New Patient Information

Patient Name: _____DOB: _____ Age: _____
(Nombre de Paciente) (Fecha de Nacimiento) (Edad)

Address: _____ City: _____ ST: _____ Zip_____
(Direccion) (Ciudad) (Estado) (Codigo)

SSN: _____-_____-_____ Home Phone#_____ Work: _____ Cell: _____
(Numero de seguro social) (Telefono de casa) (Telefono de Trabajo) (Telefono de cellular)

Employer: _____ Phone#: _____
(Nombre de Empleo) (Telefono de Empleo)

Spouse's Name: _____ DOB: _____ Age: _____
(Nombre de Esposo/a) (Fecha de Nacimento) (Edad)

Spouse's Employer: _____ SSN: _____-_____-_____
(Empleo de Esposo/a) (Numero de seguro social)

Insurance Information

(Informacion sobre su Aseguransa)

Primary Insurance: **_____ Phone#: _____**
(Nombre de Aseguransa Primaria) (Numero de Telefono)

Claims Address: _____ City: _____ST: _____ Zip: _____
(Direccion) (Ciudad (Estado) (Codigo)

Insured's Name: _____ Group#_____
(Nombre de el persona que tienes el Aseguransa) (Numero de Grupo)

Member/ID#: _____ Policy#: _____
(Numero de miembro o ID) (Numero de Poliza)

Secondary Insurance

(Informacion sobre su Aseguransa Segundaria)

Secondary Insurance: _____ Phone#: _____
(Nombre de Aseguransa) (Numero de Telefono)

Claims Address: _____ City: _____ ST: _____ Zip: _____
(Direccion) (Ciudad) (Estado) (Codigo)

Insured's Name: _____ Group#_____
(Nombre de el persona que tienes el Aseguransa) (Numero de Grupo)

Member/ID#: _____ Policy#: _____
(Numero de miembro o ID) (Numero de Poliza)

Attorney's Name: _____ Phone#: _____
(Nombre de Abogado) (Telefono de su Abogado)

Address_____ City: _____ ST: _____ Zip: _____
(Direccion) (Ciudad) (Estado) (Codigo)

Date of Injury: _____ Who may we thank for referring you to our office? _____
(Fecha que fue lastimado) (Aquien le debemos las gracias por su referencia?)

Patient's Signature: _____ Date: _____
(Firma de Paciente) (Fecha)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By Joseph J. Schifini, MD, LTD. (JJS)

Patient Name: _____
Last First M.I**.** (Previous or Other Names Used)

Address: _____

_____

Date of Birth: _____

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

I authorize the release of medical records from: Joseph J. Schifini, MD, LTD
600 S. Tonopah Drive
Suite 240
Las Vegas, NV 89106

Please release requested medical records to:

Name: _____

Address: _____

City: _____

State: _____

ZIP: _____

Telephone Number: ( ) -

Fax Number: ( ) -

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

□ Emergency Records
□ Clinic Records
□ Lab Reports
□ Shot Records
□ Slides
□ Hospital Records
□ Radiology Reports
□ Radiology Films
□ Pathology Reports
□ Other _____

This authorization will expire on the 180th day of the signing unless a lesser date is specified below:

By signing this Authorization Form, I understand that I am giving my authorization for JJS to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying JJS in writing to Joseph J. Schifini, MD, LTD Health Information Management Department, 600 S. Tonopah Drive, Suite 240, Las Vegas, Nevada 89106 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by JJS before JJS received my written notice of revocation. If neither federal nor Nevada privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Nevada privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from JJS.

_____ _____
Signature of Patient or Authorized Personal Representative **Date**

_____ _____
Relationship to the Patient (If signed by a Personal Representative) **Date**

Joseph Schifini, M.D. **DATE** ____/____/____

PLEASE FILL OUT THIS FORM *COMPLETELY* SO WE CAN HELP YOU WITH YOUR PAINFUL CONDITION.

NAME:_____ **AGE**:_____ **SEX**: M / F **HEIGHT** ___'___" **WEIGHT**_____**lbs**
OCCUPATION:_____ **DATE LAST WORKED**____/____/____

CC: **WHY** WERE YOU REFERRED TO OUR CLINIC?_____

HPI: PLEASE **DESCRIBE YOUR PAIN** BY ***SHADING*** IN THE AFFECTED AREAS AND ***PLACING AN 'X'*** ON THE AREA THAT HURTS THE MOST. ***CIRCLE*** ALL APPLICABLE DESCRIPTIVE WORDS.

CONSTANT **T**EMPORARY

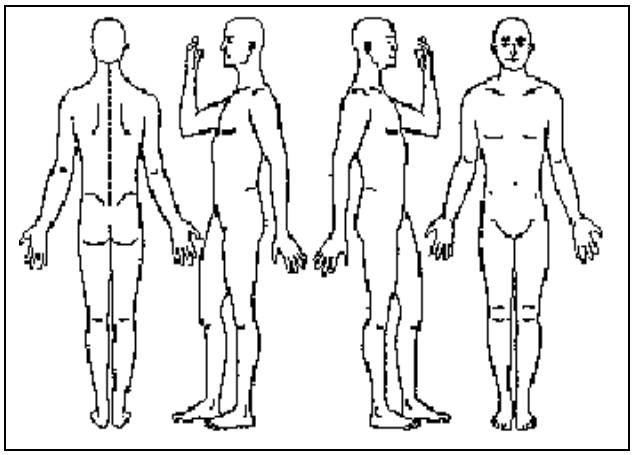
DAILY **O**CCASIONAL

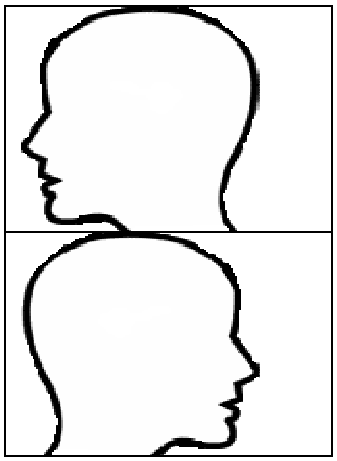
ACHING **S**HOOTING

BURNING **S**TABBING

NUMBING **T**INGLING

PINS/**N**EEDLES





PLEASE ATTEMPT TO QUANTIFY YOUR PAIN USING PERCENTAGES. YOUR TOTAL PAIN SHOULD ADD UP TO 100%. (*EXAMPLE:* 20% LOW BACK PAIN AND 80% RIGHT LEG PAIN = 100%.)

HEAD_____% **N**ECK_____% **R**IGHT **A**RM_____% **L**EFT **A**RM_____%

CHEST_____% **A**BDOMEN_____% **U**PPER **B**ACK_____% **M**ID **B**ACK_____%

LOWER **B**ACK_____% **H**IPS/**B**UTTOCKS_____% **R**IGHT **L**EG_____% **L**EFT **L**EG_____%

CIRCLE THE ACTIVITIES WHICH TEND TO ***INCREASE*** YOUR PAIN:

WALKING **L**IFTING **B**ENDING **T**WISTING **S**TANDING **S**ITTING

FILL IN ACTIVITIES WHICH ***DECREASE*** YOUR PAIN:_____

DOES THIS PAIN AFFECT YOUR **SLEEP**? **Y**ES / **N**O

CURRENT ***PAIN*** MEDICATIONS:_____PRESCRIBED BY **DR.**_____

MARK YOUR *AVERAGE* PAIN SCORE:
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

MARK YOUR *WORST* PAIN SCORE:
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
NOTE: (*ZERO* EQUALS *NO PAIN* AND *TEN* EQUALS YOUR *WORST* IMAGINABLE PAIN)

***WHEN* DID THIS PAIN BEGIN?**_____ (**S**PONTANEOUS/ **I**NJURY/ **A**CCIDENT/ **S**URGERY/ **O**THER)
PLEASE ***DESCRIBE*** **HOW** IT BEGAN:
_____
_____
_____
_____

HAVE YOU EVER HAD ANY ACCIDENTS OR INJURIES AFFECTING THESE SAME AREAS BEFORE? YES / NO
IF **YES**, WHEN?_____

TREATMENT: WHICH TYPES OF TREATMENT HAVE YOU HAD IN THE PAST TO TREAT YOUR CURRENT PAIN. PLEASE ***CIRCLE*** ALL THAT APPLY.

PAIN **C**LINIC **P**HYSICAL **T**HERAPY **M**ASSAGE **C**HIROPRACTIC **I**NJECTIONS **S**URGERY

ACUPUNCTURE **M**AGNETS **H**ERBS **O**THER:_____

PLEASE *LIST* ALL TREATMENT BELOW:

HEALTH CARE PROFESSIONAL	**APPROXIMATE DATES**	**DIAGNOSIS**	**TREATMENT/ MEDICATIONS**

DIAGNOSTIC EXAMINATIONS: PLEASE ***CIRCLE*** ALL THAT APPLY

XRAY **CT-**SCAN **M**RI **M**YELOGRAM **E**MG/**N**CV **O**THER_____

PAST/CURRENT MEDICAL HISTORY: PLEASE ***CIRCLE*** ALL THAT APPLY:

ARTHRITIS **A**STHMA **B**LEEDING **P**ROBLEMS **C**ANCER **C**IRRHOSIS **C**OLITIS **D**IABETES **E**MPHYSEMA
HEART TROUBLE **H**EPATITIS / **J**AUNDICE **H**IGH **B**LOOD **P**RESSURE **H**IV / **A**IDS **K**IDNEY **D**ISEASE
MURMUR **S**EIZURE **S**TROKE **T**HYROID **T**ROUBLE **U**RINATING **U**LCER **V**ASCULAR **D**ISEASE
ARE YOU TAKING ANY **BLOOD THINNERS** SUCH AS **COUMADIN, WARFARIN, PLAVIX, OR TICLID? YES / NO**
LIST ALL CURRENT **MEDICATIONS:**_____

ALLERGIES TO **MEDICATIONS**:_____

PAST SURGICAL HISTORY: (PLEASE ***LIST*** **ALL OPERATIONS** YOU HAVE HAD)_____
_____

SH: SINGLE____ **M**ARRIED____ **D**IVORCED____ **S**EPARATED____ **W**IDOWED____ **#** OF **C**HILDREN_____

PACKS OF **CIGARETTES** SMOKED/DAY_____ # OF **ALCOHOLIC** BEVERAGES/DAY_____

HISTORY OF **SUBSTANCE ABUSE YES / NO** IF **YES**, WHAT TYPE?_____

FH: ***LIST*** **ANY ILLNESSES** WHICH RUN IN YOUR **FAMILY:** _____

ROS: PLEASE ***CIRCLE*** ALL **SYMPTOMS** YOU MAY CURRENTLY HAVE: **C**HANGE IN **V**ISION **C**HEST **P**AIN
COUGH **D**IARRHEA / **C**ONSTIPATION **D**IZZINESS **E**ASY **B**LEEDING **F**AINTING **F**EVER **I**TCHING
SHORTNESS OF **B**REATH **S**TOMACH **P**ROBLEMS **U**RINARY **P**ROBLEMS **W**EIGHT **L**OSS / **W**EIGHT **G**AIN

WHO IS YOUR CURRENT **PRIMARY CARE PHYSICIAN / PROVIDER?**_____