

Rockland SpineCare

1581 Route 202
Pomona, NY 10970

PATIENT INFORMATION

Name: _____ Sex: _____ SS #: _____ Marital Status _____ Age _____

Address): _____ City _____ State _____ Zip _____

DOB _____ Home Tel: _____ Work Tel: _____ Cell Phone: _____

Email Address: _____ Occupation: _____ Primary Physician: _____

Spouse Name: _____ Referred by _____

Employer _____ EmployerAddress _____

MEDICAL HISTORY

What is your major complaint? _____

On a scale of 0-10 (with 0 being none), how severe is your pain: _____ How frequent: _____

Do you experience pain when sleeping? Yes No How about when you wake up in the AM? Yes No

How long have you had this condition? _____ Since your condition began, your symptoms are:
() improving () Worse () Same

What makes your condition worse? _____

How does your condition restrict your activities? (at home and at work) _____

Check symptoms you have experienced since the accident:

- | | | | |
|----------------------------------------|-------------------------------------------------|------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Light sensitive | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head seems heavy | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Constipation | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pain in Arms | <input type="checkbox"/> Pain in Legs |

Symptoms other than above:

Do you notice any activity restrictions as a result of this injury? Yes No If yes, please describe:

Other Doctors seen and Previous Treatments: _____

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List any surgical procedures you have had and when: _____

List any Medications that you are currently taking: _____

Have you had a CT scan? Yes No MRI? Yes No EMG? Yes No Other: _____
For Females: Are you pregnant or is there a chance you are pregnant? Yes No

INSURANCE INFORMATION

Is your Condition due to a reported On-The-Job injury? ____ Due to an Auto Accident? ____

Name of Insurance Company: _____ Address _____

Insured's Name _____ Patient's Relationship to Insured _____

Insured's Sex ____ Insured's DOB _____ Insured's ID # _____ Group # _____

Insured's Employer _____ Address _____

Employer Telephone: _____

Authorization and Assignment:

I hereby authorize that payment from the insurance company(s) direct benefits for services go directly to:
Rockland SpineCare
Pacesetter Park Rt. 202
Pomona, N.Y. 10970

This is a direct assignment of my rights and benefits under my policy. I have agreed to pay in full or regular installments any balance of said professional services/charges over and above the insurance payments.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself and agree that payment of all services rendered to me are my personal responsibility. Rockland SpineCare, as a courtesy, has agreed to wait for the insurance assignment benefits, but this does not absolve me from my personal responsibility in the event the insurance company does not pay for my services in full or part. In case suit or action is instituted to collect above said fees or any portion thereof, I agree to pay all collection costs and such additional sums as the court may adjudge reasonable such as court costs, attorney fees, service of process, etc., in said suit or action.

I understand that this office will prepare any necessary reports or forms to assist me in making collection from the insurance company; thereof, I also authorize the release of any information pertinent to the processing of this claim to the above mentioned insurance company(s) and or attorney(s) involved in my case. This agreement also applies to any insurance company or plan that I switch to in the future.

Patient Signature _____ Date _____