JOZEF M. DEBIEC, MD

NY PAIN AND SPINE
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Date: _____ Last Name: _____ First Name: _____

Social Security: _____ Birth date: _____ Gender: ◯ M ◯ F

Marital Status: ◯ S ◯ M ◯ D ◯ W Sexual Orientation _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Email: _____

Would you like to recive emails for: ◯ Updates ◯ Billing ◯ Promotions

Current Occupation: _____ Employer: _____

Emergency Contact: _____

Relation to patient: _____ Phone: _____ Alt Phone: _____

Insurance Information

Please provide complete detailed information.

Insurance: _____ ID #: _____ Group #: _____ D.O.B.: _____

Effective Date: _____ Policy Holder's Name: _____

2nd Insurarance: _____ ID #: _____ Group #: _____

Effective Date: _____ Policy Holder's Name: _____ D.O.B.: _____

If this is a Worker's Compensation or No Fault claim. Please provide complete detailed information.

Carrier: _____ WCB# _____ Case File: _____

Carrier Address: _____ Date of Accident: _____

Occupation at time of injury: _____ Employer: _____

Employer Address: _____ Phone: _____

Adjuster: _____ Phone: _____ Fax: _____

2nd Insurarance: _____

These forms are to be completed one time by each patient. Although the questionnaire contains personal information, it is vital you answer all questions completely and thoroughly, so the Pain Management Team, can tailor a plan of care for you. Our records are strictly confidential and no unauthorized person is permitted to see your case record without your written permission or consent.

Other - physicians that you are seeing?

Referring Physician: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Ortho/Neurology Physician: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Please describe your pain

What is the problem you would like us to help you with? _____

_____

When, where and how did your pain start? _____

_____

_____

Do you have any of the following? ◯ Numbness ◯ Tingling ◯ Weakness ◯ Bowel/Bladder Dysfunction

What makes the pain worse? _____

What makes your pain feel better? _____

Does this pain interrupt your sleep? ◯ Yes ◯ No

Circle the number that best describes your pain: 0 = None 1-3 = Mild 4-6 = Moderate 7-10 Severe

At its worst: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

At its best: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

On Average: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Does this pain interfere with your daily activities? _____

How often? _____

Studies and Past Pain Treatments

Current Weight: _____ Height: _____

Are you currently talking blood thinners such as aspririn or NSAIDs?_____

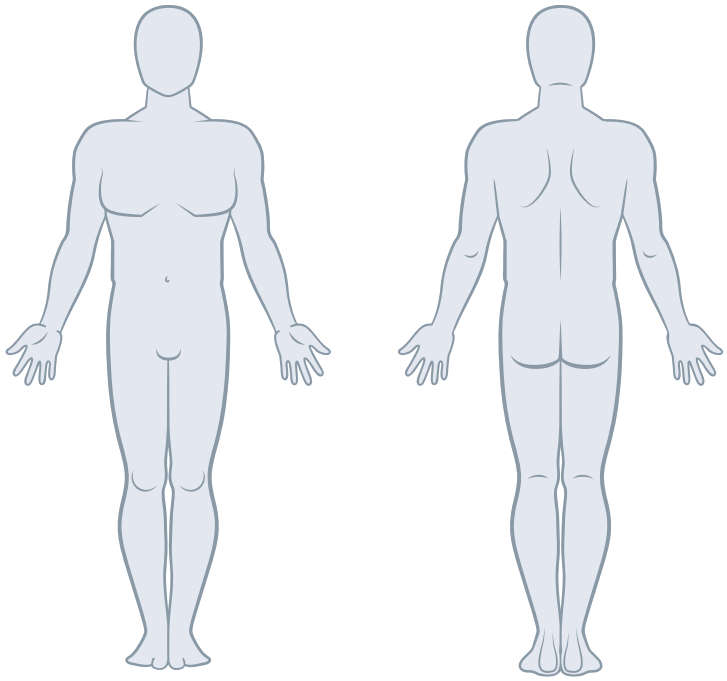
Please check all that apply also list dates and/or results:

PROCEDURE/TREATMENT	DATE	LOCATION OF TREATMENT
Nerve Block/Injections		
Back Surgery		
EMG		
MRI/CT Scan		
Physical Therapy		
Chiropractor		
Acupuncture		
Other		

In the figure provided, please indicate the location and description of your pain by circling the areas and placing a check in the box below which corresponds for the area indicated.

Dominant Hand

- ○ Right Hand
- ○ Left Hand



Throbbing Pounding Tight Unbearable	Jumping Flashing Shooting Numb	Pricking Drilling Stabbing Intense	Sharp Lacerating Crushing Annoying	Pinching Gnawing Cramping
Tugging Wrenching Dull	Hot Burning Searing	Tingling Itchy Stinging	Sore Aching Heavy	Tender Taut Splitting
Cold Cool Freezing	Suffocating Tearing Squeezing	Radiating Penetrating Piercing	Punishing Grueling Tolerable	Wretched Blinding Torturous

Patient Name: _____

Release of Information (all):

I hereby authorize any physician, health care practitioner or other medically related service, to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurer.

I also authorize my health insurer to disclose to a hospital, provider or health care service plan, self insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under Group Contact held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my health insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.

Patient's Signature: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

Medicare Recipients Only:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that provider to me. I authorize any holder of medical information about me to release to the Centers for Meidcare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

Authorization to pay (all):

I request that payment of this claim and if the payer accepts assignment, authorize payment direct to the physician or supplier for the services described.

Patient's Signature: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

Notice of Privacy

Available to you is a copy of Jozef M. Debiec, MD, PLLC Notice of Privacy Practices. Please do not hesitate to request to view the Notice of Privacy Practices. Your name and signature on this cover sheet indicate that you have received and read a copy of Jozef M. Debiec, MD, PLLC Notice of Privacy Practices on the date and time indicated. If you have any questions regarding the information set forth in the Notice of Privacy Practices, please do not hesitate to contact the privacy officer:

Jozef M. Debiec, MD, PLLC
Attention: Privacy Officer
Phone: (914) 681-9089
Fax: (914) 831-3922

Name: _____
Please Print

Signature: _____

Date and Time Notice Received: _____

Other than your Medical Doctors, whom do you allow us to share your information with?

Name: _____
Please Print

Phone: _____

Relationship: _____

Patient Name: _____

Release of Information (all):

List all medications you are currently taking including, non-pain medications:

1. _____ How often _____
2. _____ How often _____
3. _____ How often _____
4. _____ How often _____
5. _____ How often _____
6. _____ How often _____
7. _____ How often _____

ALLERGIES

Do you have allergies to the following:

◯ Insulin ◯ Non-Insulin ◯ Lavender ◯ Shellfish ◯ Eggs ◯ Contrast/CAT scan dye

Do you have any medicinal allergies? ◯ Yes ◯ No

If Yes, list: _____

Endocrine: ◯ Diabetes ◯ Thyroid

Medications for diabetes: _____

Eyes: ◯ Narrow Angle ◯ Glaucoma ◯ Wide Angle

Cardio: ◯ High Pressure ◯ Heart Attack ◯ Valve Problem ◯ Angina

Circulation: ◯ Chronic Edema ◯ Peripheral Vascular Disease

Neurological: ◯ CVA/Stroke ◯ Seizures

Respiratory: ◯ Emphysema ◯ Asthma ◯ COPD

Gastrointestinal: ◯ Ulcers ◯ Heartburn ◯ Acid Reflux ◯ Liver Issues

Genitourinary: ◯ Urinary Issues ◯ Kidney Stones ◯ Erectile Dysfunction

Musculoskeletal: ◯ Arthritis ◯ Joint Replacement

Psychiatric Difficulties: ◯ Depression ◯ Anxiety ◯ Claustrophobia

Hematologic Difficulties: ◯ Low Platelets ◯ Excessive Bleeding ◯ Poor Clotting ◯ Anemia

History of sleep apnea? ◯ Yes ◯ No

OTHER HISTORY

Family history: _____

_____

Social history: ◯ Cigarettes - How often: _____

◯ Alcohol - How often: _____

◯ Drug Use - What type/How Often: _____

Surgical history: _____

_____

_____

_____

Do you have a Pacemaker? ◯ Yes ◯ No

Do you have any metal implants of any kind? ◯ Yes ◯ No

If yes, where? _____

Are you suing anyone because of your pain or injury? ◯ Yes ◯ No

Are you receiving compensation or disability? ◯ Yes ◯ No

Do you have a application for compensation or disability payments pending? ◯ Yes ◯ No

The onset of your pain symptoms were after an injury on the job: ◯ Yes ◯ No

What happened? _____

Job Title: _____ Hours worked per week before injury? _____

Are you still working? ◯ Yes ◯ No

If No, last of work? _____

If Yes, is this the same job as before you were injured? ◯ Yes ◯ No (specify, type of work)

_____

If Yes, are you now working? ◯ Light Duty ◯ Full Duty

_____

If Yes, how many hours per week do you now work?

_____

Is there anything causing stress in your life other than your current pain problem? ◯ Yes ◯ No

If yes, please describe:

_____

OTHER HISTORY

What are you expecting from treatment at the Pain Center? Also, please include any additional information which we should know? _____

_____

Have you ever been treated for Pain Management? ◯ Yes ◯ No

If Yes, List where and when? _____

Was it for your current issue? ◯ Yes ◯ No

If no, what were you treated for? _____

_____

_____

The following questions below are given to all patients who may be taking, or are being considered for opioid treatment for their pain. Please answer each question honestly. This information is for our records and will remain confidential. Your answers alone will not determine treatment. Thank you.

Please answer the questions below using the following scale:

(0) Never (1) Seldom (2) Sometimes (3) Often (4) Very Often

1. Do you have mood swings? ◯0 ◯1 ◯2 ◯3 ◯4
2. Have you ever taken medicine other than the way prescribed? ◯0 ◯1 ◯2 ◯3 ◯4
3. Has your medication ever been lost or stolen? ◯0 ◯1 ◯2 ◯3 ◯4
4. Have others expressed concerns regarding your use of medications? ◯0 ◯1 ◯2 ◯3 ◯4
5. Have you ever had cravings for medications? ◯0 ◯1 ◯2 ◯3 ◯4
6. Have you ever been asked to have a urine screen for drug abuse? ◯0 ◯1 ◯2 ◯3 ◯4
7. Have you used illegal drugs in the past 5 years?

Please list any additional information you feel we need to know in relation to the questions above?

_____

_____

_____

_____