

New Patient Information

Patient Name: _____ **DOB:** _____ **Age:** _____
(Nombre de Paciente) (Fecha de Nacimiento) (Edad)

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____
(Direccion) (Ciudad) (Estado) (Codigo)

SSN: _____ - _____ - _____ **Home Phone#:** _____ **Work:** _____ **Cell:** _____
(Numero de seguro social) (Telefono de casa) (Telefono de Trabajo) (Telefono de celular)

Employer: _____ **Phone#:** _____
(Nombre de Empleo) (Telefono de Empleo)

Spouse's Name: _____ **DOB:** _____ **Age:** _____
(Nombre de Esposo/a) (Fecha de Nacimiento) (Edad)

Spouse's Employer: _____ **SSN:** _____ - _____ - _____
(Empleo de Esposo/a) (Numero de seguro social)

Insurance Information

(Informacion sobre su Aseguransa)

Primary Insurance: _____ **Phone#:** _____
(Nombre de Aseguransa Primaria) (Numero de Telefono)

Claims Address: _____ **City:** _____ **ST:** _____ **Zip:** _____
(Direccion) (Ciudad) (Estado) (Codigo)

Insured's Name: _____ **Group#:** _____
(Nombre de el persona que tienes el Aseguransa) (Numero de Grupo)

Member/ID#: _____ **Policy#:** _____
(Numero de miembro o ID) (Numero de Poliza)

Secondary Insurance

(Informacion sobre su Aseguransa Secundaria)

Secondary Insurance: _____ **Phone#:** _____
(Nombre de Aseguransa) (Numero de Telefono)

Claims Address: _____ **City:** _____ **ST:** _____ **Zip:** _____
(Direccion) (Ciudad) (Estado) (Codigo)

Insured's Name: _____ **Group#:** _____
(Nombre de el persona que tienes el Aseguransa) (Numero de Grupo)

Member/ID#: _____ **Policy#:** _____
(Numero de miembro o ID) (Numero de Poliza)

Attorney's Name: _____ **Phone#:** _____
(Nombre de Abogado) (Telefono de su Abogado)

Address: _____ **City:** _____ **ST:** _____ **Zip:** _____
(Direccion) (Ciudad) (Estado) (Codigo)

Date of Injury: _____ **Who may we thank for referring you to our office?** _____
(Fecha que fue lastimado) (A quien le debemos las gracias por su referencia?)

Patient's Signature: _____ **Date:** _____
(Firma de Paciente) (Fecha)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By Joseph J. Schifini, MD, LTD. (JJS)

Patient Name: _____
Last First M.I. (Previous or Other Names Used)

Address: _____

Date of Birth: _____

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

I authorize the release of medical records from: Joseph J. Schifini, MD, LTD
600 S. Tonopah Drive
Suite 240
Las Vegas, NV 89106

Please release requested medical records to:

Name: _____
Address: _____
City: _____
State: _____
ZIP: _____
Telephone Number: () -
Fax Number: () -

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

- | | |
|--|--|
| <input type="checkbox"/> Emergency Records | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Clinic Records | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Films |
| <input type="checkbox"/> Shot Records | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Slides | <input type="checkbox"/> Other _____ |

This authorization will expire on the 180th day of the signing unless a lesser date is specified below:

By signing this Authorization Form, I understand that I am giving my authorization for JJS to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying JJS in writing to Joseph J. Schifini, MD, LTD Health Information Management Department, 600 S. Tonopah Drive, Suite 240, Las Vegas, Nevada 89106 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by JJS before JJS received my written notice of revocation. If neither federal nor Nevada privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Nevada privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from JJS.

Signature of Patient or Authorized Personal Representative **Date**

Relationship to the Patient (If signed by a Personal Representative) **Date**

Joseph Schifini, M.D.

DATE ___/___/___

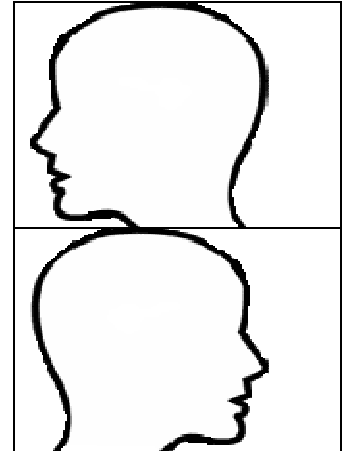
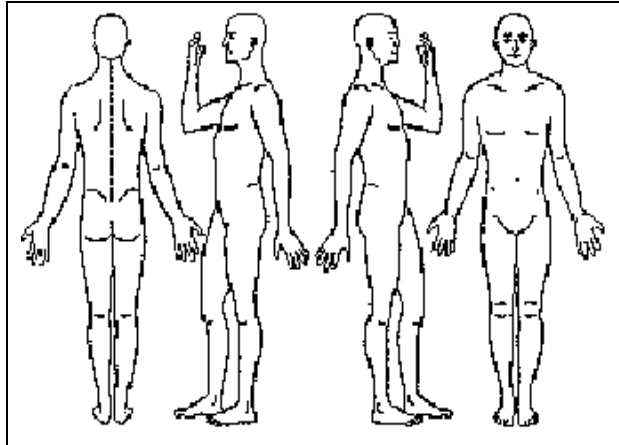
PLEASE FILL OUT THIS FORM **COMPLETELY** SO WE CAN HELP YOU WITH YOUR PAINFUL CONDITION.

NAME: _____ AGE: _____ SEX: M / F HEIGHT ___'___" WEIGHT _____ lbs
OCCUPATION: _____ DATE LAST WORKED ___/___/___

CC: WHY WERE YOU REFERRED TO OUR CLINIC? _____

HPI: PLEASE DESCRIBE YOUR PAIN BY **SHADING** IN THE AFFECTED AREAS AND **PLACING AN 'X'** ON THE AREA THAT HURTS THE MOST. **CIRCLE** ALL APPLICABLE DESCRIPTIVE WORDS.

- CONSTANT TEMPORARY
- DAILY OCCASIONAL
- ACHING SHOOTING
- BURNING STABBING
- NUMBING TINGLING
- PINS/NEEDLES



PLEASE ATTEMPT TO QUANTIFY YOUR PAIN USING PERCENTAGES. YOUR TOTAL PAIN SHOULD ADD UP TO 100%. (EXAMPLE: 20% LOW BACK PAIN AND 80% RIGHT LEG PAIN = 100%.)

HEAD _____% NECK _____% RIGHT ARM _____% LEFT ARM _____%

CHEST _____% ABDOMEN _____% UPPER BACK _____% MID BACK _____%

LOWER BACK _____% HIPS/BUTTOCKS _____% RIGHT LEG _____% LEFT LEG _____%

CIRCLE THE ACTIVITIES WHICH TEND TO **INCREASE** YOUR PAIN:

WALKING LIFTING BENDING TWISTING STANDING SITTING

FILL IN ACTIVITIES WHICH **DECREASE** YOUR PAIN: _____

DOES THIS PAIN AFFECT YOUR SLEEP? YES / NO

CURRENT PAIN MEDICATIONS: _____ PRESCRIBED BY DR. _____

MARK YOUR **AVERAGE** PAIN SCORE:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

MARK YOUR **WORST** PAIN SCORE:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

NOTE: (**ZERO** EQUALS **NO PAIN** AND **TEN** EQUALS YOUR **WORST** IMAGINABLE PAIN)

WHEN DID THIS PAIN BEGIN? _____ (SPONTANEOUS/ INJURY/ ACCIDENT/ SURGERY/ OTHER)

PLEASE **DESCRIBE** HOW IT BEGAN:
