The Center for the Functional Restoration of the Spine, LLC
Marc S. Menkowitz, MD, LLC
Marc S. Menkowitz, MD

DATE: _____

LAST NAME | FIRST NAME | MIDDLE INITIAL | GENDER | CELL PHONE

STREET ADDRESS | CITY | STATE | ZIP

HOME PHONE | SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE | MARITAL STATUS

EMAIL ADDRESS (FOR PATIENT PORTAL)

EMPLOYEER | ADDRESS | WORK PHONE

SPOUSE'S NAME (OR PATIENT ACCOMPANYING MINOR) | SSN | DATE OF BIRTH | AGE

EMERGENCY CONTACT | RELATION | PHONE NUMBER

PRIMARY CARE PHYSICIAN | ADDRESS | PHONE NUMBER

PHARMACY | ADDRESS | PHONE NUMBER

ALLERGIES

INSURANCE INFORMATION: _____ Medicare _____ Private _____ Motor Vehicle _____Worker's Compensation

Name of Company | Address, City, State, Zip

Insurance Phone Number | Insurance Policy Number | Group Number

Subscriber Name | Social Security Number | Date of Birth | Gender | Relationship to Patient

Do You Have a Secondary Insurance? _____ Yes _____ No (If Yes, Complete Below)

Name of Company | Address, City, State, Zip

Insurance Phone Number | Insurance Policy Number | Group Number

Subscriber Name | Social Security Number | Date of Birth | Gender | Relationship to Patient

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Marc S Menkowitz, LLC (Marc S. Menkowitz, MD) or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day healthcare operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Marc S Menkowitz, LLC (Marc S. Menkowitz, MD) may or may not agree to restrict the use or disclosure of your protected health information.

If Marc S Menkowitz, LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal standards.

Revocation or Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Marc S Menkowitz, LLC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Marc S Menkowitz, LLC (Marc S. Menkowitz, MD) to use and disclose my health information in accordance with it.

Name of Patient (Print or Type) _____

Signature of Patient _____

Date: _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____

The Center for the Functional Restoration of the Spine, LLC
Steve J. Paragioudakis, MD
Marc S. Menkowitz, MD

1131 Broad Street
Tel. 732-380-1212

Shrewsbury, NJ 07702
Fax 732-380-1372

Legal Assignment of Benefits & Designation of Authorized Representative

I, _____, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Steve J. Paragioudakis, M.D. and/or Marc S. Menkowitz, M.D., the "provider(s)"), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

_____
Print Name of Insured/Guardian

Date Completed: _____ Age: _____

WHAT IS THE MAIN REASON FOR YOUR VISIT?

_____

PAST MEDICAL HISTORY

Circle YES or NO for any major, significant illnesses which apply to you.

Anemia	YES	NO	Hay Fever/Sinus Problems	YES	NO
Asthma/ Bronchitis/Emphysema	YES	NO	Heart Problems	YES	NO
Arthritis	YES	NO	Hepatitis	YES	NO
Bleeding/Bruising/Blood Disorder	YES	NO	High Blood Pressure	YES	NO
Cancer (type) _____	YES	NO	Immune Disorder	YES	NO
Depression	YES	NO	Kidney Disease	YES	NO
Diabetes			Liver Disease	YES	NO
Insulin Injection Dependent	YES	NO	Stroke	YES	NO
Non Insulin Dependent	YES	NO	Thyroid Disease	YES	NO
Drug Abuse/Alcohol Dependency	YES	NO	Tuberculosis (TB)	YES	NO
Epilepsy/Seizures	YES	NO	Stomach Ulcers	YES	NO
Other (please describe) _____					

Please list previous hospitalizations/major surgeries/serious injuries and approximate dates:

Medications- List all medications you are taking and their dosages (prescription and all over the counter drugs):

Have you had significant exposure to: Pesticides? YES/NO Toxic Waste? YES/NO

Have you had previous treatment with or exposure to Radiation? YES/NO?

If YES, please explain: _____

FAMILY HISTORY

Some illnesses "run" in families. Please list health problems in your family.

	AGE	MEDICAL PROBLEMS	CAUSE OF DEATH
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Grand-	_____	_____	_____
Parents	_____	_____	_____

SOCIAL HISTORY

Do you (or did you in past) use Tobacco? YES/NO

Cigarettes: Packs per day: _____ how many years: _____ if you quit, when? _____

Other Tobacco use: Amount per day: _____ How many years: _____ If you quit, When? _____

Do you drink alcohol? YES/NO How often and how much? _____

Do you use any drugs other than prescribed or over the counter medication? YES/NO

If yes, please list: _____

Do you eat a balanced diet? YES/NO Is your weight stable? YES/NO

Please indicate anything else of importance the Doctor should know about you:

_____

Birthplace: _____

Current Occupation: _____

Relationship/Marital Status: _____

Who currently lives at home with you? _____

REVIEW OF SYSTEMS

Do you presently have any problems or symptoms in the following areas?
Please Circle Yes for anything that applies

GENERAL

Fatigue	YES
Decreased Appetite	YES
Fevers	YES
Weight Loss	YES
Weight gain	YES
Insomnia	YES

CARDIOVASCULAR

Chest Pain	YES
Palpitations	YES
High blood pressure	YES
Stroke	YES
Swelling of legs	YES
History of blood clot	YES

NEUROLOGICAL

Headaches	YES
Numbness or Tingling	YES
Weakness	YES
Paralysis	YES
Change in memory	YES
Difficulty Walking	YES
Dizziness	YES

ENDOCRINE

Heat Intolerance	YES
Cold Intolerance	YES
Excess Thirst	YES
Excess Urination	YES
Thyoid Problems	YES

GASTROINTESTINAL

Change in Appetite	YES
Severe Heartburn	YES
Ulcers	YES
Nausea/Vomiting	YES
Frequent Diarrhea	YES
Constipation	YES
Bloody Stools	YES
Rectal Bleeding	YES
Abdominal Pain	YES

RESPIRATORY

Shortness of Breath	YES
Cough	YES
Wheezing	YES

SKIN

Rash	YES
Changing Moles	YES
Skin Cancer	YES
Non-healing Wound	YES
Breast pain/lump	YES
Change in hair/nails	YES
Itching	YES

HEMATIOLOGICAL

Easy Bruising	YES
Frequent Bleeding	YES
Enlarged Lymph Nodes	YES

MUSCULOSKELETAL

Joint Stiffness	YES
Muscle Pain	YES
Muscle Cramping	YES
Weakness in muscles	YES
Back Pain	YES
Difficulty Walking	YES

Eyes/Ears/Nose/Throat

Visual Changes	YES
Hearing Loss	YES
Sore Throat	YES
Nasal Congestion	YES
Runny Nose	YES
Ear Pain	YES

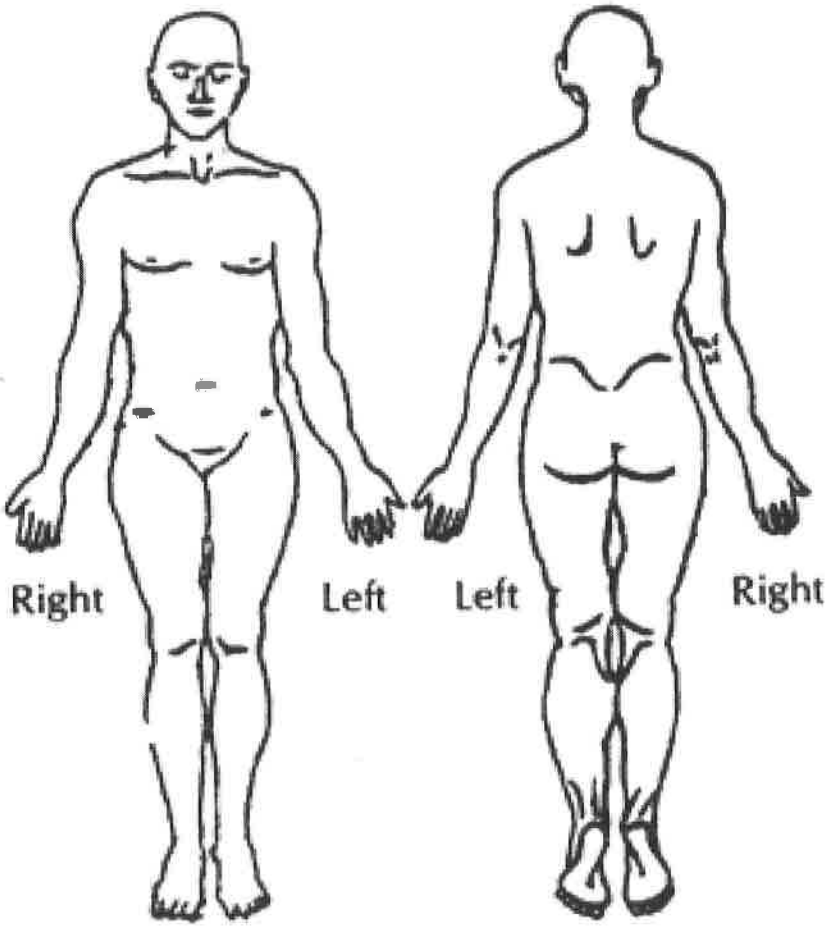
GENITOURINARY

Painful Urination	YES
Bloody Urine	YES
Increased Urination	YES
Leaking Urine	YES
Erectile Dysfunction	YES

PAIN DRAWING

The pain drawing will help us understand the pain you have been experiencing. Please diagram your pain using the following symbols.

NUMBNESS : ------
BURNING: XXXX
PINS & NEEDLES: OOOO
STABBING: ////
OTHER: **



Height: _____ Weight: _____ Years of education completed: _____

Date of accidents (s): _____

Out of work: Days: _____ Months: _____ Years: _____

Partial days missed from work due to your problems: _____

PATIENTS WITH BACK, HIP OR LEG PAIN, ANSWER THE FOLLOWING:

How long have you had your present attack of back and/or leg pain? _____

When were you first aware there was something wrong with your back? _____

How many attacks of pack pain and/or leg pain have you had per year? _____

On a scale of 0-10, with 0 being no pain and 10 pain so severe that you could not live with it more than a few minutes, how would you rate NOW?

Back: _____ Right Leg: _____ Left Leg: _____ Right Hip: _____ Left Hip? _____

Did your back pain get better once the leg pain started? _____

Is your back and/or leg pain (Check one): _____ Constant _____Intermittent (comes and goes)

Is your back and/or leg pain (Check one):

_____ Better _____ Staying the same _____ Getting worse

Does your pain in the back and/or leg affect your sleep in any of the following ways?

_____ No _____ Cannot sleep at all because of pain _____Once I fall to sleep, I am OK

____ I must get up and walk around to relieve the pain ____ I awake the same time every night

____I must take medicine to sleep _____ Cannot sleep on Right/or Left side

____Cannot sleep on stomach

How much time during the usual waking hours do you spend lying down? _____

What makes your pain worse? _____

What make the pain better? _____

Is the pain worse on first arising in the morning? _____

Is the pain worse toward the end of the day? _____

Is the pain worse when first changing position (i.e. standing after sitting)? _____

____ Feel like you must urinate and cannot ___Dribbling _____Loss of feeling of voiding

____Inability to void _____Urgent desire to void and cannot hold it _____Constipation

____Difficulty with sex

Do you have difficulty with walking? _____

Do you stumble? _____ Due to pain? _____

Do you limp? _____ Due to pain?_____

Which of your knees give way? RIGHT LEFT NONE

In which foot do you have weakness? RIGHT LEFT NONE

In which foot do you have numbness? RIGHT LEFT NONE

Who have you seen for your pain and when?

Names: _____

Type of Doctor/Therapist _____

What treatments have you had for your pain? _____

Which treatments helped your pain the most? _____

How many times have you been hospitalized for your back? _____

Approximate dates: _____

Please list the dates and types of all back surgeries you have had:

_____

Other tests for your back? Number and date(s):

CT Scan _____

Myelogram _____

MRI _____

Bone Scan _____

Other (EMG, Epidural Venogram) _____

CERVICAL SPINE QUESTIONARE: How long have you had neck trouble?

_____

What started it? _____

TODAY: Rate pain 1-10/10 (10 being so severe it could be tolerated for only seconds)

☐ NECK ☐HEADACHES

☐RIGHT SHOULDER ☐RIGHT ARM

☐LEFT SHOULDER ☐ LEFT ARM

Does pain interfere with your sleep? Yes/ No

Weakness in ___ arms ___ hands ___ legs?

Clumsiness in ___ arms ___ hands ___ legs?

Numbness in hands? Yes/ No

Difficulty walking? Yes/ No How far can you walk? _____

Accident? _____

Law Suit? _____

Workers Comp? _____

Last day worked? _____

Current occupation: _____

Injury history: _____

Neck/ Back surgeries: _____

_____

Other tests for your NECK? Number and date(s):

CT Scan _____

Myelogram _____

MRI _____

Bone Scan _____

Other (EMG, Epidural Venogram) _____

THE CENTER FOR THE FUNCTIONAL RESTORATION OF THE SPINE.
1131 BROAD STREET SUITE 201, SHREWSBURY, NJ 07702

Dr. Steve Paragioudakis

Dr. Marc Menkowitz

Courtney Ellenberger, NP

Physician – Patient Pain Contract

Patient Name _____

The goals of this medicine are:

- O To improve my ability to work and function at home.
- O To help my pain/anxiety as much as possible without causing dangerous side effects.

I have been told that:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants
2. The reasons as to why the prescription is necessary and the goals of treatment with this medication.
3. Alternative treatments that may be available including but not limited to interventional pain management
4. The risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.
5. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.

I agree to the following:

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
- I will bring the pill bottles with any remaining pills of this medicine to each office visit. I agree to give a blood or urine sample, if asked, to test for drug use.
- I understand that urine drug screening may be conducted in the office setting if found necessary by the prescribing provider.

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Refills

Refills will be made only during regular office hours—Monday through Friday, 8:30AM-5:00 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made. I will not come to the office for my refill until I am called by the office staff.

Pharmacy: I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name & telephone number of my pharmacy is _____.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Orthopedic Office in the original bottle, even if there are no pills left.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way. I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working. If deemed necessary, a urine drug screen will be performed in the office or outpatient setting.

Patient's signature Date **Date**

_____ _____

Physician / Provider's signature **Date**

_____ _____