Frederick
196 Thomas Johnson Dr
Suite 215
Frederick, MD 21702
Phone (301) 668-9988
Fax (301) 668-9977

Prince Frederick
80 Sherry Lane
Suite 101
Prince Frederick, MD 20678
Phone (410) 414-9229
Fax (410) 414-9339

Waldorf
3581 Old Washington Rd
Suite F
Waldorf, MD 20602
Phone (301) 638-4400
Fax (301) 638-2200

Leesburg
161 Ft. Evans Rd, NE
Suite 340
Leesburg, VA 20176
Phone (703) 443-8000
Fax (703) 443-8100

Newbridge

Welcome to Newbridge Spine & Pain Center

Thank you for choosing Newbridge Spine & Pain Center to manage your medical care. Our specialists are dedicated to providing you with the latest pain management treatments and procedures to aid in the relief of your chronic pain. We appreciate the trust you have given us and will continually strive to exceed your expectations.

To prepare for your first visit, please **complete the enclosed New Patient Packet** and take a moment to read through and **complete the last page of the Patient Handbook**. Please use only *blue or black ink* to complete these forms. This handbook features helpful information about our practice and the care we will be providing to you at our office.

Be sure to bring the following items with you to your first appointment:

- Your **entire signed and completed New Patient Packet**
- The **last page of your Patient Handbook** (please sign and date)
- Medical insurance card (*Our pre-authorization specialist will verify your insurance coverage prior to your first visit.)*
- Any copay and/or deductible payment
- Driver's license or photo identification
- Referral documentation from your referring physician
- All previous written reports of x-rays, MRIs, CT scans and/or EMGs

If you have any questions please feel free to contact us anytime. We look forward to meeting you soon.

Best Regards,

Jay Gonchigar

Jay Gonchigar, M.D.

Newbridge

Please complete using only blue or black ink

NEW PATIENT INFORMATION

NAME (Last, First, Middle Initial)			SUFFIX EG: Jr. Sr., II, III
STREET ADDRESS/ MAILING ADDRESS (PO BOX)		CITY	
COUNTY	STATE	ZIP CODE	GENDER ❑ MALE ❑ FEMALE
MARITAL STATUS ❑ SINGLE ❑ SEPARATED ❑ MARRIED ❑ DIVORCED ❑ WIDOWED		SOCIAL SECURITY #	DATE OF BIRTH
PHONE: HOME ❑ PRIMARY ❑ SECONDARY	PHONE: WORK ❑ PRIMARY ❑ SECONDARY	PHONE: CELL ❑ PRIMARY ❑ SECONDARY	

HOW DID YOU HEAR ABOUT US?

❑ PRIMARY CARE ❑ OTHER PHYSICIAN ❑ FAMILY/ FRIEND ❑ PRINT AD ❑ RADIO AD ❑ BROCHURE
❑ SOCIAL MEDIA ❑ SEARCH ENGINE / WEBSITE ❑ OTHER INTERNET ❑ OTHER _____

REFERRING PHYSICIAN (IF APPLICABLE)

REFERRING PHYSICIAN NAME (*IF APPLICABLE*) (Last, First)		PHONE	
STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE PHYSICIAN (IF APPLICABLE)

PHYSICIAN NAME (Last, First)		PHONE	
STREET ADDRESS	CITY	STATE	ZIP CODE

OTHER PERSONAL INFORMATION

EMPLOYMENT STATUS ❑ EMPLOYED ❑ UNEMPLOYED ❑ RETIRED ❑ DISABLED	OCCUPATION	EMPLOYER NAME

PLEASE PROVIDE YOUR EMAIL ADDRESS TO ACCESS / REVIEW YOUR MEDICAL INFORMATION/ PATIENT PORTAL ONLINE:

RACE	ETHNICITY
❑ NATIVE AMERICAN/ALASKAN NATIVE ❑ AFRICAN AMERICAN ❑ NATIVE HAWAIIAN/ PACIFIC ISLANDER ❑ ASIAN ❑ WHITE/CAUCASIAN ❑ OTHER _____ ❑ DECLINED ❑ MULTIRACIAL - SPECIFY_____	❑ HISPANIC OR LATINO ❑ NON-HISPANIC OR LATINO ❑ DECLINE TO PROVIDE INFORMATION

PRIMARY LANGUAGE

IF YOU ARE HERE AS A RESULT OF A WORKER'S COMPENSATION OR AUTO INJURY COMPLETE BELOW

❑ WORKERS COMPENSATION ❑ AUTO INSURANCE	DATE OF INURY
CLAIM #	CLAIM ADJUSTER NAME
WORKERS COMP OR **AUTO INSURANCE** CARRIER NAME	PHONE

Newbridge

Please complete using only blue or black ink

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER
INSURANCE CARRIER NAME	INSURANCE CARRIER NAME
INSURANCE PHONE #	INSURANCE PHONE #
INSURANCE ID#	INSURANCE ID #
GROUP #	GROUP #
SUBSCRIBER (POLICY HOLDER) NAME	SUBSCRIBER (POLICY HOLDER) NAME
BIRTHDATE (POLICY HOLDER)	BIRTHDATE (POLICY HOLDER)
POLICY HOLDER ADDRESS IF DIFFERENT FROM PATIENT	POLICY HOLDER ADDRESS IF DIFFERENT FROM PATIENT
PATIENT-SUBSCRIBER RELATIONSHIP ❑ SELF ❑ SPOUSE ❑ DEPENDENT ❑ OTHER	PATIENT-SUBSCRIBER RELATIONSHIP ❑ SELF ❑ SPOUSE ❑ DEPENDENT ❑ OTHER

Medical Billing Policy

- Payment is required when services are rendered. Accepted forms of payment include cash, checks, money orders, VISA and MasterCard.
- Rescheduling or canceling an appointment or procedure must be done at least 24 hours prior. If 24-hour advance notice is not provided, the patient will be assessed a $25 fee for office visits and $100 fee for procedures.
- Deductibles, co-payments and co-insurance amounts must be paid in full prior to receiving medical care and/or seeing a physician. Patients are responsible for verifying the amount of their deductible with their insurance company prior to their initial visit. Deductibles are due in full at the time of initial and subsequent visits.
- Insurance claims are filed on behalf of patients, however, patients are financially responsible for paying their own personal deductible and/or insurance co-payment.
- Patients are responsible for providing current primary and secondary insurance information at the time of their initial visit. Otherwise patients are financially responsible for any charges not covered by their insurance.
- Patients are responsible for providing any insurance changes and/or updates. If a patient's bill is incorrectly submitted to an insurance company due to a lack of updated information, the patient will be charged a $25 service fee and held financially responsible for charges not covered by their insurance.
- Patients without insurance and those unable to pay their deductible and/or co-payments are required to schedule and attend a meeting with the practice billing manager during which a payment plan must be arranged. At each appointment the payment plan must be current prior to receiving medical care or seeing a physician.
- If a patient's check is returned unpaid for any reason by the issuing bank, patients are liable for the amount of each returned check plus a $25 service charge.
- If a collection agency is required to collect a past due amount, the patient remains financially responsible and will be charged for the collection agency's fee in addition to the past due amount.
- This medical practice complies with Stark Law in regards to governing physician referrals and payments for those practices.

Medical Billing Policy (Page 2)

- Patients are required to present insurance cards for re-verification at each visit.
- Patients are assessed a $25 fee if additional paperwork, such as disability forms and/or secondary insurance forms, must be completed by our office staff.
- Patients are assessed a fee according to current state law if medical records are provided to an authorized party.
- It is the policy of Newbridge to extend "in-network benefits" to all our patients. Patients will be responsible for payments based on their in-network benefits. Payment of their in-network benefit amount is due at the time of service unless prior arrangements are approved by management.
- Patients are required to sign a copy of this billing policy agreement to be placed in the patient's medical file prior to their initial consultation.
- **Referrals:** If a patient's insurance company requires a referral be obtained prior to services rendered at a specialist, it is the patient's responsibility to obtain the referral from their primary physician and present it during their initial visit in order to be seen by the physician. If a patient inadvertently receives medical care or visits with the physician without a required referral, the patient will be financially responsible for the visit. If subsequent referrals are required, it remains the patient's responsibility to obtain and present the referrals at each applicable visit.
- **HMO:** Accepted providers must be verified by the patient and applicable referral paperwork must be provided to our office prior to receiving medical care.
- **Personal Injury Protection (PIP):** A pre-authorization specialist will verify the amount of PIP coverage available. Personal health insurance information is required so charges not covered by PIP can be submitted to the patient's personal health insurance company. If a patient's health insurance company requires a referral, it *must* be obtained and presented during the patient's first visit, even if a claim is being filed to PIP.
- **Worker's Compensation:**
    - Worker's compensation patients are required to provide correct case and financial coverage information prior to their first visit related to the case. Otherwise a $25 service fee will be charged to update medical and financial records as needed.
    - Worker's comp medical claims cannot be filed with personal insurance companies because treatment related to a worker's comp case is not covered under personal insurance plans. If submission of worker's comp charges to a personal insurance company is attempted, the worker's comp patient is then personally responsible for all charges.
    - Worker's comp patients are responsible for securing approval from their case worker for treatment prior to the patient's *initial* visit. Approval for subsequent visits will be obtained by the medical staff.
    - Worker's comp patients must bring the following to their first appointment: date of injury, claim number, name of worker's comp insurance company, name of case worker, case worker's phone and fax numbers.

Patient Acknowledgement

I have received, read, fully understand and agree to abide by the terms of this billing policy.

PATIENT SIGNATURE	DATE

Notice

As required by state and federal regulations, this notice serves to inform you that Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, and Newbridge Surgery Center at Prince Frederick, LLC, are solely owned by Jay Gonchigar, MD.

Treatment Consent and Assignment of Benefits

I hereby authorize the physicians of Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC, to provide medical treatment and release information pertaining to treatment, as deemed necessary, to my insurance companies, attorney, referring physician, primary care physician and any other medical professionals from which I am receiving treatment including pharmacies and other physicians not listed. I agree to allow Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC, to receive direct payments, for professional treatment of me, which would otherwise be payable to me for services rendered. My insurance carrier or I may revoke this authorization at any time in writing. In any case where insurance payment for services at Newbridge is sent directly to me I agree to endorse payment and mail this to Newbridge.

I hereby authorize direct medical benefit payments issued by my insurance company or companies be provided to the above named entities. I understand and agree to be financially responsible for all charges incurred as a result of my decision to be treated by Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC. I understand I am financially responsible for payment of deductibles, co-pays and non-covered charges as outlined by my healthcare insurance policy contract.

I indicate with my signature below that I have read, fully understand and accept the above statements.

PATIENT SIGNATURE	DATE

Disclosure of Medical Records and Medical Information

Patient records may be audited by health insurance companies, Medicare or the Office of Inspector General of the United States, for compliance with regulations. Medical records may also be seen by accrediting organizations, including Joint Commission for Accreditations of Healthcare Organizations, AAAHC or AAAASF. Patients have the right to receive a list of any and all entities receiving copies of their medical records and the reasons for disclosure. Patients must provide written notice if they do not want their records reviewed by regulatory agencies.

I understand it is Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC, policy to maintain patient privacy and confidentiality as mandated by the HIPPA Act of 1996. A patient's medical information will only be disclosed to previously unauthorized outside parties with the patient's written permission and verbal acknowledgment to a staff member that they are giving up their right to patient privacy and confidentiality. Patients are asked to make their family and friends aware of this patient confidentiality policy.

I understand I may be referred to Newbridge Spine & Pain Center, LLC, Newbridge Spine & Pain Center of Virginia, LLC, Newbridge Surgery Center at Frederick, LLC, Newbridge Surgery Center at Waldorf, LLC, Newbridge Surgery Center at Prince Frederick, LLC, for a procedure to be performed at said location. I acknowledge I am aware of the financial interest held by above said physician in said facilities.

I indicate with my signature below that I have read, fully understand and accept these policies

PATIENT SIGNATURE	DATE

Privacy Act Statement

This statement gives notice as required by the Healthcare Portability & Accountability Act of 1996.

Sections 1102(a), 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act of 1974 provides our office with the authority to collect your information, including your social security number, for assessment.

- Patients have the right to have their personal healthcare information kept confidential.
- Every patient's personal health information is kept confidential and only provided to authorized parties.
- No information will be shared with a spouse, family member, friend or significant other without a signed release from the patient.
- No medical records will be released to an unauthorized third party without a signed release from the patient with the exception of the patient's referring and primary care provider.
- Safeguards are in place with passwords for all employees to guard against illegal entry into our computer system by unlawful users. Users are restricted to only the information needed to perform duties for the office. No employee is allowed to take work home.
- If a chart must be removed from the office, it will be signed out only by a physician solely responsible for safeguarding and returning the records as soon as possible.
- A locked fireproof box is required for transport of medical records from this office.
- All employees and vendors sign a confidentiality agreement to protect patient information.
- All patient charts are locked in a file cabinet when the office is not occupied.

Reasons for collecting information from patients:

- A complete assessment must be done to accurately reflect a patient's current health. This includes information that can be used to show progress toward a patient's health goals.
- Information must be received from each patient to document quality standards are being met and appropriate health care is being provided to patients.
- Personal and demographic information is collected and utilized for patient identification and insurance verification purposes.
- Patients have the right to refuse to provide information. If patients refuse to provide or provide inaccurate information, the information will be completed as best as possible. However, if a patient does not provide enough information to provide proper treatment, providers have the right to deny services to the patient.
- Patient information is protected under HIPAA's privacy and security provisions.
- Patients have the right to see, copy, review, and request correction of their information at any time.

Purposes for which a patient's information is intended to be used:

- To file insurance claims on the patient's behalf for reimbursement for services rendered.
- To supply documentation on the patient's behalf for disability claims or litigation brought by the patient for injuries involving Worker's Compensation or PIP.
- To supply information to primary or referring physicians documenting the patient's treatment progress.
- To support regulatory and policy functions.
- To assess the effectiveness and quality of care.
- For survey and certification by Health Care Financing Administration (HCFA), State of Maryland, Commonwealth of Virginia and Joint Commission of Healthcare Organizations.
- To provide information to a patient's insurance provider for payment of the patient's claim.

Purposes for which patient information is intended to be used (*continued*):

- To provide information for disability claims by the patient.
- To provide information on a patient's condition for Worker's Compensation.
- For any litigation by the Department of Justice involving HCFA.

Privacy Act Statement (Continued)

- For contractors or consultants working for the HCFA to assist in the performance of a service related to this system of records and who need to access these records to perform their activities.
- For an agency of the state for developing and operating Medicaid reimbursement systems.
- For Federal or State agencies to contribute to the accuracy of HCFA's health insurance operations.
- For peer review organizations for the purpose of assessing and improving care.
- For any congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.
- Patients must provide written notice if they do not want their records reviewed by regulatory agencies.

Effects on a patient if a patient does not provide requested information:

- As correct and complete information is needed to give patients high quality of care, incorrect or false information may compromise a patient's quality of care
- Incorrect or incomplete information may result in billing errors
- If a patient does not provide enough information to provide proper treatment, providers have the right to deny services to the patient.

Patient health information rights:

While patient medical records remain the physical property of the office, the information belongs to the patient. Patients have a right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy their health record as provided for in 45 CFR 164.524.
- Amend their health record as provided in 45 CFR 164.528.
- Obtain an accounting of disclosures of their health information as provided in 45 CFR 164.528.
- Request communications of their health information by alternative means or at alternative locations
- Request restriction on certain uses and disclosures of information as provided by 45 CFR 164.522.
- Revoke authorization to use or disclose information except to the extent of action already taken.

AUTO-REMIND	
NAME (Last, First, Middle Initial)	DOB:
PLEASE INDICATE IF YOU WISH TO RECEIVE REMINDERS REGARDING YOUR APPOINTMENT ❑ YES ❑ NO	
IF YES, PLEASE INDICATE **HOW** YOU PREFER TO RECEIVE REMINDERS ❑ TEXT ❑ EMAIL PHONE: ❑ HOME ❑ CELL OR ❑ ALTERNATE	
CELL NUMBER FOR TEXT REMINDERS	NUMBER FOR PHONE REMINDERS
EMAIL ADDRESS FOR REMINDERS	

STATEMENTS ON PATIENT ADVANCE DIRECTIVES

PLEASE READ AND **CHECK** THE APPLICABLE STATEMENTS

AN ADVANCE HEALTH DIRECTIVE IS A SET OF WRITTEN DOCUMENTS SPECIFYING WHAT ACTIONS SHOULD BE TAKEN FOR A PATIENT IF THAT PATIENT IS NO LONGER ABLE TO MAKE HEALTH DECISIONS DUE TO THEIR OWN ILLNESS OR INCAPACITY. AN ADVANCE DIRECTIVE APPOINTS AN AGENT TO MAKE SUCH DECISIONS ON THE PATIENT'S BEHALF. PLEASE INDICATE BELOW IF YOU HAVE AN ADVANCE DIRECTIVE AND THEN SELECT A STATEMENT TO BEST DESCRIBE YOUR ADVANCE DIRECTIVE STATUS.

I HAVE AN ADVANCE DIRECTIVE

- ❑ I AM PROVIDING A COPY OF MY ADVANCE DIRECTIVE TODAY TO BE PLACED IN MY MEDICAL FILE.
- ❑ I WILL PROVIDE A COPY OF MY ADVANCE DIRECTIVE AT A LATER DATE TO BE PLACED IN MY MEDICAL FILE.
- ❑ I DO NOT WISH TO PROVIDE A COPY OF MY ADVANCE DIRECTIVE TO BE PLACED IN MY MEDICAL FILE.

I DO NOT HAVE AN ADVANCE DIRECTIVE

- ❑ I WOULD LIKE INFORMATION ABOUT ADVANCE DIRECTIVES (OFFICE USE: DISTRIBUTED MATERIALS INITIAL)
- ❑ I DO NOT WISH TO RECEIVE INFORMATION ABOUT ADVANCE DIRECTIVES.

STATEMENTS OF EMERGENCY CARE

PLEASE READ AND CHECK THE APPLICABLE STATEMENTS

IF AN EMERGENCY ARISES DURING MY TREATMENT, I UNDERSTAND ALL EMERGENCY MEASURES WILL BE TAKEN UNTIL I AM TRANSPORTED TO THE NEAREST EMERGENCY ROOM. I ALSO UNDERSTAND ANY ADVANCE DIRECTIVES IN MY FILE WILL BE SENT WITH ME TO THE EMERGENCY ROOM.

IN CASE OF EMERGENCY, I UNDERSTAND THE EMERGENCY CONTACT PERSON I AM NOTING BELOW WILL BE NOTIFIED:

EMERGENCY CONTACT PERSON NAME		
ADDRESS		
CITY	STATE	ZIP
PRIMARY PHONE	SECONDARY PHONE	OTHER PHONE

I INDICATE WITH MY PRINTED NAME AND SIGNATURE BELOW THAT I HAVE READ, UNDERSTAND AND ACCEPT THE ABOVE STATEMENTS ON EMERGENCY CARE:

PATIENT PRINTED NAME	
PATIENT SIGNATURE	DATE

Newbridge

Please complete using only blue or black ink

YOUR HEALTH HISTORY

NAME (LAST, FIRST)	DATE OF BIRTH	TODAYS DATE

FEMALES – DATE OF LAST MENSTRUAL PERIOD (IF APPLICABLE)

CURRENT MEDICATIONS - COMPLETE THE CHART BELOW FOR ALL CURRENT MEDICATIONS AND INCLUDE ANY HERBAL MEDICATIONS OR OVER-THE COUNTER MEDICATIONS. ATTACH AN ADDITIONAL LIST IF NEEDED.

MEDICATIONS: PLEASE INDICATE IF YOU TAKE ANY OF THE FOLLOWING MEDICATIONS (CHECK ALL THAT APPLY)

❑ NONE ❑ AGGRENOX ❑ ASPIRIN ❑ COUMADIN ❑ EFFIENT ❑ HEPARIN ❑ LOVENOX ❑ PLAVIX
❑ PRADAXA ❑ TICLID ❑ ANTI-INFLAMMATORY DRUGS ❑ OTHER BLOOD THINNERS *(please describe)*

Please specify dosage below

MEDICATION	DOSAGE	FREQUENCY OF DOSAGE	PRESCRIBING PHYSICIAN

YOUR PHARMACY (If Applicable)

PHARMACY NAME	LOCATION	PHONE #

ALLERGIES: INDICATE IF YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING MEDICATIONS AND/ OR FOODS (CHECK ALL THAT APPLY)

❑ NONE ❑ ASPIRIN ❑ CODEINE ❑ ERYTHROMYCIN ❑ HYDROCODONE ❑ IODINE ❑ LATEX ❑ MORPHINE
❑ MOTRIN/NSAIDS ❑ PENICILLIN ❑ SULFA ❑ TETRACYCLINE ❑ KEFLEX/CEPHALOSPORIN
❑ OTHER (*please describe*): _____

DESCRIBE YOUR ALLERGIC REACTION(S) TO THE ABOVE CHECKED MEDICATIONS AND/OR FOODS:

PLEASE COMPLETE THE CHART BELOW IF YOU HAVE HAD ANY OF THE FOLLOWING TESTS FOR YOUR CURRENT PAIN

X-RAY FILM, CT SCAN, MRI, EMG/NERVE STUDIES

TEST PERFORMED	DATE	FACILITY WHERE TEST WAS PERFORMED	RESULTS

IMPORTANT: PLEASE BRING ALL REPORTS INCLUDING X-RAYS, CT SCANS, MRIS, LABORATORY, EMGS, DISCOGRAM, MYELOGRAM AND/OR ANY RELATED RESULTS TO YOUR FIRST APPOINTMENT. **PLEASE ONLY BRING REPORTS** - FILMS ARE NOT NECESSARY UNLESS SPECIFICALLY REQUESTED.

YOUR FAMILY HISTORY

IS THERE A HISTORY OF DIABETES IN YOUR FAMILY? ❑ YES ❑ NO	RELATIONSHIP
IS THERE A HISTORY OF HEART DISEASE IN YOUR FAMILY? ❑ YES ❑ NO	RELATIONSHIP
IS THERE A HISTORY OF CHRONIC PAIN IN YOUR FAMILY? ❑ YES ❑ NO	RELATIONSHIP

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Please complete using only blue or black ink

NAME (LAST, FIRST)	DATE OF BIRTH	TODAYS DATE

YOUR HABIT HISTORY

DO YOU USE ALCOHOL? ❑YES ❑NO	IF YES, HOW MUCH & HOW OFTEN?
DO YOU USE TOBACCO? ❑YES ❑NO ❑QUIT	DATE OF LAST TOBACCO USE IF QUIT

WHAT TYPE OF TOBACCO DO YOU USE? ❑CIGARETTE ❑CIGAR ❑CHEWING/SNUFF ❑OTHER

HOW OFTEN DO YOU USE TOBACCO?	NUMBER (I.E. PACKS)	PER (I.E. WEEK)

DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE? ❑YES ❑NO (PLEASE EXPLAIN)

MEDICAL HISTORY (CHECK ALL THAT APPLY)

❑	ARTHRITIS (OSTEO OR RHEUMATOID)	❑	FIBROMYALGIA	❑	NEUROLOGIC PROBLEMS
❑	ASTHMA/LUNG DISEASE	❑	HEADACHES/MIGRAINES	❑	PANCREATITIS
❑	AIDS/HIV	❑	HEART DISEASE	❑	PERIPHERAL VASCULAR DISEASE
❑	BLEEDING DISORDER	❑	HEPATITIS	❑	SEIZURES
❑	CANCER (TYPE _____)	❑	HIGH BLOOD PRESSURE	❑	STROKES/TIAS
❑	DIABETES ❑INSULIN OR ❑NON-INSULIN	❑	KIDNEY DISEASE	❑	THYROID DISEASE
❑	DVT/PULMONARY EMBOLISM	❑	LUPUS	❑	TREATMENT FOR DEPRESSION OR ANXIETY
❑	EASY BRUISING/BLEEDING	❑	MULTIPLE SCLEROSIS	❑	ULCERS
❑	SLEEP APNEA	ON AVERAGE, HOW MANY HOURS OF SLEEP DO YOU GET/ NIGHT? (_____)			
❑	OTHER: _____				

CURRENT LEVEL OF PAIN

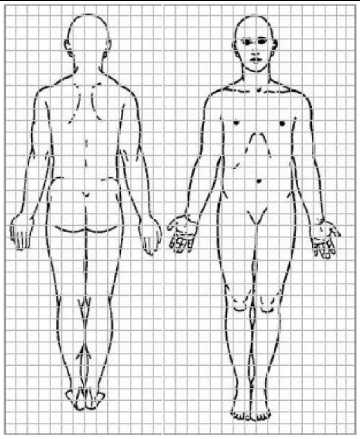
WHAT IS YOUR PAIN LEVEL TODAY? **MINIMAL** ❑0 ❑ 1❑ 2 ❑ 3 ❑ 4❑5 ❑ 6 ❑ 7❑8 ❑9 ❑ 10 **SEVERE**

DESCRIBE THE LOCATION AND CHARACTERISTICS OF YOUR PAIN

HOW LONG HAVE YOU HAD THIS PAIN? (APPROXIMATE DATE)

WHAT MAKES THE PAIN FEEL BETTER?	WHAT MAKES THE PAIN FEEL WORSE?

ON THE DRAWING TO THE RIGHT, MARK THE AREAS WHERE YOU FEEL THE PAIN AND INDICATE WITH AN **E** IF THE PAIN IS EXTERNAL, **I** IF THE PAIN IS INTERNAL OR **EI** IF THE PAIN IS BOTH EXTERNAL AND INTERNAL NEXT TO THOSE AREAS. INDICATE ANY AREAS OF NUMBNESS WITH A LETTER **X**



HAVE YOU EVER BEEN SEEN AND / OR TREATED BY A PAIN MANAGEMENT SPECIALIST?

❑YES ❑NO

Newbridge

Please complete using only blue or black ink

NAME (LAST, FIRST)	DATE OF BIRTH	TODAYS DATE

YOUR SOCIAL HISTORY

WHAT IS YOUR OCCUPATION?	❑ PART-TIME ❑ PERMANENT ❑ RETIRED ❑ CURRENTLY WORKER'S COMP
ARE YOU DISABLED? ❑ YES ❑ NO	WHAT IS YOUR MARITAL STATUS? ❑ SINGLE ❑ SEPARATED ❑ MARRIED ❑ DIVORCED ❑ WIDOWED
WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?	
ARE YOUR FAMILY & FRIENDS SUPPORTIVE OF YOUR CHRONIC PAIN SITUATION? ❑ YES ❑ NO	
WHO IS YOUR MAIN SUPPORT PERSON?	

PLEASE DESCRIBE THE MEDICAL CARE YOU EXPECT TO RECEIVE DURING YOUR TREATMENT HERE

PLEASE NOTE ANY ADDITIONAL INFORMATION WE MAY NEED TO KNOW TO PROVIDE MEDICAL CARE

SURGERY - PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

❑	ADENOIDECTOMY	❑	EXPLORATORY LAPAROTOMY	❑	LUMBAR FUSION
❑	APPENDECTOMY	❑	FOOT SURGERY	❑	LUMBAR LAMINECTOMY
❑	BREAST AUGMENTATION	❑	GASTRIC BYPASS	❑	PACEMAKER IMPLANT
❑	CARPAL TUNNEL SURGERY	❑	HEART SURGERY	❑	PROSTATE SURGERY
❑	CATARACT SURGERY	❑	HERNIA REPAIR	❑	SHOULDER ARTHROSCOPY
❑	CERVICAL FUSION	❑	HIP REPLACEMENT	❑	SPINAL CORD STIMULATION IMPLANT
❑	CESAREAN SECTION	❑	HYSTERECTOMY	❑	TONSILLECTOMY
❑	CHOLECYSTECTOMY (GALL BLADDER)	❑	INTRATHECAL PUMP IMPLANT	❑	TUBAL LIGATION
❑	CYSTECTOMY	❑	KNEE ARTHROSCOPY	❑	WRIST SURGERY
❑	ELBOW SURGERY	❑	KNEE REPLACEMENT	❑	OTHER_____

HAVE YOU BEEN IMMUNIZED AGAINST THE FLU?		HAVE YOU BEEN IMMUNIZED AGAINST PNEUMONIA?	
❑ YES, DATE _____	❑ NO, REFUSED	❑ YES, DATE _____	❑ NO, REFUSED

Newbridge

Please complete using only blue or black ink

NAME (LAST, FIRST)	DATE OF BIRTH	TODAYS DATE

SOAPP ® - R					
PLEASE ANSWER EACH QUESTION AS HONESTLY AS POSSIBLE. THERE ARE NO RIGHT OR WRONG ANSWERS.	NEVER	SELDOM	SOMETIMES	OFTEN	VERY OFTEN
HOW OFTEN DO YOU HAVE MOOD SWINGS?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU FELT A NEED FOR HIGHER DOSES OF MEDICATION TO TREAT YOUR PAIN?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU FELT IMPATIENT WITH YOUR DOCTORS?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU FELT THAT THINGS ARE JUST TOO OVERWHELMING THAT YOU CAN'T HANDLE THEM?	❑	❑	❑	❑	❑
HOW OFTEN IS THERE TENSION IN THE HOME?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU COUNTED PAIN PILLS TO SEE HOW MANY ARE REMAINING?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU BEEN CONCERNED THAT PEOPLE WILL JUDGE YOU FOR TAKING PAIN MEDICIATION?	❑	❑	❑	❑	❑
HOW OFTEN DO YOU FEEL BORED?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU TAKEN MORE PAIN MEDICATION THAT YOU WERE SUPPOSED TO?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU WORRIED ABOUT BEING LEFT ALONE/	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU FELT A CRAVING FOR MEDICATION?	❑	❑	❑	❑	❑
HOW OFTEN HAVE OTHERS EXPRESSED A CONCERN OVER YOUR USE OF MEDICATION?	❑	❑	❑	❑	❑
HOW OFTEN HAVE ANY OF YOUR CLOSE FRIENDS HAD A PROBLEM WITH ALCOHOL OR DRUGS?	❑	❑	❑	❑	❑
HOW OFTEN HAVE OTHERS TOLD YOU THAT YOU HAD A BAD TEMPER?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU FELT CONSUMED BY THE NEED TO GET PAIN MEDICATION?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU RUN OUT OF PAIN MEDICATION EARLY?	❑	❑	❑	❑	❑
HOW OFTEN HAVE OTHERS KEPT YOU FROM GETTING WHAT YOU DESERVE?	❑	❑	❑	❑	❑
HOW OFTEN, IN YOUR LIFETIME, HAVE YOU HAD LEGAL PROBLEMS OR BEEN ARRESTED?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU ATTENDED AN AA OR NA MEETING?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU BEEN IN AN ARGUMENT THAT WAS SO OUT OF CONTROL THAT SOMEONE GOT HURT?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU BEEN SEXUALLY ABUSED?	❑	❑	❑	❑	❑
HOW OFTEN HAVE OTHERS SUGGESTED THAT YOU HAVE A DRUG OR ALCOHOL PROBLEM?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU HAD TO BORROW PAIN MEDICATIONS FROM YOU FAMILY OR FRIENDS?	❑	❑	❑	❑	❑
HOW OFTEN HAVE YOU BEEN TREATED FOR AN ALCOHOL OR DRUG PROBLEM?	❑	❑	❑	❑	❑
OFFICE ONLY: add columns	_____	_____	_____	_____	_____
TOTAL					_____

Newbridge

Please complete using only blue or black ink

NAME (LAST, FIRST)	DATE OF BIRTH	TODAYS DATE

PHQ - 9				
OVER THE LAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS? (CHECK TO INDICATE YOUR ANSWER	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
LITTLE INTEREST OR PLEASURE IN DOING THINGS	❑	❑	❑	❑
FEELING DOWN, DEPRESSED, OR HOPELESS	❑	❑	❑	❑
TROUBLE FALLING OR STAYING ASLEEP, OR SLEEPING TOO MUCH	❑	❑	❑	❑
FEELING TIRED OR HAVING LITTLE ENERGY	❑	❑	❑	❑
POOR APPETITE OR OVEREATING	❑	❑	❑	❑
FEELING BAD ABOUT YOURSELF – OR THAT YOU ARE A FAILURE OR HAVE LET YOURSELF OR YOUR FAMILY DOWN	❑	❑	❑	❑
TROUBLE CONCENTRATING ON THINGS, SUCH AS READING THE NEWSPAPER OR WATCHING TELEVISION	❑	❑	❑	❑
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED. OR THE OPPOSITE – BEING SO FIGETY OR RESTLESS THAT YOU HAVE BEEN MOVING AROUND A LOT MORE THAN USUAL	❑	❑	❑	❑
THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD, OR OF HURTING YOURSELF	❑	❑	❑	❑

OFFICE ONLY: add columns _____ _____ _____ _____

TOTAL _____

IF YOU CHECKED OFF ANY PROBLEMS, HOW DIFFICULT HAVE THESE PROBLEMS MADE IT FOR YOU TO DO YOUR WORK, TAKE CARE OF THINGS AT HOME, OR GET ALONG WITH OTHER PEOPLE?		
	NOT DIFFICULT AT ALL	❑
	SOMEWHAT DIFFICULT	❑
	VERY DIFFICULT	❑
	EXTREMELY DIFFICULT	❑