

Quincy Spine Center
Richard V. Mazzaferro, D.O.

Patient: _____

Date of Birth: _____ / _____ / _____ Social Security: _____ - _____ - _____ Sex: M F Age: _____

Address: _____

Home PH: (____) _____ - _____ Work PH: (____) _____ - _____ Email: _____

Employer: _____ Occupation: _____

Nearest Friend/Relative: _____ Phone: (____) _____ - _____

Referring Physician: _____

Address: _____ Phone: _____ UPIN #: _____

Current Physician: _____

Address: _____ Phone: _____ UPIN #: _____

Diagnosis: _____

Have you had any films or reports taken (MRI's, CT's, EMG's, etc.): Yes No
If answered yes, please try to bring the original(s).

How did the injury occur: Worker's Compensation Yes No
Auto Accident Yes No

Primary Insurance
Name: _____

ID #: _____

Group #: _____

Subscriber: _____

SSN of Subscriber: _____ - _____ - _____

Ins. Address: _____

Secondary Insurance
Name: _____

ID #: _____

Group #: _____

Subscriber: _____

SSN of Subscriber: _____ - _____ - _____

Ins. Address: _____

If you are unable to make your appointment, we kindly request you give a 24 hour notice. You will be subject to a \$25.00 "No Show" fee for your appointment.

Signature: _____ **Date:** _____ / _____ / _____

I hereby reassign to the physician for medical services rendered to me/my dependents. I understand that I am responsible any amount not covered by my insurance(s).

Signature: _____ **Date:** _____ / _____ / _____

WORKER'S COMPENSATION ONLY

Insurance: _____ Claim #: _____

Date of Injury: _____ / _____ / _____ Date Last Worked: _____ / _____ / _____

Billing Address: _____

Adjuster: _____ PH: (____) _____ - _____ FAX: (____) _____ - _____

RN Manager (Nurse Case Manager): _____ PH: (____) _____ - _____ FAX: (____) _____ - _____

Attorney: _____

Name

Address

Phone

RICHARD MAZZAFERRO, D.O.
RECEIPT OF PRIVACY PRACTICES

I, _____ have received a copy of Dr. Richard Mazzaferro's Notice of Privacy Practices.
Patient's Name

Health Insurance and Medicare Authorization

I authorize payment for medical services performed by Richard Mazzaferro, D.O. to be paid directly to Richard Mazzaferro, D.O. These include medical services and treatment resulting from motor vehicle accidents, and work related injuries and other injuries resulting in third party liability. I authorize the staff of Dr. Richard Mazzaferro's office to release my health insurer and/or the Health Care Finance Administration (HCFA) and its agent and information needed to determine benefits. I authorize the release of information to Medicare under Title XVII of the Social Security Act. I understand that I am financially responsible for any allowed balance not covered under my insurance benefits. A copy of this signature is as valid as the original.

Referral Responsibility

I understand that I am responsible for obtaining all my referrals to Dr. Richard Mazzaferro, D.O. from my primary care physician or pediatrician, under the terms of my contract with my managed care health insurance plan. These include original, as well as subsequent referrals. If referrals are not obtained, and insurance coverage is denied or benefits reduced, I accept full responsibility for the cost of medical services provided.

Appointment Confirmation and Physician/Staff Phone Calls

I give permission for Dr. Richard Mazzaferro, D.O. and/or his staff to contact me at my registration phone numbers to leave messages regarding upcoming appointments. In signing this I agree to only request return phone calls to the phone numbers listed on my registration form. Messages cannot be returned to "call-blocked" phone numbers.

Patient Authorization for use and Disclosure of Protected Health Information

By signing this authorization, I authorize *Dr. Richard Mazzaferro, D.O.* to use and/or disclose certain protected health information (PHI) about me to _____

Name of entity to receive this information.

This authorization permits Richard Mazzaferro, D.O. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) or service, type of services, level of detail to be released, origin of information, etc.)

The information will be used or disclosed for the following purpose:

"At the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

I do not have to sign this authorization in order to receive treatment from Dr. Richard Mazzaferro, D.O. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Dr. Richard Mazzaferro, D.O.
Quincy Spine Center
909 Hancock Street
Quincy, MA 02170

Signed by:

Signature of Patient or Legal Guardian (if under the age of 18)

Relationship to Patient

Patient's Name

Date

QUINCY SPINE CENTER
RICHARD MAZZAFERRO, D.O.
909 HANCOCK STREET, QUINCY, MA 02170

MEDICATION POLICY

Quincy Spine Center has a very strict policy regarding medications. No prescriptions will be written for a patient unless you have been evaluated.

Our policy is that each patient who requires renewal on any medications **will need to write to the attending physician's office requesting his or her medication at least 5 days prior to running out of medication.** When requesting a prescription renewal, patients may either mail or fax in the request. The correct mailing address and fax numbers are available from my secretary. **Each business day, requested prescriptions will be mailed directly to patient's home address. Prescriptions cannot be faxed to the pharmacies.**

Under no circumstances are patients allowed to pick up requested medications at our office. Please note that telephone calls and e-mails will not be accepted to renew medications. There are no exceptions to this policy.

This policy will circumvent any problems that often occur when phoning in analgesic medications. It is also enforced so that we can control the volume of telephone calls. By doing so, this policy allows us to direct our attention to our patients more pressing needs.

By signing below I agree to the terms of Quincy Spine Center's Medication Policy.

Patient Signature: _____ Date: _____

Print Name: _____

Patient Intake Questionnaire 1 of 3

Name: _____ Age: _____ Date: _____ Who referred you? _____

Using the symbols below, mark the area on your body where you feel the described sensations.

>>>>>> = Numbness

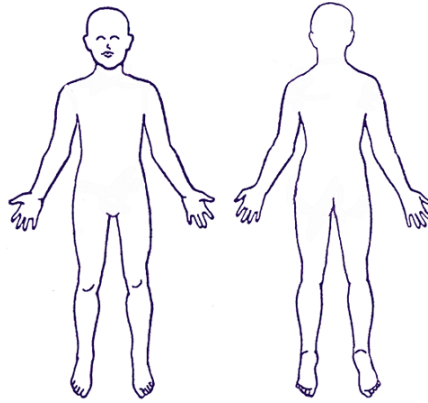
XXXXXXXX = Burning

^^^^^^^^^^ = Other Pain

00000000 = Pins and Needles

!!!!!!!!!!!! = Stabbing

□□□□□□□□ = Aching



Please place a hash mark (|) along the line at the point that corresponds to you average BACK/NECK pain over the last few days.

No Pain 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 Worst Pain Possible

Please place a hash mark (|) along the line at the point that corresponds to your average LEG/ARM pain over the last few days.

No Pain 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 Worst Pain Possible

What makes your symptoms better? _____

What makes your symptoms feel worse? _____

Are you experiencing any numbness? Yes/No _____

Weakness? Yes/No _____

Bowl/Bladder Problems? Yes/No _____

Pain with Walking? Yes/No _____

When did your symptoms begin? _____ / _____ / _____

Have you had similar attacks in the past? _____

What was the cause of your pain? _____

Doctor's Notes: _____

Office Use Only:

Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____

Patient Intake Questionnaire 2 of 3

Patient Name: _____ Date: _____

Have you had any of the following diagnostic procedures done in evaluation for **this episode** of pain?

(Date & Place)

Bone Scan	_____ / _____ / _____	_____
CT Scan	_____ / _____ / _____	_____
Myelogram	_____ / _____ / _____	_____
EMG	_____ / _____ / _____	_____
X-Rays	_____ / _____ / _____	_____
Blood Work	_____ / _____ / _____	_____
Discogram	_____ / _____ / _____	_____
MRI	_____ / _____ / _____	_____

What kind of treatment have you received in this current episode of pain?

Bed Rest	Yes _____ No _____
Medication	Yes _____ No _____
Brace	Yes _____ No _____
Physical Therapy	Yes _____ No _____
Chiropractor	Yes _____ No _____
Acupuncture	Yes _____ No _____
Facet Injections	Yes _____ No _____
Epidural Injections	Yes _____ No _____
Other Injections	Yes _____ No _____

What medications are you currently taking (include dosage)?

Allergies _____

Have you had any previous complications with anesthetics?

Yes _____ No _____

Have you had problems with addiction to prescription or non-prescription medications?

Yes _____ No _____

What type of spine surgeries have you had? _____

When _____ Where _____ By Whom _____

When _____ Where _____ By Whom _____

Past surgical history (please include dates):

Past medical history (please include dates):

Family medical history:

Are you married? _____ Single? _____ Divorced? _____ Children? _____

Do you smoke? _____ How many cigarettes/packs a day? _____ How many years? _____

Do you drink alcohol? _____ How many a drinks a day/week? _____

What is your current occupation/work status? _____

Are you currently working? _____ Are you currently receiving Worker's Compensation? _____

If so you are out of work, how long? _____

Do you exercise regularly? _____ What is your height? _____ Weight? _____

Are you involved in a personal injury lawsuit because of your pain? _____

Patient Intake Questionnaire 3 of 3

Check off any symptoms you now have:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Significant Weight Change |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Eye pain/Redness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Oral Lesions | <input type="checkbox"/> Throat Disorder |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Skipping | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Swollen Glands | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Bloody Sputum |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Reflux | <input type="checkbox"/> Change in Bowel Habits |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Menstrual Changes |
| <input type="checkbox"/> Pain in Joints | <input type="checkbox"/> Decreased Range of Motion | <input type="checkbox"/> Persistent Infections | <input type="checkbox"/> Muscle Weakness/Paralysis |
| <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Rashes/Bumps | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tremor Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Excessive Thirst |

This part of the questionnaire is designed to give your caregiver information on how your pain has affected your ability to manage in everyday life. Please answer every section to the best of your ability and mark in each section only the box that applies to you. We realize you may consider two statements in any section may relate to you, but please **mark only one box that most closely describes your problem.**

Pain Intensity

- _0 I can tolerate the pain I have without have to use painkillers.
- _1 The pain is bad, but I manage without taking painkillers.
- _2 Painkillers give me complete relief from pain.
- _3 Painkillers give me moderate relief from pain.
- _4 Painkillers give me very little relief from pain.
- _5 Painkillers have no effect on the pain and I do not use them.

Standing (in the past week)

- _0 I can stand as long as I want.
- _1 I can stand as long as I want, but it gives me pain.
- _2 Pain prevents me from standing longer than 1 hour.
- _3 Pain prevents me from standing longer than 30 min.
- _4 Pain prevents me from standing longer than 10 min.
- _5 Pain prevents me from standing at all.

Getting Dressed (in the past week)

- _0 I can dress myself.
- _1 I can dress myself without increasing pain.
- _2 I can dress myself, but pain increases.
- _3 I can dress myself, but with significant pain.
- _4 I can dress myself, but with severe pain.
- _5 I cannot dress myself due to pain.

Sleeping (in the past week)

- _0 I sleep well.
- _1 Pain occasionally interrupts my sleep.
- _2 Pain interrupts my sleep half of the time.
- _3 Pain often interrupts my sleep.
- _4 Pain always interrupts my sleep.
- _5 I never sleep well.

Lifting (in the past week)

- _0 I can lift heavy objects without pain.
- _1 I can lift heavy objects, but it is painful.
- _2 Pain prevents me from lifting heavy objects off the floor, but I can manage off the table.
- _3 Pain prevents me from lifting heavy objects in general, I can manage light to medium if they are conveniently positioned.
- _4 I can only lift light objects.
- _5 I cannot lift or carry anything.

Sex Life (in the past week)

- _0 My sex life is unchanged.
- _1 My sex life is unchanged but causes some pain.
- _2 My sex life is nearly unchanged, but very painful.
- _3 My sex life is severely restricted because of pain.
- _4 My sex life is nearly absent because of pain.
- _5 Pain prevents any sex life at all.

Walking and Running (in the past week)

- _0 I can walk and/or run without pain.
- _1 I can walk comfortably, but running is painful.
- _2 Pain prevents me from walking more than an hour.
- _3 Pain prevents me from walking more than 20 minutes.
- _4 Pain prevents me from walking more than 10 minutes.
- _5 I am unable to walk or can only walk a few steps at a time.

Social Life (in the past week)

- _0 My social and recreational life is unchanged.
- _1 My social/rec. life is unchanged, but it increases pain.
- _2 My social/rec. life is unchanged, but it severely increases pain.
- _3 Pain has restricted my social/rec. life.
- _4 Pain has severely restricted my social/rec. life.
- _5 I essentially have no social/rec. life due to pain.

Sitting (in the past week)

- _0 I can sit in any chair as long as I want.
- _1 I can only sit in a special chair for as long as I want.
- _2 Pain prevents me from sitting longer than 1 hour.
- _3 Pain prevents me from sitting longer than 1/2 hour.
- _4 Pain prevents me from sitting longer than 10 minutes.
- _5 Pain prevents me from sitting at all.

Traveling (in the past week)

- _0 I can travel anywhere.
- _1 I can travel anywhere but it gives me some pain.
- _2 Pain is bad, but I can manage to travel over 2 hours.
- _3 Pain restricts me to trips of less than 1 hour.
- _4 Pain restricts me to trips of less than 30 minutes.
- _5 Pain prevents me from traveling.