AIPM – Health History Form

Name: _____, _____ Date: _____/_____/_____
Last First

MEDICAL PROBLEMS (check all that apply):

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Arrhythmia (e.g. Atrial fibrillation)
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Bleeding or Clotting Disorder
- ☐ Stroke
- ☐ COPD
- ☐ Reflux / Stomach Ulcer
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Hepatitis / HIV
- ☐ Glaucoma
- ☐ Sleep Apnea
- ☐ Osteoporosis
- ☐ Anxiety / Depression
- ☐ Hyperthyroidism / Hypothyroidism
- ☐ Rheumatoid Arthritis / Lupus / other
- ☐ Parkinson's Disease
- ☐ Prostate Enlargement / Cancer
- ☐ Cancer (specify): _____
- ☐ Other (specify): _____

ALLERGIES:

- ☐ **NONE**
- ☐ Penicillin
- ☐ Sulfa
- ☐ IV Contrast Dye
- ☐ Latex
- ☐ Egg
- ☐ Other_____

FAMILY MEMBERS with the following:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Bleeding or Clotting Disorder
- ☐ Stroke
- ☐ Cancer (specify):_____

SURGERIES / MAJOR EVENTS:

- ☐ Spine surgery (Year): _____
- ☐ Hip surgery / Replacement (Year): _____
- ☐ Knee surgery / Replacement (Year): ____
- ☐ Heart attack (Year): _____
- ☐ Pacemaker (Year): _____
- ☐ Stents, #:_____ (Year): _____
- ☐ Heart surgery (Year): _____
- ☐ COVID infection (Date): _____
- ☐ Other_____

PREVENTIVE CARE:

- ☐ **COVID Vaccine:** # of doses: _____
  (Date of last dose): ___/___/___
- ☐ Influenza Vaccine (Year): _____
- ☐ Shingles Vaccine (Year): _____
- ☐ Colonoscopy (Year): _____
- ☐ Mammogram (Year): _____
- ☐ Pap smear (Year): _____
- ☐ Other_____

AIPM – Health History Form

REVIEW OF SYSTEMS (circle all that apply):

Musculoskeletal: Neck pain / Back pain / Joint pain
Neurologic: Numbness / Tingling / Weakness / Headache
Cardiovascular: Chest pain / Irregular heartbeats / Blue fingers or toes / Ankle swelling
Respiratory: Cough / Shortness of breath
Gastrointestinal: Nausea / Vomiting / Diarrhea / Heartburn
Constitution: Fever / Chills
Eyes: Blurry or Double vision / Loss of vision
Ears/Throat: Dizziness / Hearing loss / Ringing in the ears / Sore throat
Endocrine: Fatigue / Hot flashes / Cold feeling
Hematologic: Easy Bruising or Bleeding / Masses or lumps in armpits, groin, neck
Skin/Integumentary: Rashes / Ulcers or breaks in the skin

SOCIAL HISTORY (circle all that apply):

Dominant hand: Right Left Neither
Caffeine (# of cups/day): None 1/day 2-3/day 4+/day
Exercise (# of times/week): None 1-2/week 3+/week
Home living situation: Alone w/Spouse w/Children Other:_____
Tobacco: None Cigarettes Cigars Smokeless tobacco
Alcohol: None Light (1-13/month) Moderate (4-14/week) Heavy (>2/day)
Marijuana: None 1-2/week 3+/week
Recreational Drug use: (specify):_____

AIPM – Demographic/Insurance/Release Form

Name: _____ _____ _____
Last First Middle

Social Security #: _____-_____-_____ DOB: _____/_____/_____ Age: _____

Sex: M / F Marital Status: Single / M / Sep / Div / Wid

Home Address: _____ _____
Street Apt#

City/State/Zip: _____

Cell Phone: (_____) _____-_____ Home: (_____) _____-_____

Employer: _____ Phone: (_____) _____-_____

Address: _____

Emergency Contact:_____ Phone: (_____) _____-_____

Insurance Information:

Primary Insurance: _____ Phone: (_____) _____-_____

Policy #:_____ Group: _____

Secondary Insurance:_____ Phone: (_____) _____-_____

Policy #:_____ Group: _____

Provider Information:

Referring Physician: _____

Phone: (_____) _____-_____

Primary Care Physician: _____

Phone: (_____) _____-_____

Advanced Interventional Pain Management, LLC

Insurance companies have several types of plans with varying patient responsibilities. It is important for you to advise us of any changes in your healthcare coverage. This ensures that your medical services will be covered.

If you are covered by a managed care program, you will be responsible for your co-pay. If your plan requires referrals, you are responsible for obtaining them and bringing them at the time of your visit. You are also responsible for any deductibles and/or co-insurance as per your contract with your insurance company.

Please understand that as the patient, you are ultimately responsible to know your coverage/requirements and are accountable for all payments of medical bills.

X_____
INITIALS

Notice of Privacy Practices

By signing below, I am aware that all medical matters handled in/at Advanced Interventional Pain Management, LLC are kept privately and will not be disclosed to any other source without my knowledge or consent.

X_____
PATIENT'S SIGNATURE

Consent to Release Information

By signing this form, I hereby authorize AIPM, LLC to release any medical information to the physicians involved in my care or to authorized parties: (i.e. ins. comp, lawyer's offices, etc.). I consent that the practice may call my house or other designated locations and leave a message on voicemail or in person in reference to appointment reminders and insurance matters, and in addition, the practice may mail to my home any correspondence related to this office.

I designate the following representative(s) whom the provider/office staff may communicate with on my behalf. If you do not designate anyone, our office will be unable to speak or release any medical information to anyone in your family or friends regarding your medical condition.

_____ _____
Authorized Representative's Full Name Relationship to patient

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Consent to Obtain Information

I hereby authorize AIPM, LLC to obtain any/all medical records from other offices and facilities (i.e. doctor's office, radiology facilities, laboratories, etc.)

X_____
PATIENT'S SIGNATURE

I acknowledge I have read and signed all of the above and understand I am solely accountable for all the matters listed above.

_____ _____ X_____
Date **Patient's Name (PRINT)** **PATIENT'S SIGNATURE**

Revised 8/2022

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Advanced Interventional Pain Management, LLC medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Advanced Interventional Pain Management, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Advanced Interventional Pain Management, LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred on the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

X_____ _____

Patient / Responsible Party Signature Date

_____ _____

Witness Date

SURGERY CENTER OWNERSHIP DISCLOSURE

This is to inform you that Drs. Doss, Kang, and Kizina have a financial interest in Wayne Surgical Center, LLC and Hasbrouck Heights Rehab (Surgery Center), LLC, where they perform procedures on their patients.

If you require surgery, the doctor may perform the procedure at Wayne Surgery Center, LLC or Hasbrouck Heights Rehab (Surgery Center). You may, of course, seek treatment at another facility of your own choice.

Please acknowledge receipt of this disclosure by signing and dating this form.

X_____ _____

PATIENT'S SIGNATURE Date