PATIENT INTAKE FORM

Confidential Patient Case History

HealthBridge of Red Bank
211 Broad Street, Suite 101 Red Bank, NJ 07701

Name: _____ (M/F) Nickname? _____

Social Security #: _____

Address _____Apt #_____City_____ State_____ Zip_____

Cell #:_____ Carrier (for texts instead of emails/calls) _____

Work Phone #: _____ Home Phone #: _____

Email Address: _____ DOB: _____

Marital Status: S M P D W Spouse's Name: _____ Number of Children: _____

Contact person in case of emergency contact: _____ Phone:_____

How did you hear about our office? Insurance Company_____ ZocDoc_____ Yelp_____
Google_____ Sandwich Board _____
Name of Referral _____ Other_____

Occupation: _____ Employer: _____Employer Address: _____

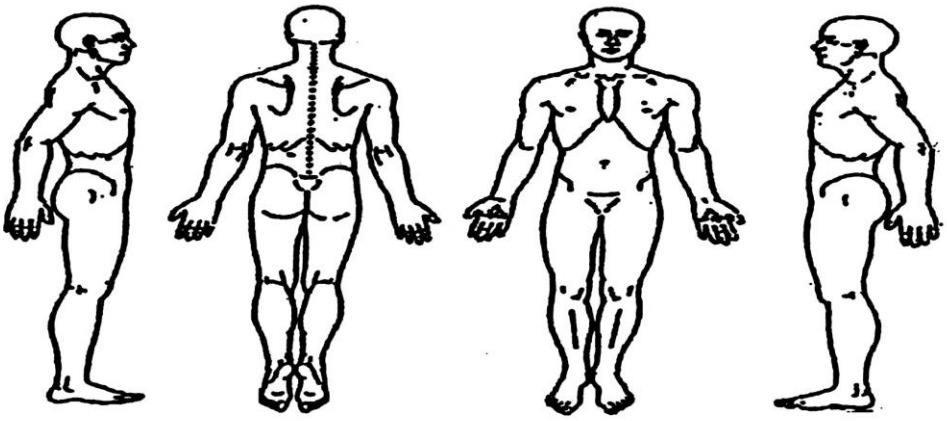
Primary Care Physician: _____ Primary Care Phone #: _____

MAIN COMPLAINT: _____ LEFT/RIGHT

OTHER COMPLAINTS: _____LEFT/RIGHT

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?
□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?
_____

12. Do you consider this problem to be severe?
□ Yes □ Yes, at times □ No

13. What aggravates your problem?
_____

14. What concerns you the most about your problem; what does it prevent you from doing?
_____

15. What is your: Height_____ Weight _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. Do you currently suffer from any of the conditions below? Please check all that apply.

☐ Headaches	☐ Wrist Pain	☐ Chest Pains
☐ Neck Pain	☐ Hand Pain	☐ Muscular Incoordination
☐ Upper Back Pain	☐ Hip Pain	☐ Visual Disturbances
☐ Mid Back Pain	☐ Upper Leg Pain	☐ Dizziness
☐ Low Back Pain	☐ Knee Pain	☐ Smoking/Tobacco Use
☐ Shoulder Pain	☐ Arthritis	☐ Other:_____
☐ Elbow/Upper Arm Pain	☐ High Blood Pressure	_____

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

Assignment/Direct Payment to Doctor
Private/Group Accident and Health Insurance

Patient: _____

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

Do you have a health savings (if yes circle one)?
FSH Flex Spending HRA HSA

I hereby instruct and direct my insurance company to pay the following provider direct payment for services rendered:

HealthBridge of Red Bank
211 Broad Street, Suite 101
Red Bank, NJ 07701

If policy provisions prohibit direct payment to physician, I hereby request payment for services rendered per current policy provisions. Payment is for the profession or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward charges for profession services rendered.

THIS IS DIRECT ASSIGGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.

This payment will not exceed any indebtedness to the above mentioned assignee and have agreed to pay, in current manner, any balance of said professional services charges over and above this insurance payment. A photocopy of this Assignment of Rights and Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated: _____ _____
Signature of Policy Holder

Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for HealthBridge of Red Bank to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

HealthBridge of Red Bank Notice of privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. HealthBridge of Red reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HealthBridge of Red at 211 Broad Street Suite 101 Red Bank, NJ 07701.

With this consent, HealthBridge of Red Bank may call my home or other alternative 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 calls pertaining to my clinical care, including laboratory results among others.

With this consent, HealthBridge of Red Bank may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, HealthBridge of Red Bank may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that HealthBridge of Red Bank restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to HealthBridge of Red Bank use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I don not sign this consent, or later revoke it, HealthBridge of Red Bank may decline to provide treatment to me.

_____ _____

Patient's Name Date

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian