Urinary Frequency		N
_	Excessive Thirst	Y	N		De' (Other		
	Too Hot/Cold		N		Respirate			
	Tired/Sluggish		N			Wheezing		N
	Other	T	14]	Frequent Cough		N
tro	intestinal					Shortness of Breath		N
	Abdominal Pain	Y	λT			COPD or Asthma	Y	N
	Nausea/Vomiting	Y Y	N			Other		
	Indigestion/Heartburn		N			logical/Lymphatic		
	Other	1	N			Swollen Glands/Necl	c Mass	ΥN
rdio	vascular				•	Blood Clotting Probl	em	ΥN
		**				Other	·	
	Chest Pain	Y	N		Psychia	tric		
	Varicose Veins/Phlebi	tis Y	N			Depression	Y	N
	High Blood Pressure	Υ.	N	•		Anxiety, Agitation	Ÿ	N
	Other Heart Problem		N			Aware of Time, Pers		
	Stents	Y	N			and Place		λī
	Pacemaker/Diffibrillate	or Y	N				1	14
Cor	Pacemaker/Difibrillate	or Y	N	vords or less):		and Place	Y	N
uin S	Scale: Low (0) & High	1 (10)		(0 to 10))	Height		Weight
xam	inee's or Patient's Sig	nature):	·				

PATIENT INFORMATION

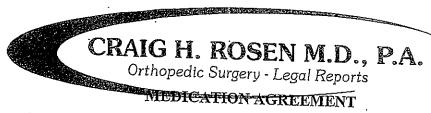
Name:	DOB:	SS#:State:Zip:
Address:	City:	State: Zin:
Home/Cell Phone:	Work Phone:	Driver's License:
Employer:	Occupation:	
Chief Complaint:		Date of Injury:
	INSURANCE INFORMAT	
Incurance Co.		
Address:	ID#	
Name of Insured:	adu.	
Thousand.	55#:	DOB:
	COMPENSATION or MOTOR	
	Workers' Compensation (WC)	
Workers' Compensation Insurar	nce Co	
Claim #:	7. 11	Phone:
Ciaiii #.	Adjuster:	Phone:
WINTOR Vehicle Industry		
Address:		
Phone:	Claim #:	Adjuster:
Are you went - Wed - NO T	Fax:	
- J :: 0211112B: 12D 01 110 Y	vas PIP notified? <i>YES</i> or <i>NO</i> Do yo involved? <i>YES</i> or <i>NO</i> If yes, were t	31 hatte a registered tichiale in NIO VCC
	mivorvour 125 of 1vO 11 yes, were t	ney at fault? YES or NO
	EMERGENCY INFORMA	ATION
Emergency Contact:	Ph	000
Relationship to Patient:		one:
<u></u> -		
PRIMARY	CARE PHYSICIAN and/or RE	FERRING PHYSICIAN
Name of Physician		
Address:	P1	none:
		ione:
	RELEASE & ASSIGNM	
Y 4 .		
I authorize and request paymer	nt of medical benefits directly to CR	AIGH. ROSEN, M.D., P.A I understand that
r arri rimanoranta responsible 10.	I all changes rendered for services r	provided to mo including the nomeicing
ourarroo arror bossinie memano	© Denemits. I authorize release of an	y medical information necessary in the
processing of the claim and se	curing authorization for treatment.	
	•	
Patient Signature:		75.
and the second s		Date:
Guarantor Signature:		Data
		Date:



PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):						
	Home telephone	. 🗆	Written communication			
	Cell		OK to mail to my home address			
	OK to leave a message with detailed information		OK to mail to my work/office			
	Leave a message with call-back number only		OK to fax to this number			
	Work telephone		Verbal via phone with verification			
	OK to leave a message with detailed information		Other			
	Leave a message with call-back number only					
☐ Guardian (insurance through guardian)						
Pat	ient Signature:		Date:			
Pri	nt Name:		DOB:			
The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.						



- 1. I will not share, sell or trade my medication for money, goods or services.
- 2. I will not attempt to get pain medications from any other health care provider. I must inform any other health care provider that I am taking pain medication. I understand that it is against the law to obtain pain medication from anyone else.
- 3. I will take the medication exactly as prescribed.
- 4. Replacements may not be given due to loss, theft, fire or any other reason.
- 5. I will keep all scheduled appointments with this office and any other specialist involved in my pain management care.
- 6. If I am a female of childbearing years, I will use appropriate measures to prevent pregnancy during the course of treatment and I will notify this office immediately should I become pregnant.

7. I will use only one pharmacy to fill my medicati	ions
Pharmacy:	Phone:
Address:	I HOHO.
8. I agree to waive any applicable privilege or right	4-6

- . 8. I agree to waive any applicable privilege or right of privacy or confidentially with respect to the prescribing of my pain medications.
 - 9. I agree to allow the doctor to communicate with my health care providers, i.e. referring physicians, pharmacist, regarding my usage of narcotics.
 - 10. I will follow the advice of the doctor in regards to the cessation of controlled substances if it is felt that this will be necessary.
 - 11. I understand that this treatment may be discontinued if any of the following occur:
 - If the doctor feels that the narcotics have not been effectively managing your pain
 - If I give away, sell or misuse the drug(s)
 - If I develop a tolerance or loss of effect from the narcotics
 - If the side effects become intolerable
 - If I obtain narcotics from any source other than this doctor

I have read this document. I understand it, and all questions have been satisfactorily answered. I consent to all the terms and conditions stated. I acknowledge that failure to abide by the terms of this agreement will result in termination of the doctor/patient relationship and I may be discharged from the practice.

•	•
Patient Signature:	
	Date:
Print Name:	Date.
Provider Signature:	