

Name: _____
 Chart #: _____
 Date: _____



I N T E R N E T

Neil B. Kirschen, M.D.
 Steven M. Shoum, M.D.
 Michael Luvin, M.D.
 Robert Iadevaio, M.D.
 Jacob J. Rauchwerger, M.D.

PATIENT DEMOGRAPHIC

Patricia Kirschen, L.Ac.
 Candra Snyder, ANP
 Nichole Lopez, FNP

Do you have an Advance Directive
 YES NO
 If yes, is it on file with us.
 YES NO

Is this related to: **Motor Vehicle Accident?** YES NO
Work Related Accident? YES NO
If YES, Please ask for additional required form

Patient Last Name		First Name		MI	Date of Birth	Age	Sex M F	
Patient Address			City	State	Zip Code	Social Security #		
Marital Status	Race	Religion		Ethnicity		Country of Birth		
Mother's Maiden Name		Father's First Name		Patient Telephone #		Cell Phone#		
Emergency Contact		Relationship	Telephone #		Primary Language Spoken			
Policy Holder Employer Name			Employer Telephone #		Employer Address			
Patient's Retirement Date		Disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO		Retired? <input type="checkbox"/> YES <input type="checkbox"/> NO		Referred to us by:		
Primary Reason(s) for Visit				Family Doctor		Telephone #		
1st Insurance		Policy #		Group #	Policy Holder Date of Birth			
Policy Holder Name		Relationship to Pt.		Insurance Billing Address				
2nd Insurance		Policy #		Group #	Policy Holder Date of Birth			
Policy Holder Name		Relationship to Pt.		Insurance Billing Address				
3rd Insurance		Policy #		Group #	Policy Holder Date of Birth			
Policy Holder Name		Relationship to Pt.		Insurance Billing Address				
PLEASE HAVE PHOTO I.D. AND ALL INSURANCE CARDS AVAILABLE								

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Comprehensive Pain Evaluation and History

Date (Fecha): _____

Height (Altura) _____ Weight (Peso) _____ lbs Age (Edad) _____ Right handed or left handed? _____

- ☉ What is the complaint which you are seeking help for? (Cual es su dolor?)

- ☉ Is the pain related to an injury, accident, cancer, surgery, or other disease? (Es relacionado a un tipo de accidente, cancer, cirugia o enfermedad?)

- ☉ When did the pain begin? How long has it been present? (Cuando empezo su dolor y cuanto tiempo lo tiene?)

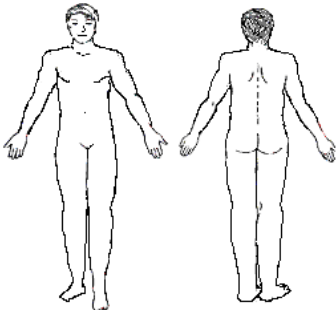
- ☉ Since it began how has the quality changed? e.g. Increased, decreased, unchanged. (Como ha cambiado su dolor? Tiene mas, menos, sin cambios desde el inicio del dolor)

- ☉ How often does the pain occur? **Circle ONE** (Con que frecuencia le ocurre su dolor? Marque Uno
Nonstop-continuous, Several times a day, Once a day several times a week (Seguido y constante,
Several times a month, Other _____ Varias veces por mes o por semana)

- ☉ **For the following please use 0-10** (Del # 0 al 10, con diez siendo el dolor mas grave anote como le afecta su dolor?)
0 = no pain disruption, 10 worst pain imaginable extremely disruptive

Pain at its worse ever? Maximo Dolor _____	Effect on work/school? Efecto en el trabajo/escolar _____
Pain at its best ever? Minimo Dolor _____	Effect on household chores? Efecto en obras de domicilio _____
Pain currently worst? Dolor Ahorra _____	Effect on social/family interactions? Efecto en familia _____
Pain currently best? _____	Effect on leisure activity? Efecto en actividades de recreo _____
Pain currently most of the time? _____	Effect on sexual activity? Efecto en actividad sexual _____

☉ Please shade in the affected areas (Marque las areas de su dolor)



☉ Which characteristics describe your pain? **Circle all that apply.** (Marque las descripciones de su dolor)

Denote how often? (Always, Often, Rarely for each circled)

Throbbing (Palpitante)	Gnawing	Tight (Apretado)	Punishing/cruel (Castigado/Cruel)
Shooting	Hot-burning (Arde)	Squeezing	Pins/needles (Sentir como agujas)
Stabbing (Apuñalado)	Aching (Agotado)	Splitting	Numb (Entumecido)
Sharp (Agudo)	Heavy (Pesado)	Tiring/Exhausting (Cansado)	Fearful (Miedoso)
Cramping (Calambres)	Tender (Tierno)	Sickening (Enfermiso)	

☉ What makes the pain better? (Que le alivia su dolor?)

☉ What makes the pain worse? (Que le empeora su dolor?)

☉ What specialist have you seen for the pain? Surgeon, Neurologist, Chiropractor, Physical therapist, psychiatrist?

Que especialistas ha consultado para su dolor? Cirujano, Neurologo, Quiropractico, Terpatia Fisica, Siquiatra?

Date seen Physical therapist (Fechas que tuvo terapia fisica?) _____

Date seen Chiropractor (Fechas que tuvo tratamientos quiropracticos) _____

Date seen Other (Fechas de otros especialistas?) _____

☉ What therapies have you tried for the pain? Circle & write in others. Surgery, nerve blocks, brace, physical therapy, biofeedback, relaxation, TENS, injections, acupuncture, chiropractic, massage, hypnosis, counseling-psychotherapy, heat, ultrasound, etc. (Que terapias le han hecho para su dolor? Marque todas y escriba si no estan listadas: Cirugia, inyecciones, terapia fisica, relajacion, maquina TENS, acupuntura, quiropractico, masajes, ultrasonido)

☉ What medicine do you currently take for your pain? Specify next to each who prescribes them to you and whether: Helps, No-help or Not sure. Include over the counter, herbal and alternative preparations. (Que medicina esta tomando para su dolor? Especifique a lado de cada una si le ayuda. Incluya todas medicinas farmaceuticas y naturales)

☉ What other medication have you taken for pain? Why were they stopped? (Que otras medicinas ha tomado para su dolor? Porque las dejo de tomar?)

☉ Please list **all other medications** you are currently taking. Including over the counter herbal and alternative supplements. (Liste todo tipo de medicamentos que esta tomando incluyendo vitaminas y hierbas naturales)

☉ Please list **all allergies** which you have, including foods. (Anote todo tipo de **ALERGIAS**, incluyendo comidas)

PATIENT NAME: _____

☉ Do you or have you had (check all that apply)

- | | | | |
|--------------------------------------------|--------------------------------------------|------------------------------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart attack (MI) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bipolar disorder | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Urinary retention | <input type="checkbox"/> Liver diseases | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low energy | <input type="checkbox"/> Thyroid disease | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nausea/ Vomiting | <input type="checkbox"/> Arrhythmia (irregular heart beat) | |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easy bruising/ Bleeding | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Excessive thirst | |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Difficulty sleeping | |

☉ Please list all other **medical conditions** you have, or other medical conditions you have, or are under treatment for?
(Liste todas sus condiciones medicas)

☉ Have you ever been diagnosed or treated for Cancer? (Tiene cancer o lo han tenido)
What type(s)? (Que tipo de Cancer?)

What therapies? e.g. Radiation, Surgery, Chemo/Hormonal therapy (Radiacion, Cirugia, Quimoterapia)
When? (Cuando)

☉ Do you or have you used **illicit or un-prescribed drugs? If so, which ones.** (Usted usa drogas ilegales? Cuales)

☉ Do you share drugs? (Comparte sus drogas?)

☉ Do you use **tobacco**? What type? How much/often? (Fuma cigarros? Cuantos?)

☉ How much **alcohol** do you consume in a week? (Cuantas bebidas alcolicas toma semanal?)

☉ Please list all previous **surgeries** and dates? (Anote todas las cirugias y fechas)

☉ What is your current employment status? What type of work do/did you do? (Esta trabajando? Que tipo de trabajo hace?)

☉ Does anyone in your family have a history of chronic pain? Who and what Pain? (Tiene familiares que sufren de dolor cronico? Quienes y que tipos de dolores?)

☉ Does anyone in your family have a history of substance abuse? (Tiene historia familiar de abuso de sustancias en su familia? Alcolismo, drogas?)

☉ Are you involved in any lawsuits ? (Tiene un caso legal ahorra contra alguien?)

☉ How much relief do you expect to obtain? _____% Reduction in my pain. (Que porcentaje de alivio espera? ____%)

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NO FAULT INFORMATION

General Information

Patient's Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Marital Status: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Referring MD: _____

Insurance Information

No-Fault Insurance Carrier: _____ Phone #: _____

Address: _____

Agent: _____

Policy Number (from I.D. card): _____

Claim # or Case # _____

Name and Address of Policy Holder: _____

Was Patient: _____ Driver _____ Passenger _____ Pedestrian

Attorney Name, Address and Telephone Number: _____

Injury Information

Date of Injury: _____ Time: _____

Were X-Rays Taken? Yes or No (Circle one) Where: _____ Date: _____

Briefly Describe the accident and your injury:

Address where accident occurred: _____

Authorization

I authorize Island Medical Pain Management Services to release all records pertaining to medical history, services rendered, or treatment to me or my dependent for insurance claims.

I authorize payment of medical benefits to Island Medical Pain Management Services, PC

I promise as guarantor for the above patient or as the patient to pay for all medical services disputed or denied by my insurance.

Patient Signature: _____ Date: _____

Name: _____
Chart #: _____
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I N T E R N E T

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ ("Assignor") hereby assign to **SOUTH NASSAU COMMUNITIES HOSPITAL** ("Assignee")

All rights privileges and remedies to payment for healthcare services provided by the assignee to which I am entitled under Article 51 (the No-Fault) statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the assignor and shall not pursue payment directly from the Assignor for services provided by said assignee for injuries sustained due to the motor vehicle accident which occurred on _____ not withstanding any other agreement to the contrary. (date of accident)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)

(Patient Address)

(Patient Address)

(Signature of Patient)

(Date of Signature)

**SOUTH NASSAU COMMUNITIES HOSPITAL
ONE HEALTHY WAY
OCEANSIDE, NEW YORK 11572**

(Date of Signature)

Name: _____
Chart #:
Appmnt Date _____

I N T E R N E T

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(Print name of Patient)

(Signature of Patient)

(Patient Address)

(Date of Signature)

(Patient Address)

Island Medical Pain Management Services, PC
77 North Centre Avenue, Suite # 202
Rockville Centre, New York 11570
Phone: 516-764-7246 Fax: 516-678-3525

(Signature of Provider)

(Date of Signature)