

PATIENT NF DEMOGRAPHIC

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 <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		Primary Language <input type="checkbox"/> ENGLISH <input type="checkbox"/> _____		Race <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Decline Info			Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> 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: _____

ID # _____

Patient Signature: _____

Name:
DOB:
Date:



Comprehensive Pain Evaluation and History - NO FAULT

Date (Fecha): _____ Height: _____ Weight: _____ lbs. Blood Pressure: _____ Right/Left Handed _____

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:** _____

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

LIFESTYLE (Current Smoking Status:)

Never Smoker Current Every Day Smoker..... Year started smoking _____ #Packs per day _____
 Former smoker Current Some Day Smoker..... Year started smoking _____ #Packs per day _____
Year Started _____ Tobacco smoker __Heavy __ Light... Year started smoking _____ # Packs / Day _____
Year Stopped _____

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

- Asthma Depression Peptic Ulcer Disease
- Arrhythmia Diabetes Seizures
- Bipolar Disorder Heart Attack Sleep Apnea
- Blood Disorder Hypertension Stroke
- Cancer: _____ Kidney Disease Thyroid Disease
- Cardiovascular Disease Liver Disease
- Cardiac Stents Migraines

Mother's Medical History No relevant history

Father's Medical History No relevant history

Please list all 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?)

In the car accident you were in, check all that apply:

- Driver Rear-ended Describe accident:
- Passenger Car was idle
- Pedestrian Car was moving

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

Name:
DOB:
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, Several times a month

Seguido y constante, Varias veces diario, Una vez al dia, varias veces semanal, varias veces mensual

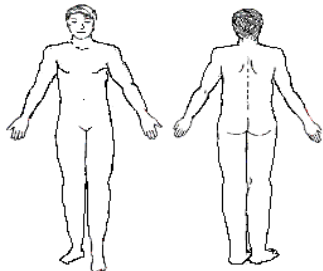
☉ **For the following please use 0-10** (Del # 0 al 10, con diez siendo el dolor mas grave anote como le afecta su dolor?)
0 = no pain disruption, 10 worst pain imaginable extremely disruptive

Pain at its worse ever? Maximo Dolor _____

Pain at its best ever? Minimo Dolor _____

Pain Score today (0 - 10): _____

☉ 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)

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Aching (agotado) | <input type="checkbox"/> Pins/Needles (hormigante) | <input type="checkbox"/> Soreness/Stiff (tierzo) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Burning (arde) | <input type="checkbox"/> Radiates (dolor se extiende) | <input type="checkbox"/> Stabbing (apunalado) | |
| <input type="checkbox"/> Cramping (calambres) | <input type="checkbox"/> Sharp (dolor que pica) | <input type="checkbox"/> Tender (tierno) | |
| <input type="checkbox"/> Dull (dolor leve) | <input type="checkbox"/> Shooting (dolor se dispara) | <input type="checkbox"/> Throbbing (palpitante) | |
| <input type="checkbox"/> Numbness (entumecido) | <input type="checkbox"/> Spasm (calambre) | <input type="checkbox"/> Tingling (dolor hormigante) | |

☉ 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:

DOB:

Date:

☉ 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 deajo 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 sus drogas?)

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

☉ What is your **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?)

Physician Signature

Date

Name:
DOB:

**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 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)