QUINCY SPINE CENTER - Richard Mazzaferro, D.O., F.A.A.P.M.R. – Jeffery Jackel, D.M.D., M.D. – Cristin McMurray, MD

Patient: ______________________________ Spoke to pt: __________

Age: ______ Date of Birth: ________________ Sex: M F Prior Pt: No Yes: When __________

Address: ____

Phone: __________________ Phone: ________________ Email: ________________

Referring Physician: ______________________________ Ph: ________________

PCP: ______________________________________ Ph: ________________

Local Pharmacy: ____

Diagnosis/Reason for visit: ____

Have you had any films or reports taken (MRI's, CT's, Xray's, EMG's, etc.): Yes No Where? ______________ When? ______________

Have you ever been seen previously by another Pain Clinic or another physician for your pain Yes No Where? ______________ When: ______________

Have you had any spinal injections: Yes No Where? ______________ When? ______________

Have you had any spinal surgeries: Yes No Where? ______________ When? ______________

Have you gone to PT? Yes No Where? ______________ When? ______________

Have you gone to chiropractor? Yes No Where? ______________ When? ______________

Worker's Compensation Yes No **Auto Accident** Yes No

<u>Primary Insurance</u>

Name: ______________________________

ID #: ______________________________

<u>Secondary Insurance</u>

Name: ______________________________

ID #: ______________________________

…….. (please circle)…. **<u>WORKER'S COMPENSATION / MOTOR VEHICLE ACCIDENT</u>**

Insurance: ______________________________ Claim #: ________________

Date of Injury: ____________ Employer: (if WC) ______________________________

Billing Address: ____

Adjuster: ____________________ PH: ______________ FAX: ______________

WC-UR: ____________________ PH: ______________ FAX: ______________

WC-Nurse: ____________________ PH: ______________ FAX: ______________

If you are unable to make your appointment, we kindly request you give a 24 hour notice. You will be subject to a $25.00 "No Show" fee for your appointment.

Signature: ______________________________________ **Date:** ______ /______ /______

I hereby reassign to the physician for medical services rendered to me/my dependents. I understand that I am responsible any amount not covered by my insurance(s).

Signature: ______________________________________ **Date:** ______ /______ /______

Health Insurance and Medicare Authorization

I authorize payment for medical services performed by Quincy Spine Center to be paid directly to Quincy Spine Center. These include medical services and treatment resulting from motor vehicle accidents, and work related injuries and other injuries resulting in third party liability. I authorize the staff of Quincy Spine Center's office to release my health insurer and/or the Health Care Finance Administration (HCFA) and its agent and information needed to determine benefits. I authorize the release of information to Medicare under Title XVII of the Social Security Act. I understand that I am financially responsible for any allowed balance no covered under my insurance benefits. A copy of this signature is as valid as the original.

Referral Responsibility

I understand that I am responsible for obtaining all my referrals to Quincy Spine Center from my primary care physician or pediatrician, under the terms of my contract with my managed care health insurance plan. These include original, as well as subsequent referrals. If referrals are not obtained, and insurance coverage is denied or benefits reduced, I accept full responsibility for the cost of medical services provided.

Appointment Confirmation and Physician/Staff Phone Calls

I give permission for Quincy Spine Center and/or his staff to contact me at my registration phone numbers to leave messages regarding upcoming appointments. Phone calls cannot be returned to "call-blocked" phone numbers/ messages left from a "call-blocked" phone number.

Patient Authorization for use and Disclosure of Protected Health Information

Sharing and Obtaining Information: I agree to allow Quincy Spine Center to share and/or obtain medical related information with/from my other treating physicians. This is essential if adverse medication interactions are to be avoided, reports and/or office notes are needed for further treatment. I agree to allow Quincy Spine Center to freely discuss my case with any other physician currently or previously involved in my medical care.

Name of Primary Care Physician and/or Referring Physician: ______________________________

I do not have to sign this authorization in order to receive treatment from Quincy Spine Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Quincy Spine Center
300 Congress Street, Suite 304
Quincy, MA 02169

Signature: ______________________________ ______________________________
Signature of Patient or Legal Guardian (if under the age of 18) Date

____
Print Name

QUINCY SPINE CENTER

RICHARD MAZZAFERRO, D.O. – JEFFREY JACKEL, D.M.D., M.D. – CRISTIN MCMURRAY, M.D.
300 CONGRESS STREET, SUITE 304, QUINCY, MA 02169

MEDICATION POLICY

The Quincy Spine Center has a very strict policy regarding medications. No prescriptions will be written for a patient unless you have been evaluated.

The Medication Policy at The Quincy Spine Center is designed to enhance patient safety and the appropriate use of medication. We have established certain guidelines concerning the use and the prescribing of pain medications. Despite our desire to relieve your pain, medication carries the potential for addiction, habituation, and unintentional abuse. It is our policy that each patient should have only the minimum amount of medication possible.

Prescriptions will not be released earlier than your appointment date.

- A follow up visit must be made in order to refill any medications. This appointment MUST be kept. If you are unable to keep ANY scheduled appointment we require at least 24-hour notice, otherwise there will be a charge of $25.00.

After business hours, holidays, and weekends: NO prescriptions will be written at these times. Prescriptions will be written only during regular office hours. Therefore, it is your responsibility to closely monitor your supply of medications.

- State and Federal laws strictly prohibit selling or distributing. This is an illegal practice and could result in criminal drug charges.
- Sharing medications is strictly prohibited. Medications are only to be used by you as prescribed.
- Driving or operating heavy machinery is prohibited when taking controlled substances. In certain cases an evaluation may be required to determine if you are able to safely operate a vehicle.
- Obtaining pain medications from more than one physician is called doctor shopping and State Law strictly prohibits it. This is an illegal practice and could result in criminal drug charges.

This office will not be held responsible for lost or stolen medication.

If it comes to our attention that you are getting pain medications from another doctor as well as Dr. Mazzaferro, we will need to terminate our relationship with you as an established patient.

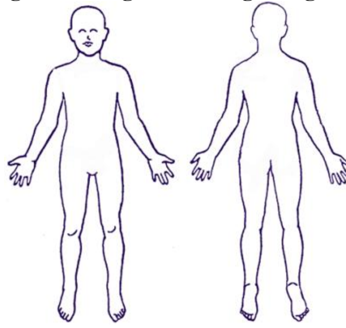
By signing below I agree to the terms of Quincy Spine Center's Medication Policy.

Patient Signature: ______________________________ Date: ______________________

Print Name: ____

Name: ______________________________ Age: _______ Date: _________ Who referred you? _______________________

Using the diagram below, mark the area on your body where you feel the most pain.
Please describe type of pain (i.e. numbness, aching, burning, stabbing, tingling, etc.)



Please circle the number that corresponds to you average BACK/NECK pain over the last few days.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

Please circle the number that corresponds to you average LEG/ARM pain over the last few days.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

What makes your symptoms better? ____

What makes your symptoms feel worse? ____

Are you experiencing…

Numbness? Yes/No ____

Weakness? Yes/No ____

Bowel/Bladder Problems? Yes/No ____

Pain with Walking? Yes/No ____

When did your symptoms begin? _____ /_____ /______ (approximate date)

Have you had similar attacks in the past? ____

What was the cause of your pain? ____

What medications are you currently taking (include dosage)? (If you have a copy of your meds, please attach)

____

____

____

____

____

____

Patient Name: ______________________________ Date: ________________

Have you had any of the following diagnostic procedures done in evaluation for **this episode** of pain?

	DATE:	WHERE:
Bone Scan	_____ /_____ /_____	______________________
CT Scan	_____ /_____ /_____	______________________
Myelogram	_____ /_____ /_____	______________________
EMG	_____ /_____ /_____	______________________
X-Rays	_____ /_____ /_____	______________________
Blood Work	_____ /_____ /_____	______________________
Discogram	_____ /_____ /_____	______________________
MRI	_____ /_____ /_____	______________________

What kind of treatment have you received in this current episode of pain?

Bed Rest	Yes ____	No ____		Acupuncture	Yes ____	No ____	When____
Medication	Yes ____	No ____		Facet Injections	Yes ____	No ____	When____
Brace	Yes ____	No ____		Epidural Injections	Yes ____	No ____	When____
Physical Therapy	Yes ____	No ____	When____	Other Injections	Yes ____	No ____	When____
Chiropractor	Yes ____	No ____	When____				

Allergies ____

Have you had any previous complications with anesthetics?

Yes ____ No ____

Have you had problems with addiction to prescription or non-prescription medications?

Yes ____ No ____

What type of spine surgeries have you had? ______________________________

When __________________ Where ____________________ By Whom ____________________

When __________________ Where ____________________ By Whom ____________________

Past surgical history (please include dates):

____

____

Past medical history (personal) (please include dates):

____

____

Family medical history:

____

____

Are you married: ____________ Single: ____________ Divorced: ____________ Other: ____________

Do you smoke? ____________ How many cigarettes/packs a day? ____________ How many years? ____________

Do you drink alcohol? __________ How many a drinks a day/week? ____________ How long? ____________

What is your current occupation/work status? ______________________________

If you are out of work, for how long? ______________________________

Do you exercise regularly? ________________ What is your height? __________ Weight? __________

Are you involved in a personal injury lawsuit because of your pain? ______________________

Date of last Influenza (Flu) Shot: ______________

Date of last Pneumonia Shot: ______________

Date of last Colonoscopy: ______________

Date of last Mammogram: ______________

Date of last Osteoporosis Screening: ______________

Patient Intake Questionnaire

Patient Name: ______________________________ Date: ______________

Check off any symptoms you now have:

__Fever/Chills __Excessive Sweating __Fatigue __Significant Weight Change
__Vision Changes __Eye pain/Redness __Headaches __Insomnia
__Hearing Loss __Nose Bleeds __Oral Lesions __Throat Disorder
__Heart Trouble __Chest Pain __Heart Skipping __Palpitations
__Swollen Ankles __Leg Cramps __Swollen Glands __High Blood Pressure
__Shortness of Breath __Cough __Wheezing __Bloody Sputum
__Heartburn __Abdominal Pain __Reflux __Change in Bowel Habits
__Incontinence __Urinary Frequency __Blood in Urine __Menstrual Changes
__Pain in Joints __Decreased Range of Motion __Persistent Infections __Muscle Weakness/Paralysis
__Skin Lesions __Rashes/Bumps __Jaundice __Easy Bruising
__Numbness __Tremor Dizziness __Fainting __Prolonged Bleeding
__Nervousness __Depression __Anxiety __Excessive Thirst

This part of the questionnaire is designed to give your caregiver information on how your pain has affected your ability to manage in everyday life. Please answer every section to the best of your ability and mark in each section only the box that applies to you. We realize you may consider two statements in any section may relate to you, but please **check only one number that most closely describes your problem.**

Pain Intensity
__0 I can tolerate the pain I have without have to use painkillers.
__1 The pain is bad, but I manage without taking painkillers.
__2 Painkillers give me complete relief from pain.
__3 Painkillers give me moderate relief from pain.
__4 Painkillers give me very little relief from pain.
__5 Painkillers have no effect on the pain and I do not use them.

Getting Dressed (in the past week)
__0 I can dress myself.
__1 I can dress myself without increasing pain.
__2 I can dress myself, but pain increases.
__3 I can dress myself, but with significant pain.
__4 I can dress myself, but with severe pain.
__5 I cannot dress myself due to pain.

Lifting (in the past week)
__0 I can lift heavy objects without pain.
__1 I can lift heavy objects, but it is painful.
__2 Pain prevents me from lifting heavy objects off the floor, but I can manage off the table.
__3 Pain prevents me from lifting heavy objects in general, I can manage light to medium if they are conveniently positioned.
__4 I can only lift light objects.
__5 I cannot lift or carry anything.

Walking and Running (in the past week)
__0 I can walk and/or run without pain.
__1 I can walk comfortably, but running is painful.
__2 Pain prevents me from walking more than an hour.
__3 Pain prevents me from walking more than 20 minutes.
__4 Pain prevents me from walking more than 10 minutes.
__5 I am unable to walk or can only walk a few steps at a time.

Sitting (in the past week)
__0 I can sit in any chair as long as I want.
__1 I can only sit in a special chair for as long as I want.
__2 Pain prevents me from sitting longer than 1 hour.
__3 Pain prevents me from sitting longer than ½ hour.
__4 Pain prevents me from sitting longer than 10 minutes.
__5 Pain prevents me from sitting at all.

Standing (in the past week)
__0 I can stand as long as I want.
__1 I can stand as long as I want, but it gives me pain.
__2 Pain prevents me from standing longer than 1 hour.
__3 Pain prevents me from standing longer than 30 min.
__4 Pain prevents me from standing longer than 10 min.
__5 Pain prevents me from standing at all.

Sleeping (in the past week)
__0 I sleep well.
__1 Pain occasionally interrupts my sleep.
__2 Pain interrupts my sleep half of the time.
__3 Pain often interrupts my sleep.
__4 Pain always interrupts my sleep.
__5 I never sleep well.

Sex Life (in the past week)
__0 My sex life is unchanged.
__1 My sex life is unchanged but causes some pain.
__2 My sex life is nearly unchanged, but very painful.
__3 My sex life is severely restricted because of pain.
__4 My sex life is nearly absent because of pain.
__5 Pain prevents any sex life at all.

Social Life (in the past week)
__0 My social and recreational life is unchanged.
__1 My social/rec. life is unchanged, but it increases pain.
__2 My social/rec. life is unchanged, but it severely increases pain.
__3 Pain has restricted my social/rec. life.
__4 Pain has severely restricted my social/rec. life.
__5 I essentially have no social/rec. life due to pain.

Traveling (in the past week)
__0 I can travel anywhere.
__1 I can travel anywhere but it gives me some pain.
__2 Pain is bad, but I can manage to travel over 2 hours.
__3 Pain restricts me to trips of less than 1 hour
__4 Pain restricts me to trips of less than 30 minutes.
__5 Pain prevents me from traveling.