CONNECTICUT BACK CENTER

Last Name: First Name: MI:

Address: Apt #:

City: State: Zip:

Home #: Cell #: Work #:

Email:

DOB: Gender: Marital Status: ☐ S ☐ M ☐ D ☐ W

Ethnicity: Are you a Veteran? ☐ YES ☐ NO

Primary Care Physician: Referring Physician:

How did you find out about us?

Primary Insurance:	Secondary Insurance:
ID#:	ID#:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Address:	Policy Holder Address:
Employer:	Employer:
Address:	Address:

Emergency Contact: Relationship: Phone #:

Is injury related to: ☐ MVA ☐ Work If so, Date of Accident/Injury:

Do you have an Attorney? ☐ Yes ☐ No Name: Phone #:

Patient Signature: **Date:**

Welcome to CBC!
Office Policies

Cancellation Policy:
If you cannot keep an appointment, please call the office to cancel at least 24 hours prior to that appointment. **If you do not call the office and do not show up for the appointment, you will be charged $50.00. This fee is NOT billable to your insurance company and will need to be paid prior to being seen for your next appointment.** Of course, consideration is given to appointments canceled due to inclement weather, emergencies, illness, etc.

Payments:
Co-payments are required at the time of your visit (this is an agreement between you and your insurance company). Because of this agreement, we are mandated by your insurance company to ***collect your copay at the time of service***. Those patients without health insurance (self-paying) are required to pay a $200.00 deposit at the time of their visit, and to pay for each subsequent visit at the time of the appointment, unless other arrangements are made with the office prior to the appointment. These visits are to be paid with a credit/debit card.

If a referral is required by your insurance company to see a specialist, you are responsible for obtaining that referral, and it must be sent to our office prior to your appointment by your Primary Care Physician. If it is not received, you will have to reschedule your appointment.

If you have a **worker's compensation claim**, ALL information regarding the claim must be received by our office prior to being seen. If you were involved in a **motor vehicle accident,** we MUST have a letter from your auto insurance company stating whether or not you have medical coverage (MEDPAY) with your policy, prior to being seen.

Paperwork:
If you have paperwork that requires the doctor's completion and signature, please fill out your portion of the form and either mail or bring it to the office. We do our best to have the forms ready for pickup, mailing or faxing within 7-10 business days. ***Please note there is a fee in the amount of $30.00 for completion of paperwork that is good for 1 year from the date of payment. If you are requesting Medical records, there is a fee of $0.65/page unless being directly sent to another provider.***

Discharge Policy:
It is the policy of this practice to maintain a cooperative and trusting physician-patient relationship with its patients. When such a physician-patient relationship has not been formed or a physician-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of this practice to terminate the physician-patient relationship within the bounds of applicable state and federal laws, rules, and regulations; the American Medical Association guidelines, and this policy so that the patient can develop the type of trusting relationship with another physician that is essential to successful continued care and treatment.

Patient Signature: **Date:**

HIPAA Privacy Restrictions Questionnaire

Patient Name: ____ DOB: _________________________

May we send statements to your home? ☐ Yes ☐ No

May we leave messages (including test results) on your answering machine/voicemail? ☐ Yes ☐ No

May we send you a fax? Fax #: ____ ☐ Yes ☐ No

May we contact you via email? Email Address: ☐ Yes ☐ No

____

Please list names and relationships of persons who we may release information or talk to about your care/appointments:

____

____

Consent for Treatment/Release of Medical Information

I consent to treatment necessary for the care of the patient listed above. I hereby authorize the release of all medical records to the referring and family physicians.

Signature: Date

____

For restrictions to your protected health information (PHI) other than noted above, please submit in writing to the compliance/privacy officer utilizing our “restriction of use or disclosure of protected health information” (PHI) form.

Financial Responsibility - Insurance Agreement

I acknowledge full responsibility for services rendered and agree to make definite financial arrangements for payment. I understand that the charges for professional services may not be covered fully by my insurance company and therefore, I am solely responsible for payment of all services. I authorize the release of any information necessary to determine liability or payment and to obtain reimbursement on any claims. I authorize that payment of medical benefits be made to Jesse G. Eisler, M.D. I assign the benefits payable to which I am entitled including government, private insurance and other health plans, to Jesse G. Eisler, M.D. This assignment will remain in effect until revoked by me in writing

Signature: **Date:**

____

Medication Agreement

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of a medication increases certain risks, which include but are not limited to

- Addiction/Dependence
- Allergic reactions
- Overdose
- Drowsiness, dizziness or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting and/or constipation

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from the physician.

2. I understand that due to the high potential of abuse of these medications the following rules apply:
- I will not be able to obtain early refills or receive replacement of lost or stolen medication.
- Refills will only be provided during normal business hours and I understand that Connecticut Back Center requests 72 hour notice to refill a medication.

3. I will obtain prescriptions for my spine related issues through Connecticut Back Center, and will fill these prescriptions at my designated pharmacy. In an acute emergency, another provider may prescribe medications for me. If this occurs, I will notify the Connecticut Back Center as soon as possible.

4. I will submit urine or blood tests and pill counts, if requested by my provider, in order to assess my compliance.

5. I agree to keep my regularly scheduled appointments as long as I am taking the medication.

6. If I do not follow these guidelines, I understand that my treatment may be terminated.

Patient Signature: **Date:**

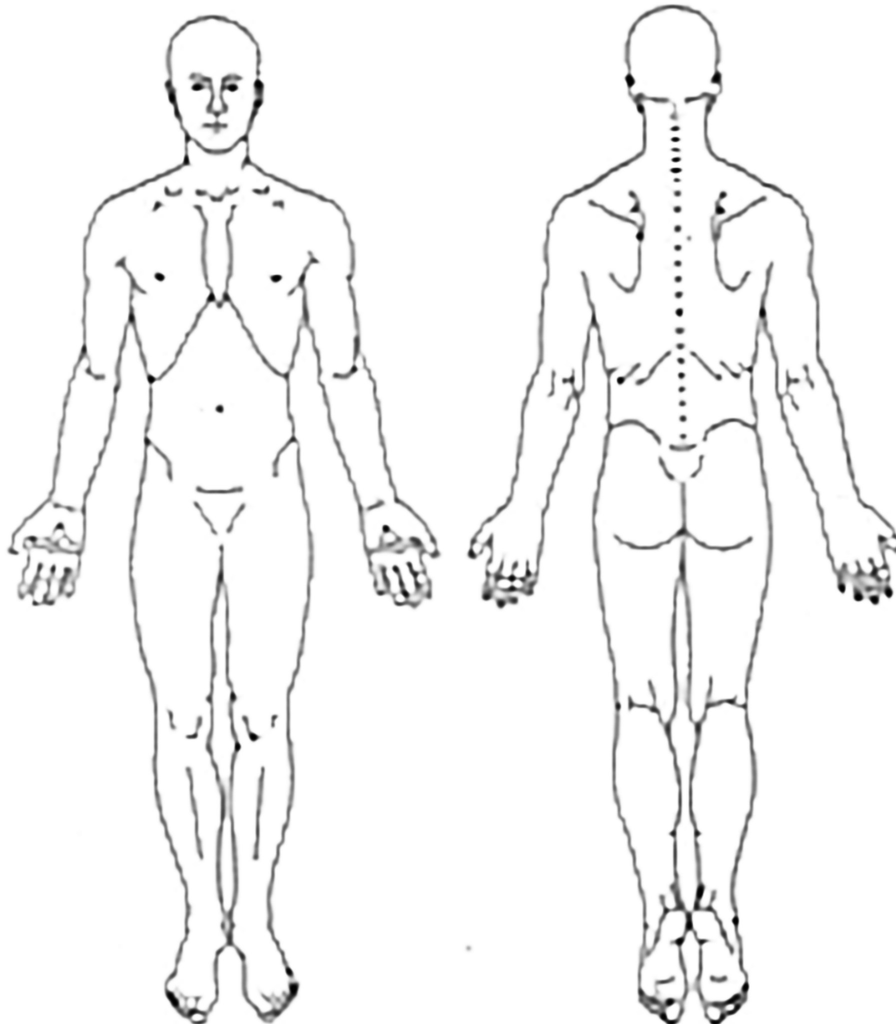
Name: DOB: Date:

Spine Intake Form

Please rate the severity of your pain by circling a number below

No Pain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	***Unbearable Pain***

On the diagram below please indicate where you are experiencing your symptoms



A = Ache **B** = Burning **N** = Numbness

P = Pins and Needles **S** = Stabbing **O** = Other

Over →

How long have your symptoms been present?

Years:	Months	Weeks:

What makes symptoms worse?

What relieves your symptoms?

Is your pain getting better, worse, or staying the same?

Pain Intensity: ☐ Mild ☐ Moderate ☐ Severe Is it: ☐ Constant or ☐ Intermittent

What are your main goals for this visit?

Have you fallen in the last year? ☐ Yes ☐ NO

Are you unsteady on your feet? ☐ Yes ☐ No

Are you afraid of falling? ☐ Yes ☐ No

Which of the following treatments have you tried?

Physical Therapy:	Dates:
Aquatic Physical Therapy:	Dates:
Chiropractic:	Dates:
Cortisone Injection:	Dates:
Massage:	Dates:
Other:	Dates:

Height	Weight:

Oswestry Upper/Lower Back Disability Index

Please answer by circling **ONE** number for each section

Section 1 - Pain Intensity
0. I have no pain at the moment
1. The pain is mild at the moment
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment
4. The pain is very severe at the moment
5. The pain is worst imaginable at the moment

Section 2 - Personal Care (washing, dressing, etc.)
0. I can look after myself normally without causing extra pain
1. I can look after myself normally but it causes extra pain
2. It is painful to look after myself and I am slow and careful
3. I need some help but manage most of my personal care
4. I need help every day in most aspects of self care
5. I do not get dressed, I wash with difficult and stay in bed

Section 3 - Lifting
0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives me extra pain
2. Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed
3. Pain prevents me from lifting heavy weights but I manage light/medium weights if conveniently positioned
4. I can lift very light weights
5. I cannot lift or carry anything at all

Section 4 - Sitting
0. I can sit in any chair as long as I like
1. I can sit only in my favorite chair as long as I like
2. Pain prevents me from sitting more than 1 hour
3. Pain prevents me from sitting more than 30 minutes
4. Pain prevents me from sitting more than 10 minutes
5. Pain prevents me from sitting at all

Section 5 - Walking
0. Pain does not prevent me walking any distance
1. Pain prevents me from walking more than 1 mile
2. Pain prevents me from walking more than ½ mile
3. Pain prevents me from walking more than 100 yards
4. I can only walk using a stick or crutches
5. I am in bed most of the time

Section 6 - Standing
0. I can stand as long as I want without pain
1. I can stand as long as I want but it gives me extra pain
2. Pain prevents me from standing more than 1 hour
3. Pain prevents me from standing more than 30 min
4. Pain prevents me from standing for more than 10 min
5. Pain prevents me from standing at all

Section 7 - Sleeping
0. My sleep is never disturbed by pain
1. My sleep is occasionally disturbed by pain
2. Because of pain I have less than 6 hours sleep
3. Because of pain I have less than 4 hours sleep
4. Because of pain I have less than 2 hours sleep
5. Pain prevents me from sleeping at all.

Section 8. - Sex life
0. My sex life is normal and causes no extra pain
1. My sex life is normal but causes some extra pain
2. My sex life is nearly normal but very painful
3. My sex life is severely restricted by pain
4. My sex life is nearly absent because of pain
5. Pain prevents any sex life at all

Section 9 - Social Life
0. My social life is normal and give me no extra pain
1. My social life is normal but increases the degree of pain
2. Pain has no significant effect on my social life apart from limiting my more energetic interests
3. Pain has restricted my social life and I do not go out as often
4. Pain has restricted my social life to my home
5. I have no social life because of pain

Section 10 - Traveling
0. I can travel without pain
1. I can travel anywhere but it gives me extra pain
2. Pain is bad but I manage journeys over 2 hours
3. Pain restricts me to journeys of less than 1 hour
4. Pain restricts me to short necessary journeys under 30 min
5. Pain prevents me from traveling except to receive treatment

PAST MEDICAL HISTORY (Please check all that apply):

CARDIAC:	[ ] Heart Attack	[ ] Murmur	[ ] Abnormal Rhythm	[ ] Other: ____________
PULMONARY:	[ ] Asthma	[ ] COPD	[ ] Emphysema	[ ] Other: ____________
ENDOCRINE:	[ ] Diabetes	[ ] Hypothyroid	[ ] Pituitary Tumor	[ ] Other: ____________
CIRCULATORY:	[ ] Hypertension	[ ] Stroke	[ ] Aneurysm	[ ] Other: ____________

PAST SURGICAL HISTORY (Please list type, date, surgeon/hospital):

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

MEDICATIONS (If more space is needed, please use back of form or attach list):

MEDICATION	**DOSAGE**	**FREQUENCY**	**DURATION TAKEN**
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

DRUG ALLERGIES: ____

FAMILY HISTORY (Please check and indicate which parent/sibling and year of illness/death):

CARDIAC:	[ ] Heart Attack	[ ] Hypertension		____________
PULMONARY:	[ ] Asthma	[ ] COPD	[ ] Emphysema	____________
ENDOCRINE:	[ ] Diabetes	[ ] Hypothyroid		____________
NEUROLOGIC:	[ ] Stroke	[ ] Aneurysm	[ ] Tumor	____________
CANCER:	[ ] Lung	[ ] Breast	[ ] Intestinal	____________
OTHER:	[ ] ____________	[ ] ____________	[ ] ____________	____________

SOCIAL HISTORY:

Occupation: ____________________ How long? ________________ Date Unemployed: ______________

Substance Use (Amount/Frequency): Tobacco: ______________ Alcohol: ____________ Other: ____________

REVIEW OF SYSTEMS (Please check all that apply):

NEUROLOGIC:	[ ] Headache	[ ] Dizziness	[ ] Memory	[ ] Numbness	Other: ____________
EYES:	[ ] Glasses	[ ] Contacts	[ ] Blurriness	[ ] Double Vision	Other: ____________
EARS/THROAT:	[ ] Deafness	[ ] Ringing	[ ] Swallowing	[ ] Hoarseness	Other: ____________
CARDIAC:	[ ] Chest Pain	[ ] Skip Beats	[ ] Rapid Beat	[ ] Edema	Other: ____________
PULMONARY:	[ ] Cough	[ ] Cough Blood	[ ] Wheezing	[ ] Short Breath	Other: ____________
INTESTINAL:	[ ] Constipation	[ ] Diarrhea	[ ] Incontinence	[ ] Bleeding	Other: ____________
URINARY:	[ ] Frequency	[ ] Burning	[ ] Incontinence	[ ] Bleeding	Other: ____________
MUSCULOSKELETAL:	[ ] Pain	[ ] Weakness	[ ] Arthritis	[ ] Cane/Walker	Other: ____________
ENDOCRINE:	[ ] Weight Gain	[ ] Weight Loss			Other: ____________
SKIN:	[ ] Bruising	[ ] Lesions	[ ] Birthmarks		Other: ____________
HEMATOLOGY:	[ ] Bleeding	[ ] Transfusion	[ ] Hepatitis		Other: ____________
PSYCHIATRIC:	[ ] Depression	[ ] Insomnia	[ ] Fatigability		Other: ____________

Signature: ____ **Date:** ____________________