VKP Medical, PLLC.
920 Main Street, Niagara Falls, NY 14301
5 Limestone Drive, Williamsville, NY 14221
(P) 716. 686. 7816 (F) 978. 495. 9911

PATIENT REGISTRATION FORM (Please Print)

Today's Date:

Thank you for selecting VKP Medical, PLLC.

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Gender:	Age:

Patient's Birth Date:	Marital Status: S M D W SEP	Social Security:	Preferred Language:

Street Address:	Apt #	City/Town:	State:	Zip Code:	Home Phone Number:

Mobile Phone Number:	Work Phone Number:	Email Address:	Preferred Method of Contact: ☐ Home ☐ Mobile ☐ Work ☐ Email

Name of Employer:	Address:	City/Town:	State:	Zip:

SPOUSE INFORMATION

Last Name:	First:	Contact Number:

EMERGENCY CONTACT

Name:	Relationship to Patient:
Primary Telephone Number:	Secondary Telephone Number:

REFERRAL SOURCE

How did you learn about us? Internet ☐ Friend/Family ☐ Physician ☐ Attorney ☐ Other ☐

Please list the name and number of the referral source:

Primary Care Physician

Primary Care Physician Name:

Street Address:

City, State, Zip:

Telephone Number:

PHARMACY INFORMATION

Name (Local):	Address:	Telephone #:	Fax#:
Name (Mail Away):	Address:	Telephone #:	Fax#:

HEALTH INSURANCE INFORMATION

Primary Insurance: Patient's Relationship to Insured: Self Spouse Child Other:

Insurance Name:	Group Number:
	ID Number:
Insured's Name (if not self, spouse or parent listed above):	Birth Date:

Secondary Insurance: Patient's Relationship to Insured: Self Spouse Child Other:

Secondary Insurance Name:	Group Number:
	ID Number:
Insured's Name (if not self, spouse or parent listed above):	Birth Date:

SYMPTOM SPECIFICATIONS (Give only a brief description in one to two sentences)

Please list your symptoms and complaints relating to your visit today:

PATIENT REGISTRATION FORM CONTINUED (Please Print)

MEDICAL TREATMENT HISTORY

Are these symptoms related to an accident? ☐ YES ☐ NO

Did you go to the hosptial? ☐ YES ☐ NO	If yes, list hopsital name:
Were you: ☐ Out-Patient ☐ In-Patient	Any X-Rays/MRI's or testing performed?
Have you seen any doctors for this inury and/or condition: ☐ YES ☐ NO	If yes, what type?

Medication(s) Prescribed:

NO FAULT MOTOR VEHICLE ACCIDENT

Insurance Company Name:	Insurance Phone Number:
Policy Holder Name:	Claim Representative:
Claim #:	Policy#

Was the accident reported to the insurance company? ☐ YES ☐ NO

Was the accident reported to the police? ☐ YES ☐ NO **(If yes, provider the front desk with a copy of the police report.)**

Where you the: ☐ Driver ☐ Passenger ☐ Pedestrian

# of people in the Vehicle:	Where was the vehicle hit? ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side

Were you working at the time of accident? ☐ YES ☐ NO

WORKERS COMPENSATION-WORK ACCIDENT

Insurance Carrier:	Employer Name & Address (at the time of accident)
Claim/Carrier Case #:	
WCB #:	
Claim/Case Manager:	Telephone Number:

Was injury reported to your employer? ☐ YES ☐ NO

Name & Phone number of Supervisor Reported to:

Injury Specifications

Date of Injury:	Accident occurred in: City:	State:

Injury resulted from: ☐ Motor Vehicle Accident ☐ Work Accident ☐ Other

- If other please specify:

Do you have an attorney representing you for this injury? ☐ YES ☐ NO

Attorney Firm Name:		Telephone Number:
Did you miss any time at work as a result of the injury? ☐ YES ☐ NO	1st Date Missed:	Date of Return:

PATIENT/GUARDIAN SIGNATURE: _____DATE: _____/_____/_____

IF GUARDIAN, PRINT RELATIONISHIP TO PATIENT: _____

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New Patient Medical History Form

Date: _____
Patient Name: _____
Date of Birth: _____

Chief Complaint

Where is your pain located? _____

Which is your worst pain? _____

How long have you had these symptoms? _____

What is your pain level today (on a scale of 0-10)? _____

Does your pain radiate? If so, where: _____

What word best describes the frequency of your pain: Constant ☐ Intermittent ☐

What is the quality of your pain? *Check all the following that describe your pain?*

Aching ☐ Burning ☐ Shooting ☐
Cramping ☐ Dull ☐ Sharp ☐

Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting			
Standing			
Walking			
Bending Forward			
Lying on your side			
Lying on your back			
Lying on your stomach			
Rising from sitting			
Coughing/sneezing			
Driving			

***Now go back and CIRCLE the box to indicate the most aggravating and most relieving activities**

Medical Treatment History:

Are these symptoms related to an accident? Yes _____ No _____ Did you go to the hospital? Yes _____ No _____

Were you: Outpatient _____ In Patient ____ Name of Hospital: _____

Were any X-rays/MRI/CT scan/EMG/NCS studies?

_____

If yes, what type(s) were done, when were they done and at what facility?

_____

Previous Treatment(s):

Have you seen other pain management/physiatrists/surgeons for your current complaints? Yes _____ No _____

Please list in chronological order and explain what they did for you.

Name:
Date last seen:
Treatments Undergone:
Why you stopped seeing them:
Name:
Date last seen:
Treatments Undergone:
Why you stopped seeing them:
Name:
Date last seen:
Treatments Undergone:
Why you stopped seeing them:

Put a check next to each type of treatment you have had for your pain control in the past. Then check the column that best describes the effect of the treatment:

Treatment	**Have had this**	**Made Pain Better**	**Made Pain Worse**	**No Change in Pain**
Anti-inflammatory				
Muscle relaxants				
Narcotic pain medications				
Physical therapy				
Exercises				
Pool therapy				
Acupuncture				
Chiropractic Adjustments				
Trigger point injections				
Epidural injections				
Facet joint injections				
SI joint injections				
Spine surgery				

Functional Status:

As limited by your pain condition (please answer the following questions):

1)How long can you drive?	0-5 mins	5-10 min	15 min	30 min	45 min	60 min	120+min
2)How long can you sit?	0-5 mins	5-10 min	15 min	30 min	45 min	60 min	120+min
3)How long can you stand?	0-5 mins	5-10 min	15 min	30 min	45 min	60 min	120+min
4)How long can you walk?	0-5 mins	5-10 min	15 min	30 min	45 min	60 min	120+min
5)How many hours of sleep do you get?		1-2	2-4	3-4	4-5	5-6	7+

Past Medical History:
Mark the following conditions/diseases that you have been treated for in the past?

General Medical		
□ Cancer - Type_____	□ Emphysema/ COPD	□ Dialysis
□ Diabetes - Type_____	□ Pneumonia	□ Kidney infection(s)
□ HIV/ AIDS	□ Tuberculosis	□ Kidney Stones
	□ Valley Fever	□ Urinary Incontinence
Head/Eyes/Nose/Throat	**Gastrointestinal**	**Hepatic**
□ Headaches	□ Bowel Incontinence	□ Hepatitis A (active/ inactive/ unsure)
□ Migraines	□ GERD (Acid Reflux)	□ Hepatitis B (active/ inactive/ unsure)
□ Head Injury	□ Gastrointestinal Bleeding	□ Hepatitis C (active/ inactive/ unsure)
□ Hyperthyroidism	□ Constipation	
□ Hypothyroidism		
□ Glaucoma		
Cardiovascular/ Hematologic	**Musculoskeletal**	**Neuropsychological**
□ Anemia	□ Amputation	□ Alcohol Abuse
□ Bleeding Disorders	□ Bursitis	□ Alzheimer Disease
□ Heart Attack	□ Carpal Tunnel Syndrome	□ Bipolar Disorder
□ High Blood Pressure	□ Chronic Low Back Pain	□ Depression
□ High Cholesterol	□ Chronic Neck Pain	□ Epilepsy
□ Mitral Valve Prolapse	□ Chronic Joint Pain	□ Prescription Drug Abuse
□ Murmur	□ Fibromyalgia	□ Multiple Sclerosis
□ Phlebitis	□ Joint Injury	□ Paralysis
□ Poor Circulation	□ Osteoarthritis	□ Peripheral Neuropathy
□ Stroke	□ Osteoporosis	□ Schizophrenia
□ Coronary Artery Disease	□ Phantom Limb Pain	□ Seizures
□ Pacemaker/Defibrillator	□ Rheumatoid arthritis	□ Reflex Sympathetic Dystrophy/CRPS
	□ Tennis Elbow	□ Other Diagnosed Conditions
	□ Vertebral Compression Fracture	
Respiratory	**Genitourinary/Nephrology**	
□ Asthma	□ Bladder infections(s)	
□ Bronchitis		

Past Surgical History:

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery
□ Gallbladder removal_____
□ Appendectomy _____
□ Other _____

Joint Surgery
□ Shoulder _____
□ Hip _____
□ Knee _____

Female Surgeries
□ Caesarean section _____
□ Hysterectomy_____
□ Laparoscopy _____

Spine I Back Surgery
□ Discectomy (levels) _____
□ Laminectomy _____
□ Spinal fusion (levels)_____

Heart Surgery
□ Valve replacement _____
□ Aneurysm repair _____
□ Stent placement _____
□ Other _____

Other Common Surgeries
□ Hemorrhoid surgery _____
□ Hernia repair _____
□ Thyroidectomy _____
□ Tonsillectomy _____
□ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary)

□ I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Social History

Are you capable of becoming pregnant? □ Yes □No

Work Status: □ Working Full Time □ Part Time □ Disabled □ Unemployed

Marital Status: □ Married □ Single □ Divorced □ Widowed

Alcohol Use:
□ Daily Limited Use
□ History of Alcoholism
□ Current Alcoholism
□ Never Drinks Alcohol
□ Drinks Alcohol Socially

Tobacco Use:
□ Current Tobacco User
Packs per day _____
How many years smoker _____
□ Former Tobacco User
□ Has Never used Tobacco

Illegal Drug Use:
□ Denies Any Illegal Drug Use
□ Currently uses Marijuana
□ Currently Using Illegal Drugs
Which:_____
□ Currently Using Someone Else's Prescription Medications
□ Formerly Used Illegal Drugs (not currently using) Which:_____

Have you ever abused alcohol, narcotic or prescription medications? □ Yes □No
If yes which one? _____
Have you ever completed a detoxification program for either opioid or alcohol abuse? □ Yes □No
If yes, where and when: _____

Family History

Mark all appropriate diagnoses as they pertain to your biological MOTHER AND FATHER only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheuamtoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: _____

□ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** □ **I AM ADOPTED (No Medical History Available).**

Allergies

Do you have any known drug allergies? □ **Yes** □ **No**

If so, please list all medications you are allergic to.

Medication Name	**Allergic Reaction Type**

Topical Allergies: □ **Iodine** □ **Latex** □ **Tape** **Are you allergic to shellfish?** □ **Yes** □ **No**

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:

□ **Aggrenox** □ **Coumadin / Warfarin** □ **Efferent** □ **Lovenox** □ **Plavix** □ **Pletal** □ **Pradaxa**
□ **Prasugrel** □ **Ticlid** □ **Other** _____

Please list all medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency

Review of Systems: **Mark the following symptoms that you currently suffer from.**		
Constitutional: □ All Negative	**Eyes: □ All Negative**	**Cardiovascular □ All Negative**
□ Denies Excessive Seating **□ Insomnia** **□ Unexplained Weight loss** **□ Fatigue** **□ Weakness**	**□ Denies Visual Changes**	**□ Denies Chest Pain** **□ Edema** **□ High Blood Pressure** **□ irregular pulse and palpitations**
Gastrointestinal: □ All Negative	**Ears/ Nose/Throat/Neck:** **□ All Negative**	**Respiratory: □ All Negative**
□ Denies abdominal pain **□ Indigestion** **□ stomach ulcers** **□ bowel incontinence**	**□ Denies difficulty swallowing** **□ Sore throat** **□ Ringing in in ears**	**□ Denies chronic cough** **□ Shortness of Breath**
Skin: □ All Negative	**Musculoskeletal: □ All Negative**	**Genitourinary: □ All Negative**
□ Denies skin, hair and nail symptoms	**□ Denies Joint pain**	**□ Denies difficulty voiding**
Neurological: □ All Negative	**Psychiatric: □ All Negative**	
□ Headaches	**□Depressed Mood** **□ Suicidal Thoughts**	

Patients Signature: _____

Date: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
VKP Medical, PLLC 5 Limestone Drive, NY 14221

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) **present**
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: **pertaining to injury of** _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
❑ At request of individual ❑ Other: **continued medical care**	**after disclosure to my doctor**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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AUTHORIZATION TO RELEASE INFORMATION

I authorize and instruct my insurance carrier, _____, to provide all information requested by **VKP Medical, PLLC**. including but not limited to state of origin of policy, deductible/co payment information and/or policy maximum information and to verify benefit eligibility, pre-certify procedures, and predetermine benefits as necessary under this policy.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

ASSIGNMENT OF BENEFITS AND PATIENT FINANICAL RESPONSIBILITY ACKNOWLEDGEMENT

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
- I will assume the responsibility to respond to any financial correspondence furnished by VKP Medical, PLLC and the billing service, and I also agree to pay any outstanding/remaining difference(s), if my initial out-of-pocket payment is not sufficient to satisfy my account once my insurance company has been billed, I understand that my insurance carrier may pay for services rendered I must submit the check to VKP Medical, PLLC upon receipt.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to VKP Medical, PLLC on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize VKP Medical, PLLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in VKP Medical, PLLC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Authorized Representative or Responsible Party	Date
Print Name of Patient, Authorized Representative or Responsible Party	Relationship to Patient