

**Welcome to NJOCSM**  
**PETER B. BLANK, D.O**

*150 NORTH FINLEY AVENUE, BASKING RIDGE, NEW JERSEY*  
NEW PATIENT QUESTIONNAIRE

NAME (last, first, middle): \_\_\_\_\_ TITLE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ CITY & ZIP \_\_\_\_\_

PREFERRED NAME: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

SEX: M \_\_\_ F \_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

WHOM MAY WE THANK FOR THIS REFERRAL? \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMERGENCY CONTACT: (last, first,): \_\_\_\_\_ Home # \_\_\_\_\_

Work# \_\_\_\_\_

Cell# \_\_\_\_\_

RELATIONSHIP TO THE PATIENT: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

NAME: \_\_\_\_\_

ADDRESS (street, city, state): \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_, FAX NUMBER: \_\_\_\_\_

**PHARMACY INFORMATION**

PHARMACY NAME \_\_\_\_\_ PHONE# \_\_\_\_\_ FAX# \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**EMPLOYER INFORMATION**

NAME: \_\_\_\_\_

ADDRESS (street, city, state, zip): \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_, FAX NUMBER: \_\_\_\_\_

OCCUPATION \_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT (if other than patient)**

NAME: \_\_\_\_\_

ADDRESS (street, city, state, zip): \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

CELL NUMBER: \_\_\_\_\_

COMPANY NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

SUBSCRIBER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER ADDRESS: \_\_\_\_\_

SUBSCRIBER #: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ ADDRESS: \_\_\_\_\_

PLAN NAME: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ INDIV. YEARLY DEDUCT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAMILY YEARLY DEDUCT: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION (IF APPLICABLE)**

SUBSCRIBER NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

SUBSCRIBER ADDRESS: \_\_\_\_\_

SUBSCRIBER #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ ADDRESS: \_\_\_\_\_

PLAN NAME: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ INDIV. YEARLY DEDUCT: \_\_\_\_\_

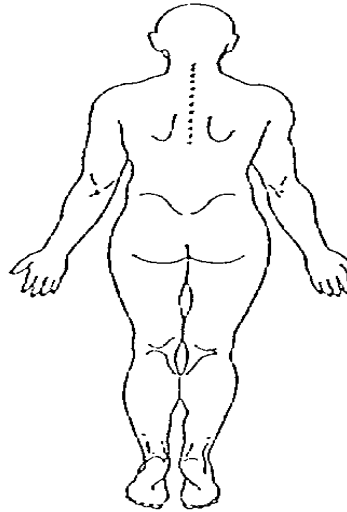
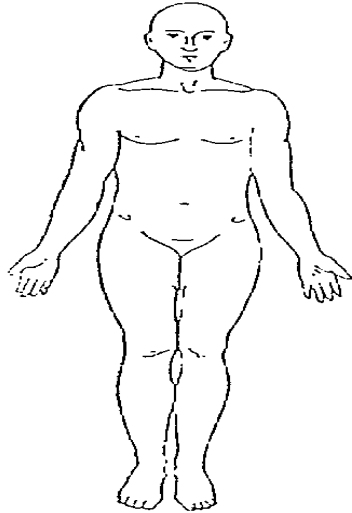
ADDRESS: \_\_\_\_\_ FAMILY YEARLY DEDUCT \_\_\_\_\_



## PLEASE COMPLETE THE PAIN DRAWING

Where is your pain? Please mark on the drawing where you feel pain right now and use the key below the figures.

*RA*



**0 = No pain, 10= Extreme pain**

1. Right Now:      0 1  
                         2 3 4 5 6 7 8 9 10
2. At Best:      0 1 2 3 4  
                         5 6 7 8 9 10
3. At Worst: 0 1 2 3 4  
                         5 6 7 8 9 10

4. What makes it worse?

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5. What makes it better?

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6. What test have you had?

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7. What treatments have you had?

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## PAST MEDICAL HISTORY

LIST MEDICAL PROBLEMS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST SURGERIES & DATES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST CURRENT MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST ANY MEDICATION ALLERGIES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING PROBLEMS?**

Heart Disease  Diabetes  High Blood Pressure  Cancer  Nerve problem

Other: \_\_\_\_\_

**Past Medical History**

- Hypertension
- Heart disease
- Respiratory disease
- Diabetes, type II
- Depression
- Back pain
- Cancer
- Anemia, iron deficient
- Diabetes insipidus
- Kidney disease
- Rheumatoid arthritis
- Thyroid disease
- Osteoarthritis

**Social History**

- Occupation  Employed  Unemployed  Retired  Student
- Smoke  Yes  No
- Alcohol  Yes  No
- Recreational drug use  Yes  No
- Exercise  None  Mild  Moderate  Heavy
- Marital status  Single  Married  Divorced  Widowed
- Education  High School  College  Graduate School

**Family History**

- Mother  Orthopedic History  Rheumatologic History
- Father  Orthopedic History  Rheumatologic History
- Siblings  Orthopedic History  Rheumatologic History
- Children  Orthopedic History  Rheumatologic History



## NOTICE OF PRIVACY PRACTICES

How may we use and disclose medical information about you.

The following categories describe ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

**For treatment:** We may use medical information about you to provide you with the medical treatment or services.

Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

**For payment:** we may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, and insurance company or third party. Example: We may need to send your protected health information, such as you name, address and treatment to your insurance company for payment.

**For health Care Operations:** we may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of staff in caring for you.

### **Other Uses or Disclosures That Can Be Made Without Your Consent or Authorization**

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health safety
- As required by military command authorities for their medical records
- To worker's compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other health care providers' payment activities
- Other covered entities healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Health oversight activities and other public health activities

We may contact you to provide appointment reminders of information about treatment alternatives or other health-related benefits and services that may be of interest to you.

### **Uses and Disclosures of Protected Health Information Requiring Your Written Authorization.**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke your authorization, in writing, at anytime. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with you authorization, and we are required to retain our records of the care we have provided you.

### **Disclosures and Changes to Your Medical Information**

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your

request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

**Right to Accounting of Non-Standard Disclosures:**

You have the right to request a list of the disclosures we have made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state in time period for which you want to receive a list of disclosures that is no longer than six years, and, may not include dates before April 14, 2003.

Your request should indicate in what form you want the list. For example: on paper or electronically. The first list that you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not kept at this practice, is not part of the information which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any corresponding rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any further authorized request for information pertaining to the appropriate portion of your record.

Access to Medical Information

**Right to Inspect and Copy:** you have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of this information, we reserve the right to charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the same person who denied your request. We will comply with the outcome of the review.

**Right to a paper copy of this notice:** You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

**Right to Request Confidential Communications:** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communication, you must make your request to the Privacy Officer at this practice. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Change to this Notice** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date on the posted copy.

**This Notice Applies To:** Any healthcare professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associated, and other locations of this practice may share medical information with each other for treatment, payment purposes of healthcare operations.