Prestige Pain Centers

Gurbir Johal M.D.
P. O. Box 370
Carteret, New Jersey 07008
T: (732)-887-2004
F: (732)-882-6364

PATIENT REGISTRATION FORM

Date: _____
Fecha

First Name: _____ **Last Name:** _____
Primer Nombre *Apellido*

Address: _____
Domicilio

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Codigo Postal*

Race/Ethnicity: _____ **Language**: _____
Raza/Etnicidad *Idioma*

Home Number: _____ **Cell:** _____
Telefono de casa *Celular*
E-mail: _____

Social Security: _____ - _____ - _____ **Date of Birth:** _____/_____/_____ **Age:** _____
Seguro Social *Fecha de Nacimiento* *Edad*

Marital Status: Married _____ **Single**_____ **Divorce** _____ **Widow** _____ **Separated** _____
Estatus Marital *Casado* *Soltero* *Divorciado* *Viudo* *Separado*

Patient's Employment: _____
Empleador Del Paciente

Address: _____
Domicilio

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Codigo Postal*

Next of Kin in Case of Emergency: _____
Contacto de Emergencia

Relationship to Patient: _____ **Phone:** _____
Relación con el Paciente

Description of Illness or Injury *Descripción de enfermedad o lesión*:

_____

_____

_____

Referred By: _____ **Phone:** _____
Referido Por *Teléfono*

Primary Care Doctor: _____ **Phone:** _____
Doctor Primario *Teléfono*

INSURANCE INFORMATION ***(INFORMACION DE LA ASEGURANZA)***

Insurance Name: _____
Nombre de la aseguranza

Claims Address: _____
Direccion

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Código Postal*

Policy or Identification Number: _____
Numero de Póliza o Identificación

Group Number: _____ **Telephone Number:** _____
Numero de grupo *Teléfono*

Insured Person's Full Name: _____
Nombre de la persona asegurada

WORKERS COMP OR MOTOR VEHICLE ACCIDENT
COMPENSACION A TRABAJADORES O ACCIDENTE AUTOMOVILISTICO

Date of Injury or Accident Occurred: _____
Fecha de Lesión o Accidente

Attorney or Insurance Carrier: _____
Abogado o Compañía de Aseguranza

Claims Address: _____
Direccion

City: _____ **State:** _____ **Zip Code:** _____
Ciudad *Estado* *Codigo Postal*

Claim Number: _____ **Telephone Number:** _____
Numero de Reclamo *Teléfono*

Employer at time of Injury: _____
Empleador en el momento de Lesión

Case Worker or Adjustors Name:_____
Ajustador o Trabajador Social

Attorney Name, Address & Phone:_____
Direccion y Teléfono de abogadoo

The above information is complete to the best of my knowledge:
La información anterior ha sido completada en lo mejor de mi conocimiento

Patient/Guardian Signature: _____ **Date:** _____
Firma del Paciente/Guardian *Fecha*

HEALTH QUESTIONNAIRE
(QUESTIONARIO DE SALUD)

Name: _____ **Age:** _____
Nombre *Edad*

1. **Are you allergic to any medication** *Usted es alergico a un medicamento***?**

_____

_____

2. **Are you going to be requesting pain medications today?** ☐ **Yes** *(Si)* ☐ **No**
Solicitará medicamentos para el dolor el dia de hoy?

3. **List previous surgeries and dates** *Liste sirugias anteriores y las fechas***:**

_____

_____

4. **List any serious injuries and dates** *Liste lesiones graves y las fechas***:**

_____

_____

5. **Do you smoke** *Usted fuma***?** ☐ **No** ☐ **Yes** *(si)*

If yes, # of packs/day *si usted confirmo si, # de paquetes al dia* ____ **Years smoked** *Años fumando* ____

If no, have you ever smoked *Si usted confirmo no, alguna vez ha fumado***?** ☐**No** ☐**Yes** *(Si)* **Years smoked** *Años fumando* _____

6. **Do you drink alcohol** *Usted consume alcohol***?** ☐ **No** ☐ **Yes** *(Si)*

If yes, # of drinks/week *Si usted confirmo si, # de bebidas a la semana* _____

7. **Do you have any history of overdosing on meds** *Tiene usted un historial de sobredosis en medicamentos***?**☐**No**☐**Yes** *(Si)*

If yes, how long ago, and on what medication *Si confirmo si, hace cuanto y en que medicamento***?**

_____

_____

8. **Do you have any history of illegal drug use** *Tiene usted historial de uso de drogas ilegales* **?** ☐**No** ☐ **Yes** *(Si)*

If yes, how long was use *Si confirmo si, por cuanto tiempo***?** _____ **When did you quit** *Cuando renuncio*? _____

and on what drug? Please circle *Y en que droga? Por favor circule***:**

Cocaine ☐ **Heroine** ☐ **Methamphetamine** ☐ **Alcohol** ☐ **Marijuana** ☐ **Other:** _____
Cocaina *Heroina* *Metanfetamina* *Otro*

Current use *Uso actual***?** ☐**No** ☐ **Yes** *(Si)*

HEALTH QUESTIONNAIRE
(QUESTIONARIO DE SALUD)

9. **Do any of the following apply to a blood relative? Circle all that apply.**
Alguno de los siguientes se aplican a un pariente de sangre? Circule el que aplique

	Relationship *(Relacion)*		
☐ **Arthritis** *(Artritis)*	_____		
☐ **Asthma** *(Asma)*	_____	☐ **Hepatitis**	_____
☐ **Bleeding Tendency** *(Tendencia a Sangrar)*	_____	☐ **High Blood Pressure** *(Alta precion)*	_____
☐ **Blood Disorders** *(Trastorno Sanguinio)*	_____	☐ **Kidney Disorder** *(Trastorno del Riñon)*	_____
☐ **Cancer**	_____	☐ **Lung Disorder** *(Trastorno del Pulmon)*	_____
☐ **Diabetes**	_____	☐ **Nerve Disorder** *(Trastorno Nervioso)*	_____
☐ **Heart Disease** *(Enfermedad del Corazon)*	_____	☐ **Stroke**	_____

10. **Have you ever been treated for any of the following problems? (Mark all that apply)**
Alguna vez a sido tratado por alguno de los siguientes problemas (Marque lo que corresponda)

☐ **Weight loss, chronic fevers** *(Perdida de peso, fiebre cronica)*
☐ **Asthma** *(Asma)*
☐ **Hepatitis**
☐ **Skin Lesions/Rashes** *(Lesiones de la piel / Erupciones)*
☐ **Visual Disturbances or Loss** *(Trastornos visuales o perdida)*
☐ **Breast Lesions** *(Lesiones de Pecho)*
☐ **Dizzy Spells / Blackouts** *(Mareos/Desmayos)*
☐ **Seizures** *(Convulciones)*
☐ **Diabetes**
☐ **Arthritis** *(Artritis)*
☐ **Difficulty Swallowing** *(Dificultad para Tragar)*
☐ **Vomiting Blood** *(Vomitando Sangre)*
☐ **Hearing Loss** *(Perdida Auditiva)*
☐ **Stomach Ulcers** *(Ulceras Estomacales)*
☐ **Ear / Sinus Infections** *(Infecciones de Oido/Sinucitis)*
☐ **Blood in Stools** *(Sangre en defeco)*
☐ **Arm or Leg Weakness** *(Debilidad en Brazos o Piernas)*
☐ **High Blood Pressure** *(Alta Precion)*
☐ **Heart Attacks** *(Ataques al Corazon)*
☐ **Urinary Tract Infections** *(Infecciones Urinarias)*
☐ **Blood in Urine** *(Sangre en la Orina)*
☐ **Thyroid Disease** *(Enfermedad de la Tiroides)*
☐ **Arrhythmia / Palpitations** *(Arritmia/Palpitaciones)*
☐ **Difficulty Voiding** *(Dificultad al defecar)*
☐ **Anemia/Bleeding Problems** *(Anemia/Problemas de sangrado)*
☐ **Tuberculosis**
☐ **Shortness of Breath** *(Falta de aliento)*
☐ **Sexual Difficulties** *(Dificultades Sexuales)*
☐ **Drug Addiction** *(Adiccion a las drogas)*
☐ **Psychiatric Illness** *(Enfermedad Psiquiatrica)*
☐ **Infectious disease (HIV, Hepatitis, H1N1)** *(Enfermedades infecciosas [SIDA, Hepatitis, H1N1])*

Signature: _____ **Date:** _____
Firma *Fecha*

Prestige Pain Centers

DATE *(FECHA)*: _____

YOUR NAME *(NOMBRE)*:_____**PHONE NUMBER** *(TELEFONO)*: _____

ADDRESS *(DOMICILIO)*: _____

INSURANCE *(ASEGURAZA)*: _____

PRIMARE CARE PROVIDER NAME *(DOCTOR PRIMARIO)*:_____

1. **WHERE IS YOUR MAIN AREA OF PAIN TODAY?(PLEASE CHECK ✓ ALL THAT APPLY)** *(DONDE ESTA SU AREA PRINSIPAL DE DOLOR)*

☐ **HEAD** *(CABEZA)*	☐ **CHEST** *(PECHO)*	☐ **ABDOMEN**	☐ **NECK** *(CUELLO)*
☐ **UPPER BACK** *(ESPALDA ALTA)*	☐ **LOWER BACK** *(ESPALDA BAJA)*	☐ **MIDDLE BACK** *(ESPALDA MEDIA)*	
☐ **KNEES** *(RODILLAS)*	☐ **Left** *(Izquierda)*	☐ **Right** *(Derecha)*	☐ **Both** *(Ambas)*
☐ **SHOULDERS** *(HOMBROS)*	☐ **Left** *(Izquierdo)*	☐ **Right** *(Derecho)*	☐ **Both** *(Ambos)*
☐ **HIPS** *(CADERAS)*	☐ **Left** *(Izquierda)*	☐ **Right** *(Derecha)*	☐ **Both** *(Ambas)*
☐ **ARMS** *(BRAZOS)*	☐ **Left** *(Izquierda)*	☐ **Right** *(Derecha)*	☐ **Both** *(Ambos)*
☐ **LEGS** *(PIERNAS)*	☐ **Left** *(Izquierda)*	☐ **Right** *(Derecha)*	☐ **Both** *(Ambas)*
☐ **HANDS** *(MANOS)*	☐ **Left** *(Izquierda)*	☐ **Right** *(Derecha)*	☐ **Both** *(Ambas)*
☐ **FEET** *(PIES)*	☐ **Left** *(Izquierdo)*	☐ **Right** *(Derecho)*	☐ **Both** *(Ambos)*

OTHER *(OTRO)*: _____

2. **HOW WOULD YOU RATE THE PAIN ON A SCALE FROM 1-10? (PLEASE CIRCLE)**
COMO CALIFICARIA SU DOLOR EN LA ESCALA DEL 1-10? (POR FAVOR CIRCULE)

☐1☐ 2☐ 3☐ 4☐ 5☐6☐7☐8☐9☐10 **with pain medication** *(con medicamentos)*

☐1☐ 2☐3☐4☐5☐6☐7☐8☐9☐10 **without pain medication** *(sin medicamentos)*

3. **HOW WOULD YOU DESCRIBE THE PAIN? (PLEASE CIRCLE)***(COMO DESCRIBIRIA SU DOLOR? FAVOR DE CIRCULAR)*

☐ **Aching** *(Doloroso*☐**Burning** *(Ardor*☐ **Stabbing** *(Cuchillad*☐ **Shooting***(Dispara*☐**Sharp***(Fuerte*☐**Electricity** *(Electrico)*,

☐ **Numbness***(Adormecido)*☐**Tingling***(Hormigueo)*☐**Soreness** *(Infamado)*☐**Throbbing***(Palpitante)*☐**Pressure** *(Presion)*,

Other (Otro):

4. **WHAT RELIEVES THE PAIN? (PLEASE CIRCLE)** *(QUE ALIVIA SU DOLOR?)*_____

☐**Rest** *(Descanso*☐**Ice** *(Hielo*☐ **Heat** *(Calor*☐**Relaxation** *(Relajacion)*☐ **Medication** *(Medicamento)*☐ **Meditation** *(Meditacion)*☐ **Changing positions** *(Cambio de posicion)*, ☐**Injections** *(Injecciones)*☐ **Lying down** *(Al recostarse)*☐ **stretching** *(Estirandose)*

Other *(Otro)*: _____

5. **WHAT INCREASES THE PAIN? (PLEASE CIRCLE)** *(QUE AUMENTA SU DOLOR?(PORFAVOR CIRCULE)*

☐**Stress** *(Estres)*☐**Activity** *(Actividad)*☐**Walking** *(Caminar)*☐**Sitting** *(Sentado)*☐**Standing** *(De Pie)*☐ **Pushing on area** *(Empujando el area)*,

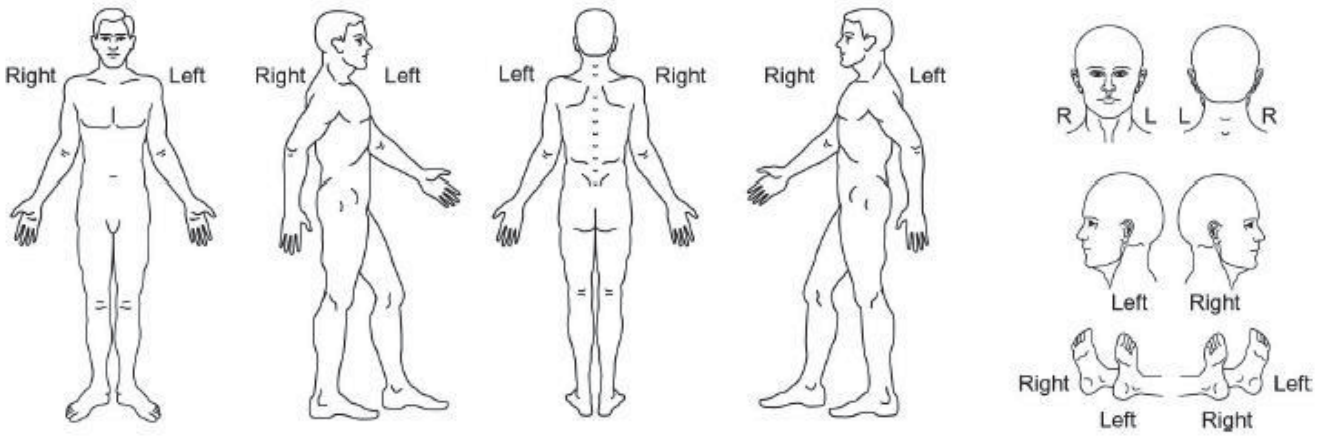
☐**Movement** *(Movimiento)*,☐ **Cold weather** *(Clima frio)*☐**Lifting** *(Levantamiento)*,☐ **Bending** *(Al doblarse)*,

Other *(Otro)*: _____

☐

Use this diagram to indicate the area of your pain. Mark the location with an "X"

(Utilice este diagrama para indicar la zona de tu dolor. Marque la ubicación con una "X")



My Current Medication List

Name: ______________________________ **DOB:** ____________________
(Nombre) *(Fecha de Nacimiento)*

Drug Allergies: ____
(Alergia a medicametos)

Medication *(Medicamento)*	**Strength** *(Dosis)*	**How Often?** *(Cada cuando)*	**Comments** *(Comentarios)*

Phone: 732-887-2004
Fax: 732-882-6364

Gurbir Johal, M.D.
Interventional Pain Medicine
Anesthesiology

CONSENT FOR MEDICAL TREATMENT

CONSENTIMIENTO PARA TRATAMIENTO MEDICO

The following information is to be completed by the patient or the patient's legally authorized representative /parent:

La siguiente informacion tiene que ser completada por el paciente o un representate/familiar legalmente autorizado:

_____

Print Patient Name *(Nombre Del Paciente)*

I consent to medical examination/treatment for myself or for the patient for whom I am the parent or, legally authorized representative. I understand that Prestige Pain Centers (Dr. Gurbir Johal) will share

Patient health information according to federal and state law for treatment, payment, and operations.

Yo consiento examen/tratamiento medico para mi o para el paciente del cual soy familiar o representante autorizado legal. Yo entiendo que Prestige Pain Centers(Dr. Gurbir Johal) compartira informacion medica del paciente de acuerdo a las leyes federales y estatales, pagos y otras opreraciones.

Signature of Patient: _____ **Date:** _____

Firma del Paciente ***Fecha***

Signature of Legally Authorized Representative:

_____

Firma del familiar o del representante autorizado

Relationship of Legally Authorized Representative to patient:

_____

Relacion del representante con el paciente

Phone: 732-887-2004
Fax: 732-882-6364

Gurbir Johal, M.D.
Interventional Pain Medicine
Anesthesiology

Patient Authorization for Use and Disclosure of Protected Health Information

Prestige Pain Centers will not disclose your medical information (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Prestige Pain Centers to release your medical information to parties indicated.

Authorized parties

By signing below, I authorize Prestige Pain Centers, to use and/or disclose any and all of my protected health information of any kind and description to the following party or parties:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I acknowledge that I have had the opportunity to review Prestige Pain Centes Notice of Privacy Practices, which is displayed for public inspection at its facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Prestige Pain Centers. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). 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 address is listed below:

Prestige Pain Centers
P.O. Box 370
Carteret, NJ 07008

Patient Name: _____

Signature of Patient or Legal Guardian: _____Date: _____

Phone: 732-887-2004
Fax: 732-882-6364

Gurbir Johal, M.D.
Interventional Pain Medicine
Anesthesiology

Authorization of Disclosure of Protected Health Information by another Covered Entity for Use by Prestige Pain Centers

Information to Be Used or Disclosed
Information to be obtained under this authorization includes:
Medical records

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:
- Third party billing and/or collection services
- Transcription services
- Interpreters for translation

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:
Legal representatives of Prestige Pain Centers

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:
Legal representatives of Prestige Pain Centers and their associates

Expiration Date of Authorization
This authorization unless revoked or terminated by the patient or the patient's personal representative**.**

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Prestige Pain Centers. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual
- You may inspect or request a copy of information that is used or disclosed under this authorization.
- You may refuse to sign this authorization.

Signature

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

Prestige Pain Centers

Gurbir Johal M.D.
P.O. Box 370
Carteret, New Jersey 07008

Billing address and inquiries
400 Route 34, Ste A
Matawan, New Jersey 07747
T: (732)-887-2004
F: (732)-882-6364

Assignment of Benefits

Patient _____

Ins. Company _____

Policy, Group _____

SS# / ID# / Claim # _____

I hereby authorize the _____ Insurance Company to pay by check made out and mailed to:

Prestige Pain Centers
Gurbir Johal, M.D.
PO Box 370
Carteret, NJ 07008

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

If my current policy prohibits direct payment to Prestige Pain Centers, I hereby also authorize you to make the check to me and mail it as follows:

c/o: **Prestige Pain Centers**
Gurbir Johal, M.D.
PO Box 370
Carteret, NJ 07008

I also hereby assign to Prestige Pain Centers all of my rights to obtain payment under the personal injury protection provisions of an automobile insurance policy or any other health insurance policy of any medical bills incurred as a result of my treatment, including the option to submit any dispute in my name to binding arbitration under the auspices of the American Arbitration Association or any other form that the provider deems appropriate.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____

X_____ _____
Signature of Policyholder Signature of Claimant, if other than Policyholder.

Prestige Pain Centers

Gurbir Johal M.D.
P.O. Box 370
Carteret, New Jersey 07008

Billing address and inquiries
400 Route 34, Ste A
Matawan, New Jersey 07747
T: (732)-887-2004
F: (732)-882-6364

Date:

Attorney:_____
_____
_____
_____

Patient Name: _____

D/A: _____

Dear Sir or Madam:

I hereby authorize the above doctor to furnish you my attorney, with a full report of his examination, diagnosis treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said doctor. I hereby further give a **lien** on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Dated: _____ Patient's Signature: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

I hereby consent to honor the terms of the above agreement in its entirety. I further agree to dispense all fees to my client's provider pursuant with R.P.C.1.15 in NJ, and DR9-102 in NY.

Dated: _____ Attorney's Signature: _____

Attorney: Please acknowledge this letter by returning a copy to the doctor's office at once.
Keep one copy for your records.