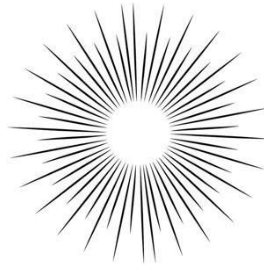

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Patient Information		
Last name:	First name:	Date of Birth:
Marital status:	Sex:	SSN:
Address		
Street:	City:	State/Zip code:
Home phone:	Cell:	Work phone:
Emergency Contact		
Last:	First:	Relationship:
Street:	City:	State/Zip code:
Home phone:	Cell:	Work:

Physician Information		
Primary Care Physician:	Phone:	Fax:
Street:	City:	State/Zip code:
Referring Physician: Specialty:	Phone:	Fax:
Street:	City:	State/Zip code:

Insurance Information			
Policy holder's name:		Date of Birth:	
Primary Insurance Carrier:	Effective Date:	Secondary Insurance Carrier:	Effective Date:
Policy#:	Group#:	Policy#:	Group#:
Claim Address:		Claim Address:	
Workers Compensation/No Fault			
Insurance Carrier:		Date of Injury:	
Claim representative:		Phone: Fax:	
WCB/Policy#:		Claim#	
Claim Address:			
Pharmacy Information			
Name:	Address:		Phone#:

INITIAL VISIT INFORMATION

DATE ___/___/______

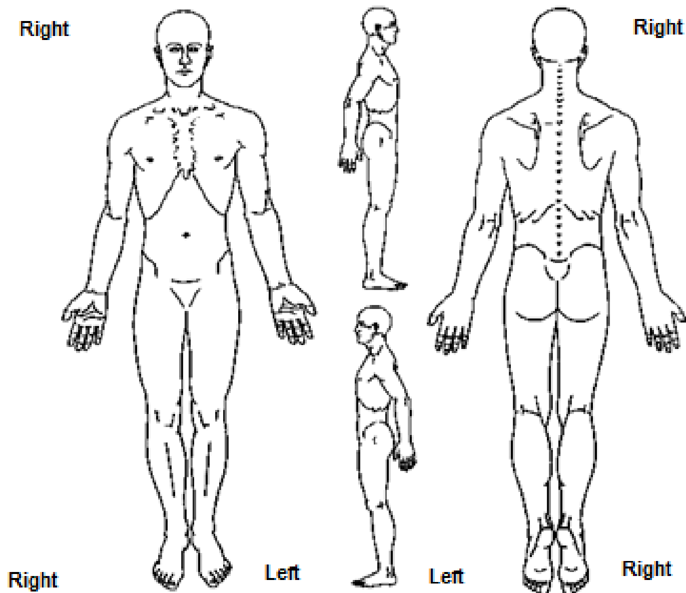
Your Name: ______________________________

Referred By: ______________________________

Age: _______ **Yrs** **Sex:** **M** **F** **(Circle)**

Current Weight/Height:

WHERE is your pain located? Using these pictures, shade with a pen or pencil the parts of your body that are affected by pain. Use an "X" to indicate specific trigger or tender points.



When / How long ago did your pain start?

_______ **Years** _______ **Month(s)**

_______ **Week(s)** _______ **Day(s)**

Any Specific Date? _____ /______ / ______

How would you describe this pain as?

- ❑ **Throbbing**
- ❑ **Shooting**
- ❑ **Stabbing**
- ❑ **Sharp**
- ❑ **Cramping**
- ❑ **Hot-burning**
- ❑ **Aching**
- ❑ **Heavy**
- ❑ **Tender**
- ❑ **Splitting**
- ❑ **Tiring-Exhausting**
- ❑ **Sickening**
- ❑ **Fearful**
- ❑ **Punishing-cruel**

Describe event(s) related to the start of your pain.

____

____

____

____

____

____

____

Check additional symptoms you are experiencing?

- ❑ **Tingling (pins-needles)**
- ❑ **Pain EVEN with bed-rest**
- ❑ **Cold / Hot skin**
- ❑ **Changes in skin color**
- ❑ **Chills / Night Sweats**
- ❑ **Sensitive areas to touch**
- ❑ **Repeated infections**
- ❑ **Uncontrolled loss of bowel**
- ❑ **Uncontrolled loss of urine**
- ❑ **Weight loss (10-15 pounds in 2 weeks or less)**
- ❑ **Weakness**
- ❑ **Numbness**
- ❑ **Imbalance**
- ❑ **Swelling**
- ❑ **Fever**
- ❑ **Cramps**
- ❑ **Difficulty in walking**

How often do you have your pain? **(Please check one)**

- ❑ **Constantly (80-100% of time)**
- ❑ **Frequently (50-80% of the time)**
- ❑ **Intermittently (25-50% of the time)**
- ❑ **Occasionally (less than 25% of the time)**

Consider "0" being 'NO PAIN' and "10" being the "WORST IMAGINABLE PAIN", then circle the number which represents the intensity of

YOUR AVERAGE daily pain

0 1 2 3 4 5 6 7 8 9 10

YOUR WORST daily pain

0 1 2 3 4 5 6 7 8 9 10

YOUR LEAST daily pain

0 1 2 3 4 5 6 7 8 9 10

How do the following affect your pain?
(please check the ones applicable to your condition)

	Increases my pain	Reduces my pain
Standing	❑	❑
Sitting	❑	❑
Lying Down	❑	❑
Walking	❑	❑
Exercise / Moving the Affected Part	❑	❑
Relaxation	❑	❑
Coughing or Sneezing	❑	❑
Urination or Bowel Movement	❑	❑

Check the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

	Excellent Relief	Moderate Relief	No Relief
Bed rest	❑	❑	❑
Exercise	❑	❑	❑
Heat or Ice	❑	❑	❑
Physical therapy	❑	❑	❑
Traction	❑	❑	❑
TENS Machine	❑	❑	❑
Chiropractor	❑	❑	❑
Acupuncture	❑	❑	❑
Relaxation Techniques	❑	❑	❑
Nerve block or Injections	❑	❑	❑
Surgery	❑	❑	❑

What activities are you having difficulty with due to your pain?

- ❑ **Going to work**
- ❑ **Driving**
- ❑ **Performing household chores**
- ❑ **Exercising**
- ❑ **Recreational Activities**
- ❑ **Self Care**
- ❑ **Lifting anything**
- ❑ **Sitting**
- ❑ **Bending**
- ❑ **Sleeping**

REVIEW OF SYSTEMS: Please review the list below. If you currently have these problem(s), please check the box ❑ next to them.

GENERAL
- ❑ Weight gain
- ❑ Weight loss
- ❑ Decreased energy
- ❑ Fever

SKIN
- ❑ Rash
- ❑ Itching
- ❑ Color Change
- ❑ Excessive Sweating

HEAD-ENT
- ❑ Headache
- ❑ Dizziness
- ❑ Fainting
- ❑ Blurry Vision
- ❑ Sensitivity to Light
- ❑ Hearing Loss
- ❑ Ringing in Ears
- ❑ Nose Bleeds
- ❑ Bleeding Gums

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Painful swallowing
- ❑ Abdominal pain
- ❑ Heartburn
- ❑ Nausea / Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Blood in stool

RESPIRATORY
- ❑ Shortness of breath
- ❑ Painful breathing
- ❑ Cough
- ❑ Sputum
- ❑ Cough with blood
- ❑ Wheezing

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Palpitations
- ❑ Swelling in legs
- ❑ Poor circulation in legs
- ❑ Varicose veins
- ❑ Blood clots in legs

NEUROLOGIC
- ❑ Seizures
- ❑ Fainting
- ❑ Tremors
- ❑ Weakness
- ❑ Tingling
- ❑ Numbness
- ❑ Memory loss
- ❑ Coordination loss
- ❑ Difficulty in Walking

GENITOURINARY
- ❑ Difficult urination
- ❑ Flank or pubic pain
- ❑ Urgency or frequency
- ❑ Urine Incontinence
- ❑ Night time urination
- ❑ Passage of stones
- ❑ Dark or bloody urine
- ❑ Erectile dysfunction
- ❑ Abnormal vaginal bleeding

PSYCHIATRIC
- ❑ Hallucinations
- ❑ Depression
- ❑ Irritability
- ❑ Tension or anxiety
- ❑ Suicidal thoughts
- ❑ Suicidal attempts

MUSCULOSKELETAL
- ❑ Painful muscle(s)
- ❑ Painful joint(s)
- ❑ Muscle cramps
- ❑ Decrease in muscle size
- ❑ Joint stiffness
- ❑ Joint swelling / redness

ENDOCRINE
- ❑ Increase Thirst
- ❑ Cold intolerance

HEMAT - LYMPHATIC
- ❑ Easy Bruising
- ❑ Bleeding tendency

SELECT / LIST YOUR MEDICAL HISTORY:

- ❑ High Cholesterol
- ❑ Asthma
- ❑ Hypertension
- ❑ Acid Reflux
- ❑ Hepatitis
- ❑ Osteoporosis
- ❑ Bleeding Disorder
- ❑ Hypothyroidism
- ❑ COPD / Emphysema: ___
- ❑ Heart Disease: _________
- ❑ Kidney Disease: ________
- ❑ Diabetes: ______________
- ❑ Osteoarthritis: _________
- ❑ Depression / Anxiety

____

____

____

DOCUMENT ANY SURGICAL PROCEDURES THAT YOU EVER HAD (if possible, by dates):

____

____

____

____

____

ALLERGIES: ❑ I HAVE NO ALLERGIES

Drug	Reaction
____________________	____________________
____________________	____________________

- ❑ Dye
- ❑ Iodine
- ❑ Shellfish
- ❑ Latex
- ❑ Any specific food item: ___________________

LIST ALL MEDICATIONS YOU ARE TAKING

Please list any medications you are currently taking, with their doses and number of times taken per day. Include "over the counter" drugs and herbal supplements. Use the back of this sheet if necessary.

____

____

____

____

____

____

ARE ANY OF YOUR FAMILY MEMBERS SUFFERING FROM THE FOLLOWING?

Select all that apply:	Relationship to you:
❑ Cancer	______________________
❑ Diabetes	______________________
❑ Kidney disease	______________________
❑ Chronic Pain	______________________
❑ Alcohol Abuse	______________________
❑ Illegal drug Abuse	______________________
❑ Prescription drug Abuse	______________________

PERSONAL: (Check the ones applicable to you)

PRESENT WORK STATUS

- ❑ I am Working: Occupation: ______________
- ❑ I am on Disability OR have a pending application
  Reason for Disability: ____________________
- ❑ I am on Worker's Compensation

LEGAL ISSUES

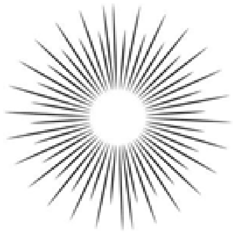
- ❑ I have a pending litigation related to my pain
- ❑ ATTORNEY ____________________________

LIVING STATUS

- ❑ I live alone
- ❑ I live with my spouse
- ❑ I live with a Domestic Partner / Friend / Kid(s)

PERSONAL HABITS

- ❑ I use Tobacco: Cigarettes per day: _____
  For how long? _________
- ❑ I use Alcohol: How often? ___________
- ❑ I have a history of street drugs use
  Which ones? ______________________
  Last use __________________________
- ❑ I have been addicted to prescription drugs in past
- ❑ I have been treated for alcohol/ drug abuse in past
- ❑ I have been sexually abused in past



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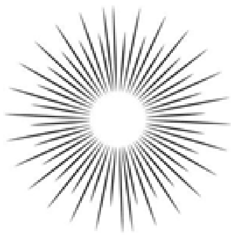
Consent to Treat

I, ______________________, the undersigned patient, consent to treatment by the provider.

Print Name: ____

Signature: ____

Date: ____



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Consent to Use and Disclose Protected Health Information (PHI)

I _____________________________________, give my consent to the provider and his or her agents to use or disclose my Protected Health Information to carry out treatment, payment, or health care operations. These individuals and entities can release, use, or disclose my PHI to other physicians, nursing practitioners, physician assistants, students in each of the above disciplines, and other such entities or persons as are deemed related to treatment, payment, and health care operations, as determined for the sole discretion of the provider and his or her respective agents.

If another provider who is involved with treatment, payment, or health care operations relating to my care requests my medical records, I consent to release my entire medical record maintained by Elvis W. Rema, MD PLLC to those requesting providers.

I agree, as part of this consent for payment operations, that the provider, its group, their billing personnel, billing agents or Management Company can disclose billing information to any person that calls the provider with billing questions, as long as that person is able to provide the correct social security number and health plan information.

I agree that the provider, their agents, or their representatives may call and leave a voicemail message at my home or other number I have provided regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or healthcare operations.

I agree that the provider may discuss my PHI with any person that accompanies me to any appointment. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree, that the provider may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional, or spiritual care, including but not limited to family, friends, clergy, and patient advocates. I also agree, that the provider and his or her agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

I agree that the provider and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding their PHI and that I have no right to receive this information.

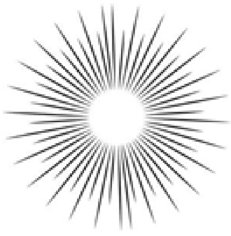
I agree the provider and his or her agents may, upon request, disclose my PHI to public health agencies, law enforcement, and the FDA.

I acknowledge that I have received a copy of a separate document entitled "Notice of Privacy Practice" which sets forth my rights regarding privacy of my PHI.

Print Name: ____

Signature: ____

Date: ____



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Release and Assignment

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMOs and commercial insurance to **Elvis W. Rema, MD PLLC.**

Elvis W. Rema, MD PLLC will bill only for the professional component of these services.

I understand that I am financially responsible for all charges for the hospital and for anesthesia if these services are used.

I understand that I am financially responsible for all charges whether or not covered by said insurance.

I authorize release of any information required to secure payment on my behalf.

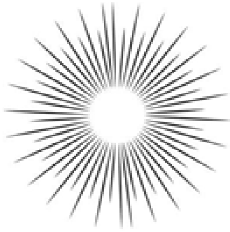
I am aware that there is a **$75.00** late cancellation fee for any appointment or procedure that is not cancelled at least 24 hours in advance.

I request that any payments of authorized Medicare benefits be made either to me or on my behalf to **Elvis W. Rema, MD PLLC**, for services furnished to me by the provider. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or the benefits payable for related services.

Print Name: ____

Signature: ____

Date: ____



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Treatment Agreement

All patients receiving controlled substances from this office are required to follow the rules outlined by this agreement. These rules are required by law to ensure that these medications are used safely.

I will not obtain controlled substances from any other providers without permission from this office.

It is my responsibility to take my medications as prescribed, and to maintain an accurate count to ensure I will not run out of medication before my next scheduled appointment.

If I travel and will not be able to return before my prescription runs out, I will find another provider to prescribe the medication until I can return to the office.

If I relocate, it is my responsibility to find a provider to continue my treatment.

I understand that these medications will only be prescribed by a face-to-face office visit.

I understand that the office will not refill the prescriptions after office hours or on days that the office is not seeing patients.

I agree to follow the labeling instructions on my medications, including not sharing prescription medications with others, no ingesting alcohol while taking medications, and keeping all medications out of the reach of children.

I have received information on New York State Public Health Law Section 3397(4).

I am aware that I am subject to random urine drug screening.

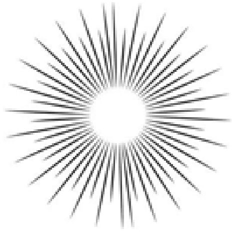
I understand that I run the risk of addiction by taking controlled substances for any length of time.

I have read all of the above-mentioned items, and my signature states that I will comply with them. I understand that the office reserves the right to terminate care for violation of this agreement.

Print Name: ____

Signature: ____

Date: ____



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Acknowledgement of Receipt of Notice of Privacy Practices

I ________________________________hereby acknowledge that I received a copy of this medical practice's Notice of Privacy and that I may request a copy of any amended Notice of Privacy.

Signed: ____________________________ Date: _____________________

***For Office Use Only*:**

☐ Acknowledgment refused:

Efforts to obtain: ____

Reason for refusal: ____

Print Name: ____

Signature: ____

Date: ____