WARREN J. BLEIWEISS, M.D., P.A.

PATIENT REGISTRATION FORM

PLEASE COMPLETE ENTIRE FORM AND MAKE SURE YOU SIGN AT THE BOTTOM

Patient Name: ______________________ Marital Status: ______________
Address: ______________________ Employer: ______________
City, State & Zip: ______________________ Employer address: ______________
Home Phone: __________ Cell: __________ Work Phone: ______________
Date of Birth: __________ Sex: ______ Soc Sec #: ______________
Emergency Contact & Tel: __________ Pharmacy Name & Tel: ______________

EMAIL Address: ______________________________________

Referring Physician Name & Address: ______________________________
Family Physician: ______________________________

PRIMARY HEALTH INSURANCE:
Insurance Co: ______________________ Identification #: ______________
Address: ______________________ Group Number: ______________
Insurance Co. Tel: ______________________ Co-Payment: ______________
Subscriber's Name & Soc Sec Nbr: ______________________________

SECONDARY HEALTH INSURANCE:
Insurance Co: ______________________ Identification #: ______________
Address: ______________________ Group Number: ______________
Insurance Co. Tel: ______________________ Co-Payment: ______________
Subscriber's Name & Soc Sec Nbr: ______________________________

If your visit is related to a car accident or work injury, please complete the section below.

COMPLETE BELOW ONLY IF: WORKER'S COMP ☐ OR NO FAULT ☐

Insurance Co: ______________________ Claim #: ______________
Ins. Co. Address: ______________________ Policy #: ______________
Ins. Co. Tel: ______________________ Date of Injury: ______________
Claims Adjuster: ______________ Attorney Name & Tel: ______________
Presently working? Yes ______ No ______ If no, date of disability ______________

ALL PATIENTS: PLEASE BE ADVISED THAT YOU MAY REQUEST A GENERIC SUBSTITUTION FOR ANY BRAND NAME DRUG THAT IS PRESCRIBED.

ASSIGNMENT & CONSENT

I hereby assign the policy rights and benefits to Dr. Bleiweiss, and authorize direct payment for professional services rendered. I further authorize Dr. Bleiweiss to release to designated third parties such information, as may be necessary, including copies of my medical records or the diagnosis from the medical records compiled during the course of treatment, for the purpose of processing claims. I agree to be personally responsible for any unpaid balances, deductibles or co-insurance; and if I receive any payments from my insurance company in error, I will sign them over to Dr. Bleiweiss. I also understand that if my account has to be sent to a collection agency, an additional fee will be added to cover the cost. Dr. Bleiweiss is an out of network provider with all insurances except for Aetna and Medicare.

Patient Signature: ______________________ Date: ______________

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or NO
Please explain any yes

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headaches	Y	N
Other ______		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other ______		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other ______		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other ______		

Endocrine Y N

Too hot/cold	Y	N
Tired/sluggish	Y	N
Other ______		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other ______		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other ______		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other ______		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other ______		

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other ______		

Genitourinary

Urine retention	Y	N
Painful	Y	N
Urinary frequency	Y	N
Other ______		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other ______		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other ______		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

PATIENT NAME: ______________ DATE: ______________

PHYSICIAN USE ONLY: (COMMENTS/NOTES)

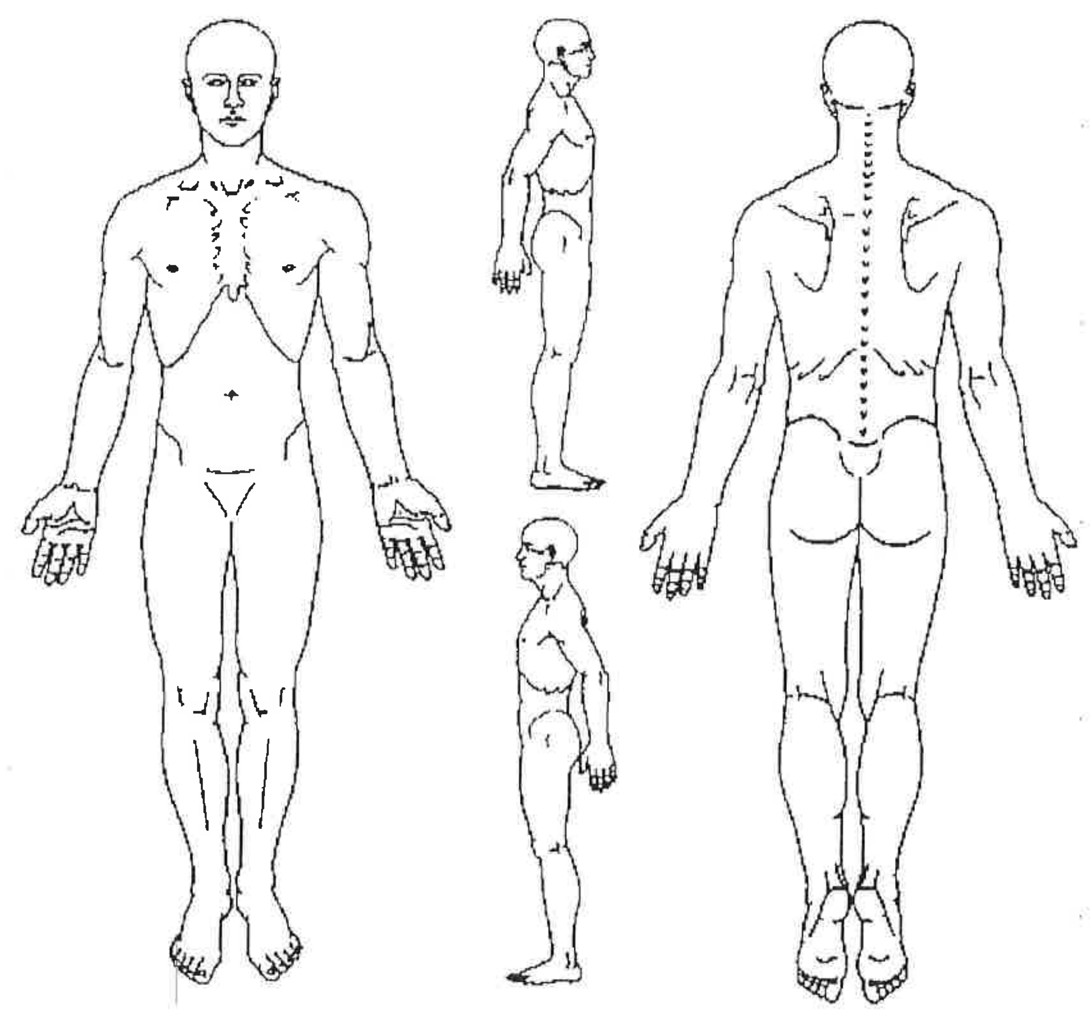
Reviewed by Physician: ______________ Date: ______________

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME ______________________________ DATE ______________

How long have you had back pain _______ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE B = BURNING N = NUMBNESS
P = PINS & NEEDLES S = STABBING O = OTHER

WARREN J. BLEIWEISS, M.D.

Diplomate American Board of Anesthesiology

Diplomate American Board of Pain Medicine

PAIN MANAGEMENT

29 SMULL AVENUE
CALDWELL, NJ 07006
PHONE: 973-403-3334
FACSIMILE: 973-403-0102

Use the chart below to help you describe to the doctor how
Bad your pain really is

CHOOSE A NUMBER FROM 0 TO 10 THAT BEST DESCRIBES YOUR PAIN

PAIN SCALE

Numeric Description	0	1	2	3	4	5	6	7	8	9	10
Verbal Description	No pain	Slight, mild pain		Annoying pain		Moderate pain		Severe pain		Worst pain	
Non Verbal Behaviors	Relaxed; Calm expression	Tense expression		Stressed expression		Guarded movement; Grimacing		Moaning; Restless		Crying out, increased intensity of above behaviors	
Facial Scale (Wong)	0 = No Hurt	Hurts a little bit		Hurts a little more		Hurts even more		Hurts a whole lot		Hurts worst	

PATIENT NAME: ______________________________ DATE: ______________

Patient Acknowledgement of Warren J. Bleiweiss, MD, PA's Office Policies

Patient Name: (Print) ______________________ Date of Birth: ______________

Insurance Information: Co-payments and Deductibles

All applicable co-payments and deductibles will be collected at the time of service. You are responsible for unpaid balances, deductibles and co-insurance; and if you receive payments from your insurance company that are due to Dr. Bleiweiss, you will forward payment to our office promptly. In the event your account must be turned over to a collections agency, an additional fee will be added to cover the cost.

Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is presented at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed.

Insurance Cards

If you change insurance, you must provide our office with your new insurance card(s). To insure that our office always has your updated information, please provide us with changes of home address and/or telephone numbers.

HIPPA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Dr. Bleiweiss' office from discussing appointments, medications, testing results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointment, or obtain testing results, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please advise the office staff.

Name of Individual Please print	Relationship to Patient

My signature below acknowledges that I was provided with a copy of the practice's Notice of Privacy Practice related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). My signature below also signifies my understanding and wiliness to comply with the above policies.

____

Patient Signature:

____

Date:

WARREN J. BLEIWEISS, MD
INSURANCE PARTICIPATION DISCLOSURE

The laws of the State of NJ and NJ Dept of Health and NJ Dept of Banking & Insurance require that a healthcare professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing that:

<u>HEALTH PLANS OUR PRACTICE PARTICIPATES WITH:</u>
Aetna
Medicare

<u>FACILITIES OUR PRACTICE IS ASSOCIATED WITH AND ADDRESSES:</u>
Northfield Surgical Center, 741 Northfield Avenue, West Orange, NJ 07052
Millburn Surgical Center, 37 East Willow Street, Millburn, NJ 07041

If your health plan is not listed above, Warren J. Bleiweiss, MD PA does not participate with your health plan. In order to proceed with any health care services, you hereby acknowledge and agree:

______ I understand that the health care professional that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan;

______ I understand that the amount or estimated amount the health care professional will bill me for the services is available upon request;

______ I understand that I may request from the provided an estimated charge for services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the healthcare professional shall disclose to me, in writing the estimated amount and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the services .

______I understand that I will have a financial responsibility applicable to heath care services provided by an out-of-network professional, in excess of my in-network copay, deductible and co-insurance, and that I may be responsible for any costs in excess of those allowed by my health care plan.

______ I have been advised that I should contact my health insurance plan for further consultation on those costs.

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law. The health care provider further agrees that if network status changes occur between the time these disclosures are made to the patient and the time of health care services take place, the patient will be notified promptly.

Acknowledgement of Receipt of Disclosures - OUT-OF-NETWORK PATIENTS

I, the undersigned patient, acknowledge receipt of this disclosure form from Warren J. Bleiweiss, MDPA, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of those disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

Patient signature:____________________ Date: ____________________

Patient name: ____________________

Acknowledgement of Receipt of Disclosures - IN-NETWORK PATIENTS

I, the undersigned patient, acknowledge receipt of this disclose form from Warren J. Bleiweiss, MDPA, and have read it and understand the contents. I understand that currently my out of pocket expenses will be limited to those described in my insurance policy and the contractual obligations between the health care provider and my insurance carrier. The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care services take place, the network status of the health care provider changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly. I certify that I am at least 18 years of age, competent, not under the influence of drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

Patient signature:____________________ Date: ____________________

Patient name: ____________________