2099 GRAND ISLAND BLVD.
Suite B
(716) 773-3300

Patient Information Form

Name: First: _____ MI: _____ Last: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: Male Female E-mail Address: _____

Emergency Contact/Phone #: _____

Referring Physician: _____

Date of Injury: _____

DO YOU HAVE AN OPEN WORKMAN'S COMP OR NO-FAULT CASE FOR THIS BODY PART? Y N

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

ID #: _____ Group #: _____

Name of Person Insured: _____ Relation: _____

Insured's Employer: _____ Insured Person's Date of Birth: _____

Describe in a ***FEW SHORT*** sentences your main reason for this appointment:

_____

_____

_____

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Medical History Form

Name: _____ Age: _____

Please indicate if you have had or now have the following:

Condition	Y	N	Condition	Y	N
High blood pressure			Abdominal or Mid-Back Pain		
Heart disease/attack, pacemaker			Open wounds		
Cancer			Skin condition		
Osteoarthritis			Metal implant/fragments		
Rheumatoid arthritis			Osteoporosis		
Diabetes			Vascular problems		
Fracture			Neck or back problems		
Stroke or TIA			Fever and chills		
Infectious disease			Unexplained weight loss		
Seizures/Epilepsy			Pregnant now		
COPD, bronchitis, asthma					
Joint Replacements					

If you marked yes above, please provide more information:

_____

_____

Please list all previous surgeries:

_____

_____

Please list all medications currently being taken (include all over the counter and herbal supplements):

_____

_____

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Pain Assessment Chart

Name: _____ Today's Date: _____

Age: _____ Occupation: _____

1. Where is your pain?

_____

2. When did it start?

_____

3. Is your pain the result of an injury?

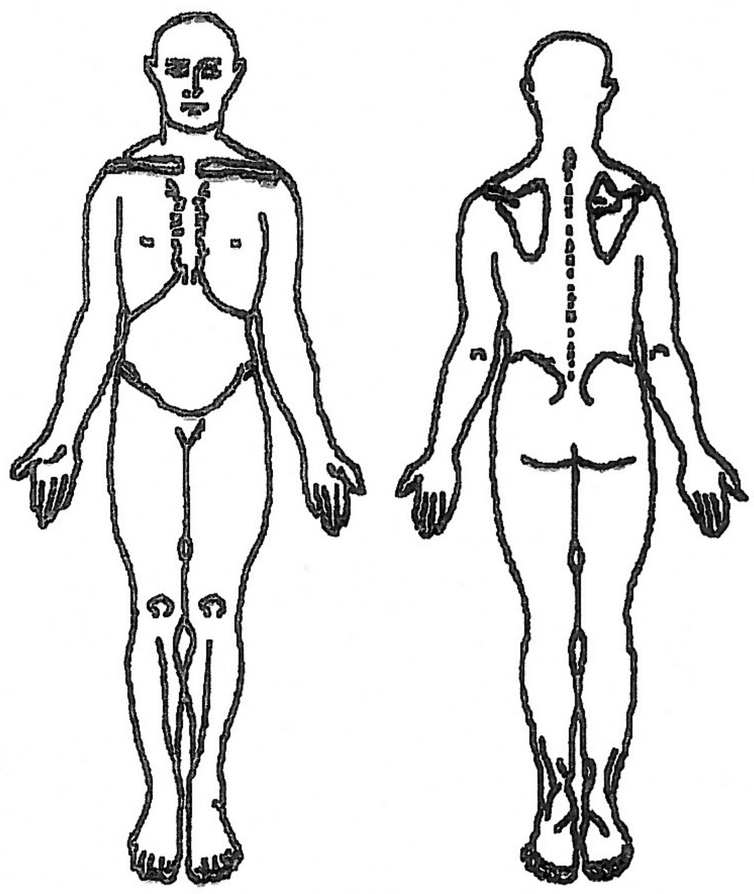
_____

4. Is your pain constant or intermittent?

5. Describe your pain:

Sharp Dull Achy Deep Burning Throbbing

Please draw pain on the body chart below:



6. Rank your pain from a scale of 1 to 10 (10 is unbearable):

At rest: _____ During activities: _____

7. Is there anything that makes your pain better?

_____

8. Is there anything that makes your pain worse?

_____

9. What tests have you had recently?

MRI CT Scan X-Ray EMG

10. What activities do you have difficulties with?

Standing Sitting Walking Stairs Lying down

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Cancellation Requirements

24 hours' notice for cancellations is greatly appreciated.
Our cancellation policy is as follows:

A NO-SHOW* OR SAME DAY CANCELLATION will result in a **$15.00 cancellation fee. There will be no exceptions.**

If we can reschedule that visit for another day in the same week, the $15.00 fee will be waived.

***3 same day no-show appointments may result in a $30.00 charge and being discharged for non-compliance.**

By signing below, you accept these cancellation terms.

Sign_____Date _____

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Please only complete this portion if you have a Workman's Comp or No-Fault Case

If your Workman's Comp or No Fault case is *denied*, we will try to bill your secondary insurance. However, if they also deny your case, **you will be financially responsible for any denied visits.**

WORKMAN'S COMP PATIENTS: It is your responsibility to call your doctor and request that they submit a new MG-2 form to the Workman's Comp Board every 6 WEEKS. If this is not done, we cannot guarantee that WC will cover your case and you could end up having to pay for these visits.

I understand and accept these terms:

Patient Name _____ Patient Signature _____ Date _____