

VKPMedical, 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 VKPMedical, 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:
Mobile Phone Number:		Work Phone Number:	Email Address:	Preferred Method of Contact: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Email	
Name of Employer:	Address:		City/Town:	State:	Zip:

SPOUSE INFORMATION

Last Name:	First:	Contact Number:
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EMERGENCY CONTACT

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

REFERRAL SOURCE	Primary Care Physician
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How did you learn about us? Internet <input type="checkbox"/> Friend/Family <input type="checkbox"/> Physician <input type="checkbox"/> Attorney <input type="checkbox"/> Other <input type="checkbox"/>	Primary Care Physician Name:
Please list the name and number of the referral source:	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 NODid you go to the hospital? YES NO

If yes, list hospital name:

Were you: Out-Patient In-Patient

Any X-Rays/MRI's or testing performed?

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

Female Surgeries

- Caesarean section _____
- Hysterectomy _____
- Laparoscopy _____

Heart Surgery

- Valve replacement _____
- Aneurysm repair _____
- Stent placement _____
- Other _____

Joint Surgery

- Shoulder _____
- Hip _____
- Knee _____

Spine I Back Surgery

- Discectomy (levels) _____
- Laminectomy _____
- Spinal fusion (levels) _____

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 Formerly Used Illegal Drugs (not currently using) Which: _____

Currently Using Illegal Drugs Which: _____ Currently Using Someone Else's Prescription Medications

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	Rheumatoid 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: <input type="checkbox"/> All Negative	Eyes: <input type="checkbox"/> All Negative	Cardiovascular <input type="checkbox"/> All Negative
<input type="checkbox"/> Denies Excessive Seating <input type="checkbox"/> Insomnia <input type="checkbox"/> Unexplained Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness	<input type="checkbox"/> Denies Visual Changes	<input type="checkbox"/> Denies Chest Pain <input type="checkbox"/> Edema <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> irregular pulse and palpitations
Gastrointestinal: <input type="checkbox"/> All Negative	Ears/ Nose/Throat/Neck: <input type="checkbox"/> All Negative	Respiratory: <input type="checkbox"/> All Negative
<input type="checkbox"/> Denies abdominal pain <input type="checkbox"/> Indigestion <input type="checkbox"/> stomach ulcers <input type="checkbox"/> bowel incontinence	<input type="checkbox"/> Denies difficulty swallowing <input type="checkbox"/> Sore throat <input type="checkbox"/> Ringing in in ears	<input type="checkbox"/> Denies chronic cough <input type="checkbox"/> Shortness of Breath
Skin: <input type="checkbox"/> All Negative	Musculoskeletal: <input type="checkbox"/> All Negative	Genitourinary: <input type="checkbox"/> All Negative
<input type="checkbox"/> Denies skin, hair and nail symptoms	<input type="checkbox"/> Denies Joint pain	<input type="checkbox"/> Denies difficulty voiding
Neurological: <input type="checkbox"/> All Negative		Psychiatric: <input type="checkbox"/> All Negative
<input type="checkbox"/> Headaches		<input type="checkbox"/> Depressed Mood <input type="checkbox"/> Suicidal Thoughts

Patients Signature: _____

Date: _____



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:

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

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: _____ 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: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
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12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
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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.

Signature of patient or representative authorized by law. Date: _____

* **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.**

Patient Name: _____

NG MR #: _____ Date of loss: _____

VKP Medical, PLLC.

Buffalo/Niagara

P.O Box 9307

Garden City, New York 11530

Office: (516) 294-4590 (Option 2)

Facsimile: (978) 313-8477

EMAIL: LiensFax@HealthPlusMgmt.com

MEDICAL LIEN

Attorney Name:

I hereby authorize and direct my attorney, to pay directly to **VKP Medical, PLLC.** such sums as may be due and owing for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to the provider and to withhold such sums from any settlement of judgment as is necessary to adequately protect the provider.

I hereby further give a lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgment in any claim or litigation arising out of the injuries for which I have been treated of injuries in connection therewith, whether such proceeds are remitted directly to me or to you my attorney.

I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers' additional protection and in consideration of the provider awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

PRINT PATIENT NAME

DATE

SIGNATURE OF PATIENT

SIGNATURE OF PARENT/GUARDIAN

ACKNOWLEDGEMENT OF ASSIGNMENT & LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect, **VKP Medical, PLLC**

ATTORNEY'S SIGNATURE

DATE

NOTE TO ATTORNEY

PLEASE SIGN AND RETURN ONE COPY TO THE PROVIDERS OFFICE; KEEP A COPY FOR YOUR RECORDS.