Corda Pain Institute

877-740-4888

Serving South Jersey for over 30 Years

P.O. Box 8890, Turnersville, NJ 08012

Browns Mills	856-740-4888
Cherry Hill	856-616-0900
Jersey City	877-740-4888
Linwood	609-813-2113
Vineland	856-691-0361
Williamstown	856-740-4888

Please fill out this entire packet of information before you arrive.

Date: ______________________________

Name: ______________________________

Address: ______________________________

City: ____________________ State: ______ Zip: ______________

Home Phone: ____________________ Cell Phone: ____________________

Date of Birth: ____________________ SS#: ____________________

Marital Status: ____________ Race: ____________ Ethnicity: ____________

Email: ______________________________

Pharmacy Name & Number: ______________________________

Emergency Contact Name & Number: ______________________________

Primary Care Physician Name & Number: ______________________________

Employer name: ______________________________

I have been informed that Dr. Peter Corda, Dr. Jeffery Poleer and Dr. Vannette Perkins, have small investment interest in the following surgical centers: Premier Surgical Center, AlantiCare Surgical Center. Dr. Peter Corda, Dr. Jeffery Poleer have a small investment interest in Jersey Shore Medical Center. Dr. Vannette Perkins has a small investment interest in Premier Orthopedic Surgical Center.

Signature: ____________________ Print Name: ____________________ Date: ____________________

Attached is a packet of information, please fill out and bring with you on the day of your scheduled appointment. **MUST BRING YOUR MOST CURRENT LAB/X-RAY/MRI REPORTS (NOT JUST FILMS) WITH YOU, DO NOT FAX OR MAIL THEM TO THE OFFICE.** If your records are extensive, bring at least the notes from your doctor(s) from the last 6 months to a year. The more information you have, the better understanding the doctor has of your condition. **IF YOU DO NOT BRING IN THE PACKET, REPORTS, AND YOUR RECORDS, YOU WILL BE RESCHEDULED.**

Your also MUST present a picture ID (ex: driver's license, NJ State ID) and your insurance cards. Please remember if you have CO-PAY to bring it with you at the time of your visit.

Name: ____________________ Age: ________ Sex: ________

Height: __________ Weight: __________

Is your pain secondary to:

Work Injury: __________ Motor Vehicle Accident: __________ Other: __________

Date it Occurred: __________

Give short summary of how pain started: ______________________________

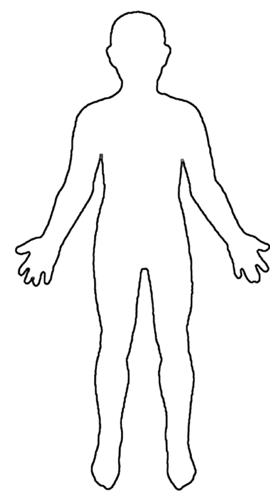
What treatment have your tried? Physical Therapy: ______ TENS: ______ Surgery: ______

Chiropractic: ______ Injections: ______ Medications: ______

Present Pain (0-10): ______ Worst Pain: ______ Best Pain: ______

Where is your worst pain: ______________________________

Occupation: __________ Currently Working: Yes ______ No: ______



Disability: No: ______ Permanent: ______ Temporary: ______

Smoker: Yes: ______ No: ______ Previous: ______ (— packs/day)

Social History: Single: ______ Married: ______ Divorced: ______ Widow: ______

Family History (ex: diabetes, heart disease, back problems: ______________________________

Past Medical History:

Cardiac:	Yes: ______	No: ______	Lung:	Yes: ______	No: ______
Heart Attack:	Yes: ______	No: ______	Asthma:	Yes: ______	No: ______
High Cholesterol:	Yes: ______	No: ______	Sleep Apnea:	Yes: ______	No: ______
High Blood Pressure:	Yes: ______	No: ______	COPD:	Yes: ______	No: ______
Other: ______________			Other: ______________		

Gastrointestinal: Yes: ______ No: ______

Peptic Ulcer: Yes: ______ No: ______

Gastritis: Yes: ______ No: ______

Reflux: Yes: ______ No: ______

Hepatitis: Yes: ______ No: ______

Hiatal Hernia: Yes: ______ No: ______

Irritable Bowel: Yes: ______ No: ______

Other: ______________________________

Neurological: Yes: ______ No: ______

Seizure: Yes: ______ No: ______

Stroke: Yes: ______ No: ______

Headaches: Yes: ______ No: ______

Shingles: Yes: ______ No: ______

RSD: Yes: ______ No: ______

MS: Yes: ______ No: ______

Other: ______________________________

Endocrinology: Yes: ______ No: ______

Diabetes: Yes: ______ No: ______

Thyroid: Yes: ______ No: ______

Sexual Dysfunction: Yes: ______ No: ______

Other: ______________________________

Psychology: Yes: ______ No: ______

Depression: Yes: ______ No: ______

Bipolar: Yes: ______ No: ______

Schizophrenia: Yes: ______ No: ______

Other: ______________________________

Orthopedics: Yes: ______ No: ______

Low Back Pain: Yes: ______ No: ______

Neck Pain: Yes: ______ No: ______

Knee Pain: Yes: ______ No: ______

Elbow Pain: Yes: ______ No: ______

Hip Pain: Yes: ______ No: ______

Carpal Tunnel: Yes: ______ No: ______

Rheumatoid Arthritis: Yes: ______ No: ______

Other: ______________________________

Urology: Yes: ______ No: ______

Kidney Stones: Yes: ______ No: ______

Pelvic Pain: Yes: ______ No: ______

Headaches: Yes: ______ No: ______

Other: ______________________________

Cancer: Yes: ______ No: ______

Type: ______________________________

Metastic: Yes: ______ No: ______

Past Surgical History:

Orthopedics: Yes: ______ No: ______

Neck Surgery: Yes: ______ No: ______

When: ______________________________

Knee Arthoscopy: Yes: ______ No: ______

Left: ______ Right: ______

Knee Replacement: Yes: ______ No: ______

Left: ______ Right: ______

When: ______________________________

Back Surgery: Yes: ______ No: ______

When: ______________________________

Hip Replacement: Yes: ______ No: ______

Left: ______ Right: ______

When: ______________________________

Other: ______________________________

Cardiac: Yes: ______ No: ______

By-Pass: Yes: ______ No: ______

Stent: Yes: ______ No: ______

Carotid: Yes: ______ No: ______

Other: ______________________________

General: Yes: ______ No: ______

Appendix: Yes: ______ No: ______

Tonsil: Yes: ______ No: ______

Gall Bladder: Yes: ______ No: ______

Hernia: Yes: ______ No: ______

Other: ______________________________

Urology: Yes: ______ No: ______

Prostate: Yes: ______ No: ______

Kidney: Yes: ______ No: ______

Hysterectomy: Yes: ______ No: ______

Tubal: Yes: ______ No: ______

Other: ______________________________

Any Other Surgeries: ______________________________

____

____

Any other system problems (Ex: fever, chills, cough, constipation, ETC): ______________________________

____

____

List Medications: ______________________________

____

____

Allergies:

Iodine/Dye: Yes: ______ No: ______ Latex: Yes: ______ No: ______

Other: ______________________________

____

Past Illicit Drug Use: ______________________________

Alcohol: ______________________________

Hepatitis: Yes: ______ No: ______

Type: ______________________________

HIV/AIDS: Yes: ______ No: ______

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There is no right or wrong answer.

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
How often do you have mood swings?					
How often have you felt a need for higher doeses of medications to treat your pain?					
How often have you felt impatient with your doctors?					
How often have you felt that things are just too overwhelming that you can't handle them?					
How often is there tension in your home?					
How often have you counted your pain pills to see how many are remaining?					
How often have you been concerned that people ill judge you for taking pain medication?					
How often do you feel bored?					
How often have you taken more pain medication than you were supposed to?					
How often have you worried about being left alone?					
How often have you felt a craving for medication?					
How often have others expressed concern over your use of medication?					
How often have any of your close friends had a problem with alcohol?					
How often have others told you that you have a bad temper?					
How often have you felt consumed by the need to get pain medication?					
How often have you run out of medication?					
How often have others kept you from getting what you deserve?					
How often, in your lifetime, have you had legal problems or been arrested?					
How often have you attended in AA or NA meeting?					
How often have you been in an argument that was so out of control that someone got hurt?					
How often have you been sexually abused?					
How often have others suggested that you have a drug or alcohol problem?					
How often have you had to borrow pain medications from your family or friends?					
How often have you been treated for an alcohol or drug problem?					

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ______________________________________, authorize release of all information including medical records, reports, test results, and any pertinent information to Corda Pain Institute (Professional Pain Management Associates.)

Mail to: PO Box 8890, Turnersville, NJ 08012
Fax to: 856-740-0558

I, ______________________________________, authorize release of all information including medical records, reports, test results, and any pertinent information to Corda Pain Institute (Professional Pain Management Associates) to any requesting physician or attorney.

______________________________________ ______________________

Patient's Signature Date

____

Print Patients Name

Corda Pain Institute

Professional Pain Management Associates

P.O. Box 8890
Turnersville, NJ 08012
Tax ID: 223351986

ASSIGNMENT OF AND AUTHORIZATION TO PAY PHYSICIAN/MEDICAL EXPENSE BENEFITS

I,
________________________________ , employed by ________________________________
Name of insured Name of employer

Hereby assign, transfer and set over unto Corda Pain Institute (Professional Pain Management) as interest may appear, all physician/medical expense benefits under by insurance.

Policy/claim # __________________________ , Group # __________________________ issued by
________________________________ , which are due or to become due my by virtue of services performed on
Insurance Company

the person ________________________________ by Corda Pain Institute (Professional Pain Management)
Name of patient

I hereby authorize said company to pay such benefits directly to Corda Pain Institute (Professional Pain Management) and any and all payments so made shall constitute and be a discharge in full to said company tot he extent of the benefits so paid.

It is understood and agreed that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate the said account, I shall be personally liable for the unpaid balance of the account.

PRINT NAME: ________________________________

SIGNATURE: ________________________________

DATE: ________________________________

Nature's RX

Professional Pain Management Associates

P.O. Box 8890
Turnersville, NJ 08012
Tax ID: 223351986

ASSIGNMENT OF AND AUTHORIZATION TO PAY PHYSICIAN/MEDICAL EXPENSE BENEFITS

I, ______________________________ , employed by ______________________________
Name of insured — Name of employer

Hereby assign, transfer and set over unto Nature's RX as interest may appear, all physician/medical expense benefits under by insurance. Policy/claim # ______________________________ , Group # ______________________
issued by ______________________________ , which are due or to become due my by virtue of services
Insurance Company
performed on the person ______________________________ by Nature's RX.
Name of patient

I hereby authorize said company to pay such benefits directly to Nature's RX and any and all payments so made shall constitute and be a discharge in full to said company tot he extent of the benefits so paid.

It is understood and agreed that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate the said account, I shall be personally liable for the unpaid balance of the account.

PRINT NAME: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

I understand that pain syndromes can sometimes be complex to treat. As a result, medication including narcotics which required strict guidelines for administration may be used for alleviating pain. These medications have potential to cause harmful effects used inappropriately. Consequently, these medications need to be monitored very carefully by your physician. All Narcotic medications are habit forming.

These medications not only cause physical and mental dependence, but your body will set tolerance to the medications, meaning you will need more medications to the same effect/pain relief. This may eventually give you more side effects. In addition, these medications are highly regulated by the state and federal government. Therefore, the following policies are instituted and bound by the physicians and Cord Pain institute.

It is the policy of Corda Pain Institute that patients who are receiving narcotic prescriptions as a part of their treatments agree to the following terms:

___ There is a risk of addiction when using narcotic medications. Narcotic medications are to be as directed. If a patient takes more medication than directed, the will not receive additional medication. If this causes the patient to go into withdrawal it is that patient's responsibility to report to the emergency room and have themselves admitted to a drug rehabilitation program.

___ Narcotic medications will not be called in by phone

___ There are no early refills on medications. Federal lae prohibits us from writing for more than a certain number of pills.

___ There will be no replacement of lost prescriptions or misplaced medication even if a police report has been filed and documented.

___ Your concerns and questions regarding your narcotic medications must be directed to your treating physician. If a patient needs to have their narcotic medication changed or directions changed, they must make an appointment with their physicians.

___ Any patient on narcotic medications may be ordered to have a blood and urine test for liver and kidney function for quantitative analysis (amount of medication in your body) on a six month basis.

___ If a patient alters the prescription in any ay, takes medication more frequently than prescribed, shares medication or takes narcotic medications from another physician or persons, they can be discharged from the treating physician's care within thirty days.

___ You may only receive narcotic medications from your treating physician at Corda Pain Institute (Professional Pain Management)

___ Only your treating physician will prescribe and manage your narcotic therapy program

___ If you do not keep scheduled office visit appointments, therapy or any other prescribed participation in the pain management program, you will not be maintained on narcotic medications and may be discharged from the program by your treating physician.

___ Many times, non-steroid antiinflammatory medication and or blend are used to decrease the amount of narcotics taken. These medications, however, can also cause harm to the liver and kidney. Therefore, you are now informed that narcotic Tylenol and steroidal anti-inflammatory (Advil, Motrin, Bextra, Celebrex) can cause liver and kidney failure, decreased breathing/respiratory depression, coma, etc. and may result in death. You understand that he treatment for pain relief with medications is not without risk, as mentioned.

___ The patient has been advised not to drive a car or operate machinery while under the influence of opiates, benzodiazepines or muscle relaxants. The patient has been advised to check with an attorney as tot he New Jersey law regarding driving under the influence of these medications. I further suggested that the patient get a driver's evaluation with an approved company that can check reaction time behind the wheel while taking medications

___ You may be asked to participate in a narcotic group counseling session.

By signing this form, you have read, understand and agree to abide by the rules set forth in this policy. My breech of the above terms could result n my discharge from Corda Pain Institute and from all physicians associated with the group.

____________________	____________________	____________________
Patient's Signature	Print Patients Name	Date

PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

______ *MEDICAL RECORDS* ______

Persons Authorized to Use or Disclose Information
Information described above may be disclosed to:

______ **CORDA PAIN INSTITUTE** *(PROFESSIONAL PAIN MANAGEMENT)* ______

____
Name of Person or Organization

Expiration Date of Authorization
This authorization is effective through ______________ unless revoked or terminated by the patient or the patients personal representative

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Corda Pain Institute. You should contact the Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations

Medical Photography
I consent to be photographed for identification/medical record purposes. ☐ YES ☐ NO

Appointment Reminders
I authorize Corda Pain Institute to leave appointment reminders on voice mail ☐ YES ☐ NO

____
Name of Patient (Print or Type)

____
Signature of Patient Date

____
Signature of Patient Representative

____
Relationship of Patient Representative to Patient

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Date: ______________________________

Dear Patient,

As a medical standard of care, new patients should be drug screened as a baseline analysis and patients that are on narcotics should be drug screened routinely. Corda Pain Institute (Professional Pain Management) will submit these charges for reimbursement to your insurance company. If your insurance company does not reimburse for these charges you will be responsible for the amount of $20.00

___________________________________ ___________________________________

Print Patients Name Patient's Signature