Rowan Medicine

Thank you for scheduling an appointment with the NeuroMusculoskeletal Institute Division of Substance Use and Addiction Medicine. In order to expedite your visit, we ask that you do the following:

- Arrive **30 minutes prior to your scheduled appointment time** so we can process your paperwork and have you meet with the Medical Assistant prior to seeing the physician.

- Please **have this form completed** in its entirety and bring it with you

- Bring your **insurance card and photo ID** (photo ID is required per Federal regulations)

- Have a **referral from your Primary Care Physician** if required by your insurance. If you do not bring one, you will be rescheduled.

- Bring your **copay**

- Be prepared to be here for a couple of hours and **arrange transportation** accordingly.

If you have any questions, please do not hesitate to contact our Intake Coordinator at **856-566-7017**.

Rowan Medicine

New Patient Information Form

Patient information:

Name: **Today's Date:**

Sex: M ◯ **F** ◯ **Date of Birth:** **SS #:**

Address:

City: State: Zip:

Home Phone #: Cell #:

Name of Emergency Contact:

Emergency Contact #:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widow ◯ Separated

Height: Weight: lbs kg

Referring Doctor:

Phone: Fax:

Primary Care Physician:

Phone: Fax:

Date Last Seen:

Name of Employer: **Employer Phone #:**

Address:

City: State: Zip:

Insurance Company Name: **Policy#:**

Relationship to subscriber: Subscriber Name:

Subscriber D.O.B. Subscriber SS#:

Secondary Insurance: Policy#:

Rowan Medicine

NAME: D.O.B.

IF YOUR INJURY/COMPLAINT IS THE RESULT OF AN ACCIDENT, YOU MUST COMPLETE THE FOLLOWING:

Auto ◯ Work Related ◯ Slip & Fall ◯

If Auto Accident, were you the Driver ◯ or Passenger ◯

If Passenger, do you have your own insurance? Yes ◯ No ◯

If Passenger, name of owner/insurer of vehicle:

Insured's Address:

City: State: Zip: Phone:

Date of accident/injury: Is the claim still open: Yes ◉ No ◯

Insurance Company Name: State accident occurred in:

Policy #: **AND** Claim #:

Adjuster/Case Manager Name:

Adjuster/Case Manager Phone #:

Attorney Name:

Attorney Address:

City: State: Zip: Phone:

Rowan Medicine

NMI: Health History Questionnaire – Substance Use and Addiction Medicine

NAME: D.O.B. TODAY'S DATE:

CURRENT PROBLEM (REASON FOR VISIT):

HOW LONG HAVE YOU HAD THIS CONDITION?

WHEN WAS YOUR LAST USE OF MEDICATIONS OR ILLICIT SUBSTANCES AND WHAT WAS IT?

WHAT ROUTE? (IV, ORAL, SNORT, SMOKE,ETC)

HAVE YOU EVER TRIED ANY OTHER ROUTES OF INGESTION:

☐ IV ☐ SNORT/INHALE ☐ SMOKE ☐ SWALLOW OTHER:

WHAT WAS THE FIRST DRUG YOU TRIED AND HOW OLD WERE YOU?

WHAT OTHER DRUGS HAVE YOU TRIED AND WHEN?

IF YOU HAD TO PICK, WHAT IS YOUR DRUG OF CHOICE?

HAVE YOU THOUGHT YOU NEEDED TO CUT BACK? YES ◯ NO ◯

HAVE OTHERS ASKED YOU TO CUT BACK OR STOP USING? YES ◯ NO ◯
YES IF YES, DID YOU TRY AND FAIL ◯ OR NOT TRY ◯ ?

WHERE ARE YOU GETTING THE MONEY FOR YOUR HABITS?

HOW MUCH ARE YOU SPENDING ON YOUR DRUGS/ALCOHOL?

WHAT WAS YOUR LONGEST PERIOD OF SOBRIETY?

IF YOU HAVE HAD A SOBER PERIOD, WHAT TYPE OF TREATMENT OR METHOD DID YOU USE (AA, NA, OTHER 12 STEP, COLD TURKEY, IN-PATIENT, IOP, MAT? (IF MAT WHAT MEDICATION?)

Rowan Medicine

NAME: D.O.B.

HAVE YOU EVER SOLD OR TRADED YOURSELF FOR DRUGS OR MONEY? YES ◯ NO ◯

HAVE YOU HAD AN STD/IV BORN INFECTION EVALUATION? YES ◯ NO ◯

HAVE YOU EVER HAD AN STD/IV BORN INFECTION? YES ◯ NO ◯
IF YES, WHAT AND WAS IT TREATED?

HAVE YOU EVER SOUGHT TREATMENT BEFORE? YES ◯ NO ◯
IF SO, WHERE AND WHEN?

IF PRESCRIBED PAIN MEDICATION, DO YOU TAKE IT AS YOU ARE SUPPOSED TO?
YES ◯ NO ◯ SOMETIMES ◯

HAVE YOU EVER RUN OUT EARLY? YES ◯ NO ◯

HAVE YOU EVER TRIED TO COME OFF OF THEM? YES ◯ NO ◯
IF YES, WHAT MEDICATION(s)?

HAVE YOU EVER BEEN ABUSED SEXUALLY, PHYSICALLY, OR VERBALLY? YES ◯ NO ◯
IF YES, AT WHAT AGE AND BY WHO?

DO YOU FEEL SAFE IN YOUR ENVIRONMENT NOW?

DO YOU FEEL LIKE HURTING YOURSELF AT THIS TIME? YES ◯ NO ◯
IF SO, DO YOU HAVE A PLAN?

DO YOU FEEL LIKE HURTING SOMEONE ELSE? YES ◯ NO ◯
IF SO, HOW AND WHY?

DO YOU HAVE ANY WEAPONS?

WHO DO YOU LIVE WITH?

WHO ELSE KNOWS YOU ARE SEEKING TREATMENT AND ARE THEY SUPPORTIVE?

DO YOU OR A FAMILY MEMBER HAVE A PSYCHIATRIC DIAGNOSIS LIKE BIPOLAR DISORDER, ANXIETY DISORDER, DEPRESSION, ETC? YES ◯ NO ◯
IF YES, WHAT DIAGNOSIS AND WHO?

Rowan Medicine

NAME: D.O.B.

IS THERE A FAMILY HISTORY OF DRUG OR ALCOHOL MISUSE (PARENT, BROTHER, SISTER, GRANDPARENTS, AUNTS, UNCLES)? YES ◯ NO ◯

DO YOU USE CAFFEINE? YES ◯ NO ◯
IF SO, WHAT FORM, HOW LONG, AND HOW MUCH?

DO YOU ALSO HAVE A PAINFUL CONDITION THAT WE NEED TO BE AWARE OF?
YES ◯ NO ◯ IF YES, WHERE IS IT LOCATED AND WHEN DID IT START?

HOW HAS IT PROGRESSED?

PRIOR TREATMENTS FOR THIS CONDITION:

PHYSICAL THERAPY? YES ◯ NO ◯ IF YES, LAST DATE OF TREATMENT AND EFFECT?

PRIOR INJECTIONS? YES ◯ NO ◯ IF YES, WHAT KIND AND WHO ADMINISTERED THEM?

PRIOR IMAGING FOR THE ABOVE CONDITION: X-RAY/MRI/CT? APPROX. WHEN?

WHAT FACILITY?

PLEASE LIST MEDICATIONS (WITH DOSAGES) YOU ARE CURRENTLY TAKING:

PLEASE LIST **ALL** ALLERGIES AND WHAT TYPE OF REACTION YOU EXPERIENCE:

Rowan Medicine

NAME: D.O.B.

DO YOU USE ANY ASSISTIVE DEVICES (CANE, WALKER, ORTHOTICS, BRACE, WHEELCHAIR)?

ARE YOU CURRENTLY EMPLOYED? YES ◯ NO ◯ IF YES, FULL ◯ OR PART TIME ◯

OCCUPATION:

IF NO, ARE YOU ON DISABILITY YES ◯ NO ◯ IF YES, SINCE WHEN?

IN THE LAST 2 YEARS HAVE YOU BEEN HOSPITALIZED? YES ◯ NO ◯
IF YES, APPROXIMATELY WHEN AND WHAT HOSPITAL:

HAVE YOU HAD ANY INJURIES?

PAST MEDICAL HISTORY, HAVE YOU EVER EXPERIENCED PROBLEMS WITH:
(CHECK ALL THAT APPLY):

☐	HEART DISEASE	☐	LUNG DISEASE	☐	BLOOD CLOTS	☐	HEART ATTACK
☐	DIABETES	☐	ARTHRITIS	☐	STROKE	☐	STOMACH ULCERS
☐	HEPATITIS	☐	THYROID DISEASE	☐	LIVER/KIDNEY	☐	CANCER
☐	NERVE DAMAGE	☐	MUSCLE WEAKNESS	☐	LEG CRAMPS	☐	FALLING
☐	HEADACHE	☐	CHEST PAINS	☐	WEAKNESS	☐	FEVER
☐	BLURRING VISION	☐	HEART SKIPPING BEATS	☐	NUMBNESS/TINGLING	☐	BOWEL PROBLEMS
☐	DIZZINESS	☐	SHORTNESS OF BREATH	☐	DIFFICULTY WALKING	☐	PERSISTENT COUGH
☐	TIREDNESS	☐	HEART BURN	☐	SPITTING BLOOD	☐	WEIGHT CHANGE
☐	URINARY DIFFICULTY	☐	DIFFICULTY SWALLOWING	☐	BLOOD IN URINE/STOOL	☐	SWOLLEN/ PAINFUL JOINTS
☐	DRY MOUTH	☐	DROPPING THINGS				

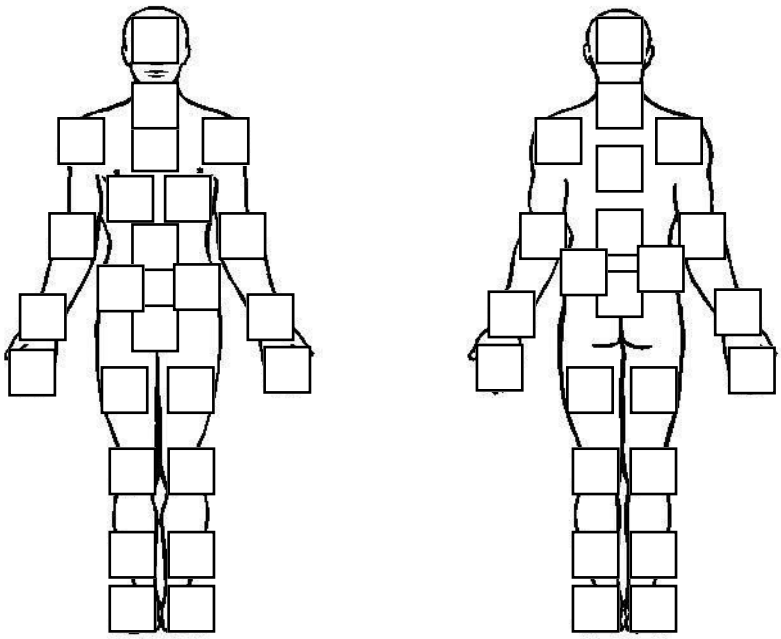
Rowan Medicine

NAME: D.O.B.

PAIN HISTORY:

Where is your pain located? Describe and mark on the drawing below:

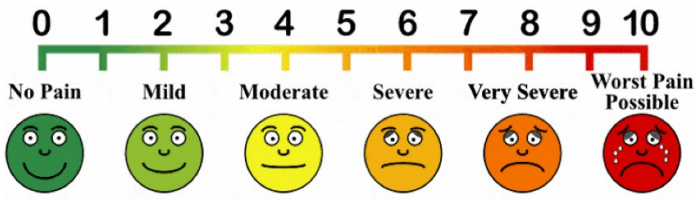
- ☐ HEADACHE
- ☐ FACIAL PAIN
- ☐ NECK PAIN
- ☐ SHOULDER PAIN ☐ LEFT ☐ RIGHT
- ☐ UPPER EXTREMITY PAIN ☐ LEFT ☐ RIGHT
- ☐ UPPER BACK PAIN LOW
- ☐ BACK PAIN
- ☐ HIP PAIN ☐ LEFT ☐ RIGHT
- ☐ LOWER EXTRMEITY PAIN ☐ LEFT ☐ RIGHT
- ☐ JOINT PAIN WHICH JOINTS?



WHEN DID YOUR PAIN START AND HOW LONG HAS IT BEEN BOTHERING YOU?

HOW DID YOUR PAIN START?

HOW BAD IS YOUR PAIN RIGHT NOW ON A 0-10 SCALE? 0 BEING NO PAIN AND 10 BEING THE WORST IMAGINABLE PAIN: _____/10



Rowan Medicine

NAME: D.O.B.

QUALITY: WHAT TYPE OF PAIN ARE YOU HAVING? PLEASE CHECK ALL THAT APPLY:

☐ DULL	☐ SHARP	☐ SHOOTING	☐ SQUEEZING
☐ CRUSHING	☐ STABBING	☐ BURNING	☐ THROBBING

ASSOCIATIONS: IS YOUR PAIN ASSOCIATED WITH THE FOLLOWING? CHECK ALL THAT APPLY:

☐ NAUSEA	☐ VOMITING	☐ HEADACHE
☐ PHOTOPHOBIA (LIGHT BOTHERING EYES)		☐ MUSCLE CRAMPS

AFFECT: WHAT DOES YOUR PAIN AFFECT? CIRCLE ALL THAT APPLY AND STATE HOW:

FUNCTIONAL LEVEL:

MOOD:

SLEEP:

SEXUAL FUNCTION:

IF THERE IS ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO PROVIDE,
PLEASE DO SO HERE:

****Please see review and sign next page.**

Rowan Medicine

Please read carefully before signing.

(Print) Patient Name

Patient Signature Date:

Signature of Parent or Guardian (where applicable) Date:

The information I have provided about my medical history is accurate to the best of my knowledge. I affirm it is my responsibility to inform you my provider of any and all changes to my medical history at any time during my visit. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition, or any changes thereto.

Reviewing/Attending Physician Signature *Required*

Provider Signature Date:

Scanned into Patient EMR/Medical Record:

Scanned by Date:

Rowan Medicine

Your Name: Birth Date:

NOTICE TO ALL NMI PATIENTS

This office operates under HIPAA guidelines, which have been set forth by the Federal Government to protect patient confidentiality and patient rights. You may request a copy of our HIPAA brochure.

Due to this fact we need your permission to leave messages either with a person other than yourself or on a machine when we call to confirm your appointments (automated system) or to let you know when your prescriptions are ready to be picked up. Please sign below if you are in agreement with the above.

Date:

I **agree to allow this office to leave messages on my machine or with someone other than myself regarding my appointments and medication renewals.**

Name of Person: **Phone #:**

Prescription pick- up only one (1) person of legal age (over 21) with photo identification may pick up prescriptions. NO EXCEPTIONS WILL BE ALLOWED.

Name of person who is authorized to pick up prescriptions **Initials of Patient**

This office has a policy of charging $25 for completion of any and all forms that are not being sent to the insurance company responsible for paying for your visits to this office. **There will be no exceptions to this policy.**

The NeuroMusculoskeletal Institute will be charging a fee of $25 to any patient who does not call to cancel their appointment and just does not show instead; a $50 fee for no showed EMG/NCS. Cancellations must be made 24 hours before the scheduled appointment time.

When calling in for refills of medications you must give five business days advance notice before you are ready to run out. When calling in for renewals, you must give your name, a phone number where you can be reached, the doctor who prescribes the medication, the name of the medication, the quantity and strength of **each individual medication** and your pharmacy phone number. **No refills will be given after hours or on weekends or holidays.** You may pick up your prescriptions during regular office hours of Monday-Friday 8:30 am- 4:00 pm. If you have any questions regarding this policy, please ask.

REFERRALS AND COPAY: ·If your insurance carrier requires a referral and/or copay for specialist visits, it is due at the time of your visit. If you fail to provide either, you will be rescheduled. NO EXCEPTIONS.

I have read and understand the above policies. Date

Rowan Medicine

Authorization For Release of Information PLEASE

COMPLETE THIS FORM IN ITS ENTIRETY

Due to new DEA Regulations regarding Controlled Drug Substance Dispensing, some Pharmacies are now requiring the prescribing provider(s) to release the following information to them prior to dispensing these prescribed medications:

Patient Name:

Birth Date:

To be completed by the Provider's Office:

Diagnosis:

Medical History:

Past Surgical Procedures (if Any):

Planned Duration of Current Prescription Treatment:

Any other pertinent information (if needed pharmacy may call provider to discuss):

Prescribing Physician: DEA#:

To be completed by the Patient or Guardian:

I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has **already been made prior to receipt of the revocation.**

If the above information is not sufficient and additional information is required, I give NMI permission to release my last 2 office visit notes and my current medication list to the Pharmacy listed below.

I hereby request and authorize Rowan Medicine NeuroMusculoskeletal Institute (NMI) to disclose the above information to:

Name of Pharmacy:

Address:

Phone Number: Fax Number:

Printed Name of Patient or Guardian:

Signature of Patient or Guardian: Date: