COMPLETE CARE

Pain And Palliative Center

www.completecarepaineandpalliative.com

(732) 336-1806 (p)
(732) 333-8178 (f)

Maged Ghattas M.D.
Triple Board Certified
completecarepp@gmail.com

☐ **495 Iron Bridge Rd., Ste. 10, Freehold, NJ 07728** ☐ **4247 US 9 North, Bldg 1, Freehold, NJ 07728**

DEMOGRAPHICS

Name (first, mi, last): _____ **D.O.B.:**___/___/_____

Address (no PO Box please): _____

_____

SSN:____-____-_____ **Gender:** ☐ M ☐ F **Martial Status:** ☐ S ☐ M ☐ D ☐ W

Ethnicity: ☐ Latino ☐ Not Latino ☐ Declined

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Other ☐ Declined

Primary Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other ☐ Declined

Home #: _____ **Cell #:** _____ **Work #:** _____

Email: _____ **Occupation:**_____

Employer: _____ **Employer Address:** _____

Referring MD: _____ **Primary MD:** _____

Emergency Contact: _____ **Phone #:**_____ **Relationship:** _____

Pharmacy Name: _____ **Pharmacy Address:** _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

How Did you hear about our office?_____

WORKER COMP / MVA

Is your visit related to: 1) Worker's Comp? 2) Motor Vehicle Accident? (If yes, circle one)

WC or MVA Insurance Name: _____

WC or MVA Address: _____

Adjuster/Case Mgr Name: _____ **Claim #:** _____

Phone #: _____ **Ext.** _____ **Date of Accident**
____/____/_____ _____

Body part(s) injured? _____

Attourney Name: _____

Address: _____

Phone #: _____ **Fax #:**_____

INSURANCE

Health Insurance: _____ **Effective Date:** ___/___/_____

Health Ins. Address: _____

Member ID #:_____ **Group #:**_____

Policyholder's Name: _____ **Referral required: Y N**

Policyholder's DOB: ____/____/_____ **SSN#:** ____-____-_____ **Deductible $** _____

Co-Pay $_____ **Relation to Insured:** _____

Policyholder's Employer: _____

*****Please bring diver's license and insurance card along with your appointment*****

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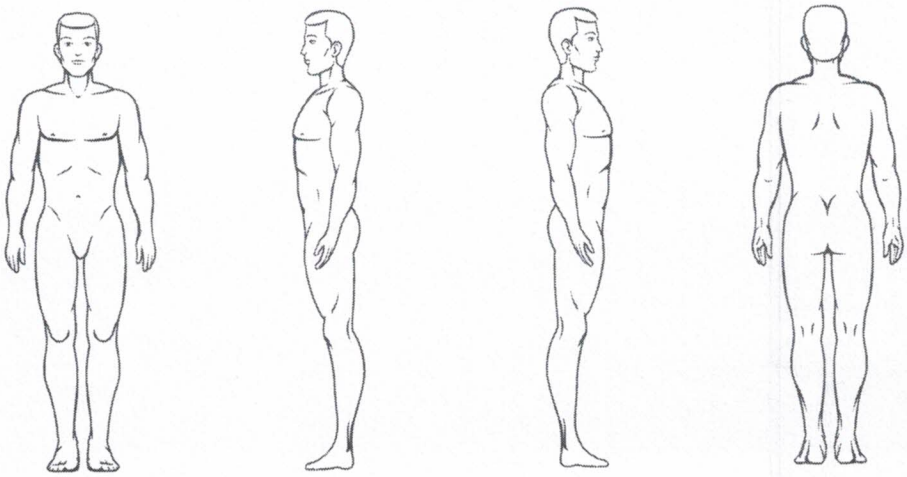
Date: _____ **Name:** _____ **Age:**_____ **Gender:**_____ **Height:**_____ **Weight:**_____

Where is your pain? _____

Please mark the diagram: P=Pain, B=Burning, T=Tingling, N=Numbness, W=Weakness



Pain Scale: (Circle the number that represents your current level of pain.)

NO PAIN

UNBEARABLE

0 1 2 3 4 5 6 7 8 9 10

When your pain is at its worst? _____ **When your pain is at its best?** _____

How long have you been in pain? _____

Is your pain: ☐ Constant (100% of the time) ☐ Frequent (75% time) ☐ Intermittent (50% time) ☐ Occasional (25% time)

How would you describe your pain? ☐ Sharp ☐ Aching ☐ Burning ☐ Throbbing ☐ Shooting ☐ Electric-like ☐ Indescribable

☐ Other: _____

What worsens your pain? ☐ Standing ☐ Walking ☐ Sitting ☐ Activity ☐ Bending ☐ Twisting ☐ Lying Down

☐ Other: _____

What relieves your pain? ☐ Medication ☐ Sitting ☐ Lying Down ☐ Standing ☐ Physical Therapy

☐ Chiropractic Manipulation ☐ Heat ☐ Ice ☐ Other: _____

Does pain affect any of the following? ☐ Concentration ☐ Work Duties ☐ Activities of Daily Living ☐ Physical Activity

☐ Appetite ☐ Sleep ☐ Other: _____

How long have you been in pain? Please be specific:

☐ Physical Therapy (when, how long, where): _____

☐ Chiropractor (when, how long, with whom): _____

☐ Acupuncture (when, how long, with whom): _____

☐ Injections (when, with whom): _____

☐ Surgery (when, with whom): _____

☐ Other: _____

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MEDICATION	DOSE / FREQUENCY

MEDICATION	DOSE / FREQUENCY

ALLERGIES:	REACTION:

ALLERGIES:	REACTION:

IMAGING STUDIES WITH DATES:

☐ **MRI** _____
☐ **CT Scan** _____
☐ **X-Ray** _____
☐ **EMG** _____
☐ **Other** _____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING PROBLEMS OR SYMPTOMS?

Unexpected Weight Gain	☐ Yes ☐ No	Unexpected Weight Loss	☐ Yes ☐ No	Fever or Chills	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Fainting Spells	☐ Yes ☐ No	Arm / Leg Swelling	☐ Yes ☐ No
Breathing Difficulties	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Cough	☐ Yes ☐ No
Abdominal Pain	☐ Yes ☐ No	Nausea or Vomiting	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Blood in Urine	☐ Yes ☐ No	Painful Urination	☐ Yes ☐ No
Difficulty Urinating	☐ Yes ☐ No	Loss of Bowel Control	☐ Yes ☐ No	Bloody Stool	☐ Yes ☐ No
Loss of Bladder Control	☐ Yes ☐ No	Rashes or Lesions	☐ Yes ☐ No	Bruising Easily	☐ Yes ☐ No
Joint Pain	☐ Yes ☐ No	Difficulty Walking	☐ Yes ☐ No	Vision Changes	☐ Yes ☐ No
Depression/Anxiety	☐ Yes ☐ No	Headaches / Migraines	☐ Yes ☐ No	Seizures / Stroke	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Blood Clots	☐ Yes ☐ No	Anemia	☐ Yes ☐ No

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PAST MEDICAL HISTORY

Cardiac
☐ Hypertension ☐ Hypercholesterolemia ☐ Coronary heart disease/MI ☐ Irregular heart beat ☐ Atrial fibrillation/flutter
☐ Internal cardiac defibrilliation/pacemaker ☐ Peripheral vascular disease
☐ If other: _____

Pulmonary
☐ Smoker ☐ Asthma ☐ COPD/Emphysema ☐ Sleep Apnea ☐ Lung Cancer
☐ If other: _____

Gastrointestinal
☐ GERD ☐ Gastritis ☐ Gastric ulcer ☐ Irritable bowel disease ☐ Hepatitis ☐ Liver cirrhosis
☐ If other: _____

Renal
☐ Renal insufficiency ☐ Renal failure ☐ Kidney stones
☐ If other: _____

Endocrine
☐ Diabetes ☐ Diabetic peripheral neuropathy ☐ Grave's disease ☐ Hypothyroid
☐ If other: _____

Musculoskeletal
☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Sjogren's disease ☐ Degenerative joint disease ☐ Fibromyalgia ☐ Lyme's disease
☐ If other: _____

Neurological
☐ Stroke ☐ TIA ☐ Migraines ☐ Seizure disorder ☐ Multiple sclerosis ☐ Alzheimer's disease ☐ Dementia
☐ If other: _____

Psychiatric
☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Panic disorder ☐ Post traumatic stress disorder ☐ History of alcohol/drug abuse
☐ If other: _____

Hematological
☐ Anemia ☐ Low platelets ☐ Bleeding disorder ☐ Blood clots ☐ Leukemia ☐ Lymphoma
☐ If other: _____

SURGICAL HISTORY

Please list past surgeries:

DATE	SURGERY	DATE	SURGERY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Do you currently smoke tobacco?
☐ Yes ☐ No ☐ Ex-Smoker When? _____
If yes: How many packs/day _____ How many years? _____
If ex-smoker: Quit when? _____
Do you currently drink alcohol?
☐ Beer ☐ Liquor ☐ Wine
Amount per day? _____ Amount per week? _____
Do you currently use any illicit drugs? _____
Currently Working? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time
Occupation: _____

FAMILY HISTORY

Condition	Family Member
☐ High Blood Pressure	_____
☐ Heart Disease	_____
☐ Lung Disease	_____
☐ Cancer (what type?)	_____
☐ Diabetes	_____
☐ Bleeding Problems	_____
☐ Problems with Anesthesia	_____
☐ Other:	_____

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ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I hereby give permission to Complete Care Pain and Palliative Center to bill my insurance company for professional medical services rendered.

I agree to pay all charges due or that become due Complete Care Pain and Palliative Center for the care and treatment provided to me by Complete Care Pain and Palliative Center P.C.

I understand that insurance benefit verification and authorization is not a guarantee of payment and if the charges are denied, the medical charges will become my responsibility and obligation.

I also understand that I am responsible to pay all copayments, coinsurance and deductible applied to my account after the insurance payment is made and/or the claim is processed. In addition, any charges denied by the insurance company because they do not meet the criteria for medical necessity will be my responsibility.

And if I do not or did not provide Complete Care Pain and Palliative Center with accurate and current information regarding my insurer, I will be personally responsible for the cost of the care rendered.

I agree that all bills are to be paid when presented or in advance of treatment, if self paid. And if I fail to pay my bill, I realize that my account will be forwarded to collection agency and attorney and court fees will be added to my balance due.

Name: _____

Signature: _____

Date: _____

(Optional)

I hereby give *Complete Care Pain and Palliative Center* permission to charge my credit/debit card for copayments, coinsurance, and deductible dues and all non-covered charges.

CD#: _____

Expiration: _____

Type: _____

Signature: _____

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Acknowledgement of Receipt for Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy practices for the company and its subsidiaries and affiliates. I understand that copies of the notice of privacy practices are available and paper copies are out and available in the office and that I can take one of these copies with me. The notice of privacy practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH ACT"), Title XIII of division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Patient (print name): _____ Date:_____

Signature: _____

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Authorization for Office to Patient Communication

Please check with the ways in which the office is able to contact you

___ Phone Call (voicemail not permitted)

___ Phone Call (voicemail permitted)

___ Email

Signature: _____ Date:_____

Please Read and Sign Insurance Assignment

We accept assignment from most Insurance Companies. Your Insurance may only pay a percentage of the approved amount. It is your obligation and the law that you pay any copay, deductible and any remaining balance. If for any reason your insurance company does not pay for the office visit, consultation or procedure, it then becomes your responsibility. It is also your responsibility to know the contract between you and your insurance company. Please provide us with the necessary information including the address and phone numbers of all insurance companies pertaining to your medical care with Complete Care Pain and Palliative Center.

By signing below I hereby read and fully understand the above

Signature: _____ Date:_____

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Release of Medical Records

Patient Name:

DOB:

I authorize Complete Care Pain and Palliative to obtain any/all necessary clinical records or test results.

Signature: