SEA GIRT PHYSICAL MEDICINE & REHABILITATION ASSOCIATES, LLC
Michael D. Dambeck, D.O.
Steven S. Neuman, M.D
Stacey Miller-Smith, M.D.

240 Parker Ave
Manasquan, NJ 08736
Tel: (732) 974-8100

Date of Initial Visit ___/___/___ **MEDICAL INFORMATION FORM**
Last Name_____First Name_____
Age_____Date of Birth_____/_____/_____Sex:_____Weight_____Height_____
Phone: Home_____Cell_____
Work_____Email_____
Who referred you_____
Referring Physician Name_____Phone_____

Please describe your main problem/complaint

_____
_____
_____

Past Medical History-check below if you have had any of the following:

___Heart Disease ____High Blood Pressure ___Diabetes ____**NONE**
___Asthma ____Kidney Disease ___ Hepatitis
___Migraine Headaches ____Bleeding Disorder ___Epilepsy
___Emotional Disorder ____ Cancer ___HIV
___Other_____

(Females only)Date of last gynecologic visit:_____
(Males only) Date of last prostate exam:_____

PAST SURGICAL HISTORY (list all past surgeries and dates if any

_____
_____
_____

FAMILY HISTORY

___Cancer ____Rheumatoid Arthritis ____Heart Disease ____**NONE**
___Osteoarthritis ____Diabetes ____Thyroid disease
___Chronic Back Pain ____Other:_____

ALLERGIES TO Medicine/Substance(include Reaction

_____
_____
_____

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CURRENT MEDICAL CONDITION

Do you have: ___Only back pain ___Only leg pain
___Back and leg pain ___Only neck pain
___Only shoulder pain ___Neck, shoulder and arm pain
___Other

Which is worse: ___Back pain ___Leg pain
___Neck pain ___Shoulder pain

How long have you had the pain?_____

My pain came on:___Gradually, __over time ___Quickly

My pain was brought on by: ___No specific incident
___Following an accident or incident at work
___Following an accident or incident NOT at work

Describe the accident/incident:_____
_____
_____
_____

Do you have: ___NUMBNESS Where_____
___TINGLING Where_____
___WEAKNESS Where_____
___BOWEL OR BLADDER CHANGES

What makes the pain **WORSE**? (sitting, standing, walking, lying down, medication, therapy,etc)_____
_____

What makes the pain **BETTER**? (sitting, standing, walking, lying down, medication, therapy,etc)_____
_____

My pain now seems to be: ___Getting better ___ Staying the same ___ Getting worse

Where have you sought help for your pain: (Check all that apply)
___Physiatrist ___Family Doctor ___Physical Therapist ___Chiropractor
___Orthopedic Doctor ___Neurologist ___Pain Clinic ___Spine Surgeon
___Psychiatrist/Psychologist ___OTHER_____

Have any of the above decreased your pain: ___NO ___YES
Specify_____
Have you had any of the following: ___Epidurals ___Manipulation ___acupuncture
___Other injection_____
Did any of the above help? ___NO ___YESelect the studies you have had: ___X-Rays
___MRI ___EMG Other:_____(Did you bring them with you?)

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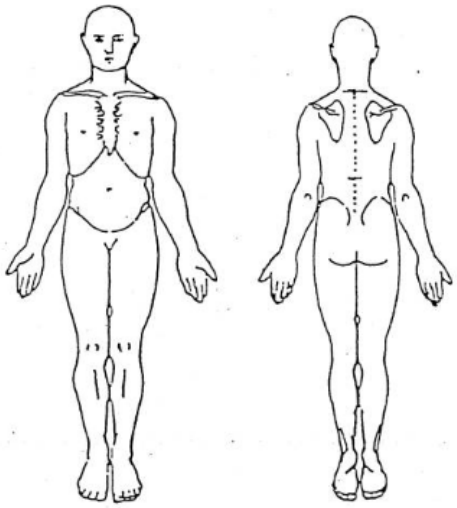
Pain rating scale: how would you rate your pain today: (circle one Number)

None 0-- 1-- 2-- 3-- 4-- 5-- 6—7-- 8-- 9--10 Worst
Mild Moderate Severe Pain



Pain Diagram:
Please use the following diagram to Show us where you are experiencing pain and numbness:

Pain: XXXXXXX
Numbness: OOOOOOO
Aching: //////////

Please circle all of the following adjectives which describe your pain.

DULL	**BURNING**
COLD	**SHOOTING**
TIGHT	**THROBBING**
ELECTRIC	**TINGLING**
OTHER_____	

Please CIRCLE the appropriate selection
SOCIAL HISTORY
Marital Status: Single, Married, Partner. Divorced, Separate, Widowed

Do you currently use Tobacco? **YES NO** (Year quit if former smoker _____)
Indicate quantity per day: Cigarettes_____ Cigars_____ Chewing Tobacco_____

Do you currently consume Alcohol? **YES NO**
Indicate quantity per day: Beer_____ Wine_____Distilled spirits_____
Do you exercise regularly? **Yes NO** What type?_____

Work Status
Occupation**:**_____
Are you currently? Working full time Working Part time Housewife
Unemployed Retired
Temporarily Disabled Permanently Disabled
Other_____
If you are currently NOT working:
How long have you been off work due to your injury? _____
Have you, or are you planning to apply for disability or workmen's compensation:
YES NO
Is there a lawsuit or litigation pending in relationship to your injury? **YES NO**

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Please CIRCLE the appropriate selection
LIVING ENVIRONMENT
Do you live **alone** or **with others** (specify)_____
Do you live in an: **Apartment, House, Other**_____
Are there steps to enter**: Yes NO (how many)**_____
Is there an elevator: **Yes NO**
Name of Power of Attorney or Decision Maker _____
REVIEW OF SYMPTOMS
Please CIRCLE any that apply

Weight Loss or Gain, Fevers, Sleep Problems, Anxiety, Depression

Headaches, Dizziness, Visual changes, Loss of Vision, Glaucoma

Stroke, Paralysis, Numbness, Tingling, Balance Problems,

Cough, Asthma, Chronic Lung Disease, Tuberculosis, Shortness of Breath,

Heart Attack, Angina/Chest Pain, Hear Failure, High Blood Pressure,

Arrhythmia (abnormal heartbeats)

Kidney Disease, Kidney Stones, Difficulty Urinating,

(Female) Pregnancy, Vaginitis

(Male) Prostate Problems

Heartburn, Reflux, Ulcers, Liver Disease (Hepatitis or Jaundice), Diarrhea, Constipation, Nausea, Vomiting.

Joint Swelling Joint Redness

Bleeding Problems, Anemia, Easy Bruising

Skin Problems, Psoriasis, Eczema, Rashes, Breast Masses

Osteoporosis, Diabetes, Thyroid problems, Allergies

Patient Name:_____
DOB:_____

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Please List Current Medications (include Non-Prescription):

Name of Medication	**Dosage**	**Frequency**	**Please circle 1**
______________________	__________________	_________________	Sublingual, Topical, Oral , injection, Intranasally
______________________	__________________	_________________	Sublingual, Topical, Oral , Injection, intanasally
______________________	__________________	_________________	Sublingual, Topical, Oral , Injection, intanasally
______________________	__________________	_________________	Sublingual, Topical, Oral , injection, Intranasally
______________________	__________________	_________________	Sublingual, Topical, Oral , Injection, intanasally
______________________	__________________	_________________	Sublingual, Topical, Oral , Injection, intanasally
______________________	__________________	_________________	Sublingual, Topical, Oral , injection, Intranasally
______________________	__________________	_________________	Sublingual, Topical, Oral , Injection, intanasally
______________________	__________________	_________________	Sublingual, Topical, Oral , Injection, intanasally
______________________	__________________	_________________	Sublingual, Topical, Oral , injection, Intranasally
______________________	__________________	_________________	Sublingual, Topical, Oral , Injection, intanasally
______________________	__________________	_________________	Sublingual, Topical, Oral , injection, Intranasally

Currently not taking medication__________

Date	changes to Medications	Medications reviewed by Doctor
______________________	__________________	_________________
______________________	__________________	_________________
______________________	__________________	_________________
______________________	__________________	_________________

Please indicate the name of your surrogate decision maker or Power of attorney:
Name:____Relationship;________________________
Date:__________ ______________ ______________ _____________ ____________ _____________ _____

Dates:___________ _____________ _____________ ____________ _________ ____________ _________
Do you Currently use Tobacco? Yes or NO (year quit if former smoker_____)
Indicate quantity per day: Cigarettes_____Cigars_______Chewing Tobacco______
Date: _____________________________
Have you received the Flu Shot? **Yes** **NO**
If no, please give a reason____
Other____

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PATIENT INFORMATION

PATIENT NAME_____DATE_____
PATIENT ADDRESS _____CITY_____
STATE:_____ZIP_____ SEX:____M_____F DATE OF BIRTH_____
TELEPHONE#: H_____W_____Cell_____
EMERGENCY CONTACT_____P#_____
PATIENT SSN#_____
PHARMACY NAME & #_____
PHARMACY ADDRESS_____
PATIENT EMPLOYER:_____
ADDRESS:_____
TELEPHONE NUMBER:_____
PRIMARY INSURANCE COMPANY:_____
ADDRESS:_____
TELEPHONE NUMBER:_____
SUBSCRIBER NAME:_____
SUBSCRIBER BIRTHDATE:_____
IDENTIFICATION NUMBER:_____
GROUP NUMBER:_____
SECONDARY INSURANCE COMPANY:_____
ADDRESS:_____
TELEPHONE NUMBER:_____
SUBSCRIBER NAME:_____
SUBSCRIBER BIRTHDATE:_____
IDENTIFICATION NUMBER:_____
GROUP NUMBER:_____
WAS THIS AN AUTOMOBILE ACCIDENT:_____YES_____NO
IF THIS WAS AN AUTOMOBILE ACCIDENT:
NAME OF AUTO INSURANCE COMPANY:_____
ADDRESS:_____
TELEPHONE NUMBER:_____CLAIM NUMBER;_____
DATE OF ACCIDENT:_____
IS THIS A WORKMAN'S COMPENSATION CASE:_____YES_____NO
IF THIS WAS A WORKMAN'S COMPENSATION CASE:
NAME OF RESPONSIBLE PARTY:_____
ADDRESS:_____
TELEPHONE NUMBER:_____CONTACT PERSON_____
POLICY NUMBER:_____CLAIM NUMBER_____
DATE OF INJURY:_____
HOW AND WHERE DID YOUR INJURY OCCUR_____
_____

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As a patient of Dr. Dambeck, Dr. Neuman and or Dr. Miller-Smith, I understand I am fully responsible for my outstanding bills unless otherwise arranged with the office. I will provide the office with my medical and hospital insurance information so that proper billing can be taken care of when necessary.
Patient's or guardian signature:_____

Authorization to release information: I authorize the release of any medical information necessary to process this claim to my insurance company.
Patient's or guardian's signature:_____

PRIVACY PRACTICES SIGNATURE REQUIRED BEFORE TREATMENT

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. Sign below if you did receive a copy of our privacy practices.

Also by signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations.

Patient or guardian_____

IF YOU HAVE MEDICARE: Please sign below to allow us to bill Medicare directly and to allow them to bill to your secondary health insurance on your behalf.

"I request that payment of authorized Medicare benefits be made on my behalf to Dr. Michael Dambeck , Dr. Steven Neuman and/or Dr. Stacey Miller-Smith for services furnished to me by Dr. Michael Dambeck , Dr. Steven Neuman and/or Dr. Stacey Miller-Smith. I authorize any holder for medical information needed to determine these benefits or the benefits payable for related services."
"I authorize any holder of Medicare information about me to release to my Medigap Insurer any information needed to determine these benefits payable for related services."

Patient or guardian signature:_____

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Our privacy procedures and Patient's rights

Patients' rights:

1. You have the right to see your medical records and have a copy of them. You must supply this office with a written request for a copy of your records.

2. You have the right to request corrections or amendments to your records. This request must be in writing and we have the right to deny your request if

    a. It was not created by us.
    b. It is accurate and complete.

3. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. This request must be in writing. An example of this would be if you asked that we only contact you at work or my mail.

4. You have the right to restrict use and disclosure of information.

5. You have the right to know who requested and received your medical information.

Privacy Procedures

1. We will only discuss our patients with those who have a legitimate reason to know.

2. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friend your condition. If you do not want anyone else informed about your condition you must put this request in writing.

3. We may use and disclose medical information when we contact you by phone as a reminder that you have an appointment for treatment.

4. When we make your appointment we will ask your permission to leave the confirmation information about your appointment on your answering machine or to whomever answers your phone.

5. We will disclose medical information about you when required to do so by Federal, State, or Local Law.

6. We will use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, the health and safety of the public or another person.

Signature;_____Date_____