CONNECTICUT BACK CENTER

PATIENT INFORMATION

Last Name: ___________________________________ First Name: _________________________________ M.I. __________

Address:____ Apt #: _______________________

City: ____ State: _____________ Zip Code: ___________________

DOB: ________/________/________ Age: _________ Gender: M F Ethnicity: __________________________________

Last 4 Digits S.S.#: ______________ Marital Status: ________ E-Mail Address: _________________________________

Home #: _____________________________ Cell #: ____________________________ Work #: __________________________

Primary Care Physician: ___________________________________ Referring Physician: _______________________________

Pharmacy Name: ___________________________ Location: ___________________________ Phone #: __________________

INSURANCE INFORMATION

Primary Insurance: __________________________________

Insur ID #: ____

Policyholder Name: __________________________________

Policyholder DOB: ___________________________________

Policyholder Address: ________________________________

____

Employer: ____

Address: ____

Secondary Insurance: ________________________________

Insur ID #: ____

Policyholder Name: __________________________________

Policyholder DOB: ____________________________________

Policyholder Address: _________________________________

____

Employer: ____

Address: ____

EMERGENCY CONTACT

Name: ______________________________________ Relationship ___________________ Daytime Phone #:________________

Have you have any imaging studies in the last year? ( ) MRI ( ) CT Scan ( ) Xrays Where? __________________________

Results, if known? ____

Any prior spine surgery? When? ____________________ With who? ____

Are present symptoms the same as prior to surgery? ( ) Yes ( ) No

Is injury related to: ( ) MVA OR ( ) Work Related Date of Accident: _________________________

Is an attorney associated with this injury? Name: _____________________________________ Phone #: __________________

Patient Signature: ____ Date: ________________________

rev 7/2014

CONNECTICUT BACK CENTER
OFFICE POLICIES

MEDICATION REFILLS - If you need a refill on a medication that does not require a written prescription, please call your pharmacy to have them fax a request to 860-872-6229, for refill of your medication. Please allow at least THREE days notice for all prescription refills.

If you need a prescription refill for a *narcotic* medication, please call the office and leave a message on the *Medication Line voice mail* with the medication information and a phone number where you can be reached if we should have any questions (you will not be called back if there are no questions). Please call prior to coming to the office to ensure that your written prescription has been authorized and is ready for pickup.

*****DO NOT ALLOW YOUR MEDICATIONS TO COMPLETELY RUN OUT BEFORE CALLING FOR A REFILL!!! CALL OUR OFFICE AT LEAST 3 DAYS BEFORE!!******

PAPERWORK

If you have paperwork that requires the doctor's completion and signature, please fill out your portion of the form and either mail or bring it to the office. We will do our best to have the forms ready for pickup, mailing or faxing within 7-10 business days. You must either have been seen at least three times in our office or be a patient of the doctors for at least 30 days before we will fill out paperwork. ***Please note that there is a $30.00 fee for completion of paperwork.***

CANCELLATION POLICY

If you cannot keep an appointment, please call the office to cancel at least 24 hours prior to that appointment. If you do not call the office and do not show up for the appointment, you will be charged $50.00. This fee is NOT billable to your insurance company and will need to be paid prior to your being seen at your next appointment. Of course, consideration is given to appointments cancelled due to inclement weather, emergencies, illness, etc. Please call the office in a timely manner to cancel any appointment you cannot keep. This will allow us time to schedule other patients in that appointment slot.

PAYMENTS

Co-payments are required at the time of your visit (this is an agreement between you and your insurance company). Because of this agreement, we are mandated by your insurance company to ***collect your copay at the time of service.***

Those patients without health insurance (self-paying) are required to pay a $350.00 deposit at the time of their visit, and to pay for each subsequent visit at the time of the appointment, unless other arrangements are made with the office prior to the appointment. These visits are to be paid in cash or with a credit card.

If a referral is required by your insurance for you to see a specialist, you are responsible for obtaining that referral, and it must be sent to our office prior to your appointment, or we will have to reschedule your appointment.

Signature: ____ Date: ___________________________

rev 7/2014

CONNECTICUT BACK CENTER
HIPAA PRIVACY RESTRICTIONS QUESTIONNAIRE

Patient Name: ____ DOB: _______________________

May we send statements and reminder cards to your home? ( ) Yes ( ) No

May we leave messages (including test results) on your answering machine? ( ) Yes ( ) No

May we send you a fax? Fax #: ______________________________ ( ) Yes ( ) No

May we contact you via e-mail? E-mail address: _____________________________ ( ) Yes ( ) No

Please list names and relationships of persons who we may release information or talk to about your care/appointments:

____ ______________________________________

____ ______________________________________

CONSENT FOR TREATMENT/RELEASE OF MEDICAL INFORMATION

I consent to treatment necessary for the care of the patient listed above. I hereby authorize the release of all medical records to the referring and family physicians.

Date: ______________________ Signature: ____

FOR RESTRICTIONS TO YOUR PROTECTED HEALTH INFORMATION (PHI) OTHER THAN NOTED ABOVE, PLEASE SUBMIT IN WRITING TO THE COMPLIANCE/PRIVACY OFFICER UTILIZING OUR "RESTRICTION OF USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION" (PHI) FORM.

FINANCIAL RESPONSIBILITY - INSURANCE AGREEMENT

I acknowledge full responsibility for services rendered and agree to make definite financial arrangement for payment. I understand that the charges for professional services may not be covered fully by my insurance company and therefore, I am solely responsible for payment of all services. I authorize the release of any information necessary to determine liability or payment and to obtain reimbursement on any claims. I authorize that payment of medical benefits be made to Jesse G. Eisler, M.D. I assign the benefits payable, to which I am entitled including government, private insurance and other health plans, to Jesse G. Eisler, M.D. This assignment will remain in effect until revoked by me in writing.

Date: ___________________ Signature: ____

rev 7/14

PAST MEDICAL HISTORY (Please check all that apply):

CARDIAC: [ ] Heart Attack [ ] Murmur [ ] Abnormal Rhythm [ ] Other: ______________
PULMONARY: [ ] Asthma [ ] COPD [ ] Emphysema [ ] Other: ______________
ENDOCRINE: [ ] Diabetes [ ] Hypothyroid [ ] Pituitary Tumor [ ] Other: ______________
CIRCULATORY: [ ] Hypertension [ ] Stroke [ ] Aneurysm [ ] Other: ______________

PAST SURGICAL HISTORY (Please list type, date, surgeon/hospital):

_____________________ ________________________ ___________________________

_____________________ ________________________ ___________________________

MEDICATIONS (If more space is needed, please use back of form or attach list)

MEDICATION	DOSAGE	FREQUENCY	DURATION TAKEN

DRUG ALLERGIES: ____

FAMILY HISTORY: (Please check and indicate which parent/sibling and year of illness/death):

CARDIAC: [ ] Heart Attack [ ] Hypertension ___________________
PULMONARY: [ ] Asthma [ ] COPD [ ] Emphysema ___________________
ENDOCRINE: [ ] Diabetes [ ] Hypothyroid ___________________
NEUROLOGIC: [ ] Stroke [ ] Aneurysm [ ] Tumor ___________________
CANCER: [ ] Lung [ ] Breast [ ] Intestinal ___________________
OTHER: [ ] ___________ [ ] ____________][ ] ____________ ___________________

SOCIAL HISTORY:

Occupation: _________________________________ How long? _______________ Date Unemployed: _______________

Substance Use (Amount/Frequency: Tobacco: ________________ Alcohol: ______________ Other: _______________

REVIEW OF SYSTEMS (Please check all that apply):

Neurologic: [ ] Headache [ ] Dizziness [ ] Memory [ ] Numbness Other:_______________________
Eyes: [ ] Glasses [ ] Contacts [ ] Blurriness [ ] Double Vision Other:_______________________
Ears/Throat: [ ] Deafness [ ] Ringing [ ] Swallowing [ ] Hoarseness Other:_______________________
Cardiac: [ ] Chest Pain [ ] Skip Beats [ ] Rapid Beat [ ] Edema Other:_______________________
Pulmonary: [ ] Cough [ ] Cough Blood [ ] Wheezing [ ] Short Breath Other:_______________________
Intestinal: [ ] Constipation [ ] Diarrhea [ ] Incontinence [ ] Bleeding Other:_______________________
Urinary: [ ] Frequency [ ] Burning [ ] Incontinence [ ] Bleeding Other:_______________________
Musculoskel: [ ] Pain [ ] Weakness [ ] Arthritis [ ] Cane/Walker Other:_______________________
Endocrine: [ ] Weight Gain [ ] Weight Loss Other:_______________________
Skin: [ ] Bruising [ ] Lesions [ ] Birthmarks Other:_______________________
Hematology: [ ] Bleeding [ ] Transfusion [ ] Hepatitis Other:_______________________
Psychiatric: [ ] Depression [ ] Insomnia [ ] Fatiguability Other:_______________________

Signature: ____ Date: ________________

rev 7/2014