Name:
DOB:

Date:

PATIENT DEMOGRAPHIC

NO FAULT

Do you have more than ONE accident? ☐ YES ☐ NO **If YES, STOP and ask for additional required forms**

Patient Last Name	**First Name**	**MI**	**Date of Birth**	**Age**	**Sex**
Patient Address	**City**	**State**	**Zip Code**	**Social Security #**	
Marital Status ☐ S ☐ M ☐ D ☐ W	Primary Language ☐ENGLISH ☐____________	Race ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Unknown ☐ White ☐ Decline Info	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Type Unknown		
Patient Telephone#	Patient Cell Phone #	Patient Work#	Email:		
Emergency Contact	Relationship	Telephone #	Family Doctor Name & Phone:		
Primary Reason for Visit	Referred to us by:	Pharmacy Name and Address:			
NF Insurance Carrier	**Claim #**	**Policy #**	**Date of Injury:**		
Carrier Address	**Was Alcohol Involved?**				
Adjuster Name:	**Phone #**	**Fax #**			
Name of the Insured:	**Relationship to Patient:**	**Any Judgments against the case?**			
Were you driver / passenger / pedestrian?	**Location of Accident:**	**Lawyer:**			
Is the case open?	**How did the accident occur?**				

PLEASE HAVE PHOTO I.D. AVAILABLE. ADDITIONAL CASES, COMPLETE ANOTHER FORM.

We can share information with your:
Spouse:______ **Significant Other:** _______ **Parent:** _______ **Children:** ______**PCP:** _______ **Attorney:** _______ **Other:** _________

☆ I have received a copy of my HIPAA Privacy Policy
☆ In the event that my No Fault Insurance terminates, I agree to have my private insurance billed. Insurance: _________________

Patient Signature: ____

BC6

Name:
DOB:
Chart:
Age:
Date:

Neil B. Kirschen, M.D.
Robert Iadevaio, M.D.
Jacob J. Rauchwerger, M.D.

Patricia Kirschen, L.Ac.
Haydee Pimentel-Tejada FNP

Comprehensive Pain Evaluation and History

Date (Fecha):________ Height: ________ Weight: ________ lbs Blood Pressure: ____ / ____

ALLERGIES: ☐ No Known Drug Allergies

Allergic to: Severity

________ ☐ mild ☐ moderate ☐ severe ☐ anaphylactic
________ ☐ mild ☐ moderate ☐ severe ☐ anaphylactic
________ ☐ mild ☐ moderate ☐ severe ☐ anaphylactic
________ ☐ mild ☐ moderate ☐ severe ☐ anaphylactic
________ ☐ mild ☐ moderate ☐ severe ☐ anaphylactic

Please list all previous **surgeries** and dates: ________

Is there a family history of addiction or chronic pain? (specify) ________

LIFESTYLE (Current Smoking Status:)

☐ Never Smoker
☐ Smoker, Current status unknown
☐ Unknown if ever smoked

☐ Former smoker …………….. Year started smoking _______ #Packs per day _______
☐ Current Every Day Smoker….. Year started smoking _______ #Packs per day _______
☐ Current Some Day Smoker…. Year started smoking _______ #Packs per day _______
☐ Tobacco smoker __Heavy __ Light...Year started smoking ____ # Packs / Day ____

☯ **MEDICAL HISTORY: Do you or have you had: (check all that apply)**

☑

☐ Hypertension	☐ Depression	☐ Kidney disease	☐ Diabetes
☐ Heart attack (MI)	☐ Dizziness	☐ Bipolar disorder	☐ Cancer: ________
☐ Stoke	☐ Urinary retention	☐ Liver diseases	
☐ Glaucoma	☐ Low energy	☐ Thyroid disease	**Mother's Medical History** ☐ No relevant history
☐ Asthma	☐ Nausea/Vomiting	☐ Arrhythmia (irregular heart beat)	________
☐ Migraines	☐ Constipation	☐ Easy bruising/ Bleeding	**Father's Medical History** ☐ No relevant history
☐ Seizures	☐ Diarrhea	☐ Excessive thirst	________
☐ Ulcer	☐ Heart failure	☐ 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)

☯ **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?)

Name:
DOB:
Chart:
Age:
Date:

☯ 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?)

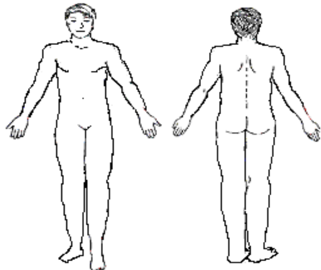
0 = no pain disruption, 10 worst pain imaginable extremely disruptive

Pain at its worse ever? Maximo Dolor ______________ Pain currently worst? Dolor Ahorra ______________

Pain at its best ever? Minimo Dolor ______________ Pain currently best? ______________

Pain currently most of the time? ______________

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



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

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

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

☯ 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? Chiropractor, Neurologist, Orthopedist, Physical Therapist, Surgeon ?
Que especialistas ha consultado para su dolor? Quiropractico, Neurologo, Ortopedista, Terapia Fisica, Cirujano ?

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

Date seen Chiropractor (Fechas que tuvo tratamientos quiropracticos) ______________

Date seen Other (Fechas de otros especialistas?) ______________

Name:
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☯ What therapies have you tried for the pain? Circle & write in others. Surgery , nerve blocks, brace, physical therapy, biofeedback, relaxation, TENS and Heat, injections, acupuncture, chiropractic, massage, hypnosis, 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 hiebras naturales)

☯ 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 o usa usted drogas?)

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

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

☯ 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? _______ %)

Physician Signature **Date**

Name:
DOB:
Chart:
Age:
Date:

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

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

I, ________________________________ ("Assignor") hereby assign to NAPPM/Pain Management Center of Long Island, PC ("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)

____
(Signature of Patient)

____
(Patient Address)

____
(Date of Signature)

____
(Patient Address)

North American Partners in Pain Management, LLP
PO Box 199
Glen Head, NY 11545
Phone: 516-945-3000   Fax: 516-945-3307

____
(Signature of Provider)

____
(Date of Signature)

NYS FORM NF-AOB (Rev 1/2004)