NEW PATIENT HEALTH INTAKE FORM

Name (Last, First, Middle): _____
Date of Birth:____/____/____ Age:_____ Sex: ____Male ____Female Other_____
Marital Status ___Single ___Married ___Widow ___Divorce ___Other
Address:_____ City:_____State:_____ Zip:_____
Home Phone:_____ Cell/Work Phone:_____
Occupation:_____
Employer/School Name & Address:_____
Emergency Contact Person:_____ Phone:_____

INSURANCE INFORMATION

Primary Insurance
Insurance name: _____
Subscriber: _____
Policy Number: _____
Group Number: _____
Insured's DOB: _____
No Fault: _____
Claim Number: _____

Secondary Insurance
Insurance Name: _____
Subscriber: _____
Policy Number: _____
Group Number: _____
Insured's DOB: _____
Workers Compensation: _____
Policy Number: _____

PHYSICIAN(S) INFORMATION

Referring Physician: _____ Phone #:( )_____
Primary Care Physician: _____ Phone #:( )_____

TRIGGER POINT INJECTION CONSENT

THE TREATMENT

Trigger point injections (TPI) is used to treat extremely painful and tender areas of muscle. Normal muscle contracts and relaxes when it is active. A trigger point is a knot or tight band in muscle that forms when muscle fails to relax. The knot often can be felt under the skin and may twitch involuntary when touched (called a jump sign). The trigger point can trap or irritate surrounding nerves and cause referred pain-pain felt in another part of the body or in teeth. Scar tissue and loss or range of motion and weakness may form over time. A small needle is inserted into the trigger point and local anesthetic (e.g., Lidocaine), and or Sarapin is Injected and have been found to be very effective in relieving pain, and may be used in combination with home exercise, heat, cold and individualized

RISK AND COMPLICATIONS

Before undergoing the procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks that are not Included on this list. Some of these risks, if they occur, may necessitate additional surgery, prolonged hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential to; 1. You may develop infection; 2. You may experience bleeding; 3. You may develop irritation at the injection site; 4. There may be skin changes; 5. You may develop bruising, redness or swelling; 6. The lung (or the pleura, which Is the surrounding membrane) may be punctured if the procedure is performed In a muscle near the ribcage, and 7. The procedure may fail to reduce the pain symptoms.

RESULTS

You may receive the following benefits. The doctors cannot guarantee you will receive any of these benefits. Only you can decide if the benefits are worth the risk. Trigger point injections are used to alleviate myofascial pain syndrome (chronic pain involving tissue that surrounds muscle) that does not respond to other treatments, although there is some debate over its effectiveness. Many muscle groups especially those in the arms, legs, lower back, and neck are dysfunction, and other types of orofacial pain.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with trigger point injections for myofascial pain. TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

_____ _____ _____
Patient's Name (or guarantor) Signature Date

_____ _____ _____
(Provider) Name Signature Date

PATIENT MEDICAL INFORMATION

CHIEF COMPLAINT (S)/ INJURY DESCRIPTION

Patient Name: _____ DOB: _____

ALLERGIES: _____ NO _____ YES please list: _____

●Chief Complaint(s):_____

●Onset date: when did this symptom (s) begin?_____• Have you had this symptom(s) before? __ No __Yes when?_____

●**IS this an injury**? __NO __Yes: Date of Accident/Injury:___/___/___Location:_____

Nature of the injury: **__Auto Collision __On-the-Job Injury** __Other Description:_____

If auto accident, you were a __Driver __Passenger __Pedestrian and struck from __Behind __Rt. Side __Lt Side __Front

If an Attorney is Involved, Attorney's Name:_____ Phone:_____

●Are you currently working? __N/A __ No __Yes: if no, last date worked:_____ If yes, any restrictions?_____

● Have you had Surgery for this Injury? __No __Yes: Type of surgery:_____ Date of surgery:_____

●Medical Care/Treatment related to current condition/injury (check all that apply and write date of the care/treatment)

□Primary Doctor:_____ □X-Ray:_____ □Orthopedic Dr.:_____

□ Neurologist:_____ □MRI:_____ □Chiropractor:_____

□Physical Therapy:_____ □Other:_____

●Have you received any Physical Therapy Service this year? □None □1-5 visits □6-10visits □11-15 visits □16-20 visits □ ≥ 21 visits

PAIN HISTORY DESCRIPTION

• How would you rate your pain on a scale of 0-10?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate		Severe		Very Severe		Worst

• Pain Description (mark all that apply)

□ Sharp □Stabbing □Dull □Aching □Burning □Numb/Tingling □Spasm/Stiff □Radiating

• What makes It better? Activity:_____ Time of day:_____

• What makes It worse? Activity:_____ Time of day:_____

• Check those activities below during which you experience difficulty:

□ Sit to Stand □ Standing for long time □Walking □ Stair Climbing □ Running □Sports

□ Pulling □ Pushing □ Lifting □ Bending forward/backward □ Squatting □ Sitting for long time

□ Dressing □Toileting □ Bathing □ Getting In/out of car □ Sexual Activity □ Grocery Shopping

MEDICAL CONDITION/MEDICATIONS

● Do you have any of the following? (Mark all that apply)

□ AIDS/HIV positive	□ Epilepsy	□ Osteoporosis	□ Endometriosis
□ Allergies	□ Gout	□ Pacemaker	□ Miscarriage
□ Anemia	□ Heart Attack	□ Parkinsonism	□ Heart Surgery_____
□ Arthritis	□ Hepatitis	□ Pneumonia	□ Vaginal Infection
□ Asthma/Bronchitis	□ Hernia	□ Prostate Problem	□ Pins/Metal Implants:_____
□ Blood Clot	□ High Blood Pressure	□ Sleeping Problems	□ Joint Replacement:_____
□ Cancer: _____	□ High Cholesterol	□ Stroke/TIA	□ Neck/Back Surgery
□ Cataracts/Glaucoma	□ kidney disease:_____	□ Thyroid Problems	□ Shoulder/Arm/Hand Surgery
□ Coronary Heart Disease/Angina	□ Liver Disease:_____	□ Ulcers:_____	□ Knee/Ankle/Foot Surgery
□ Pelvic Inflammatory Disease	□ Incontinence(urinary/Fecal)	□ Multiple Sclerosis	□ Migraine/Headaches
□ Complicated Pregnancy/Delivery	□ Diabetes	□ Emphysema/COPD	□ Other:_____

List Medications/Drugs/Supplements/Herbs you are currently taking:_____

Rutman Medical PLLC
Phone: 631 886 1500

OUT OF NETWORK DISCLOSURE FORM AND FINANCIAL AGREEMENT

Thank you for choosing our facility for your care. We are committed to providing quality medical care for you. To reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it prior to beginning treatment.

Out of Network:

We are an out of network health care provider with most health care plans. In many instances, your health care plan may not fully pay our charges for medical services. As a result, we have an obligation to bill you for coinsurance, deductible and costs share amount for non-covered services. You, the patient, agree that you will be responsible for these potential fees.

Should your insurer remit payment to you directly for services provided, you agree to immediately forward those payments to Rutman Medical PLLC. Insurance checks must be endorsed on the back to Rutman Medical PLLC after which the patient will sign their name.

Overdue Balances:

Should payment for services not be forthcoming, the matter may be referred to an attorney for collection. If the matter is sent to an attorney, in addition to the full balance due, the patient will also be responsible for legal fees and court costs in connection with the collection.

I hereby authorize Rutman Medical PLLC to release information required by my insurance company for payment of my medical bills or to review activities related to my healthcare provider's participation in my health plan. I assign Rutman Medical PLLC all benefits to which the patient or insured party is entitled for medical services rendered.

I have read this Financial Policy and agree to abide by it:

_____	_____	_____
Patient Name (Please Print)	Signature of Patient or Guardian	Date