MENON
Regenerative Institute

NEW PATIENT REGISTRATION FORM

(Please print clearly)

Today's Date_____ ❑ Male ❑ Female Date of Birth _____/_____/_____

Name _____ Height: _____ Weight: _____

SSN: _____ Referred By: _____

Home Address_____
Street *City* *State* *Zip*

Mailing Address (if different)_____
Street *City* *State* *Zip*

Email: _____

Home Phone _____ Work Phone _____ Other/Cell Phone _____

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced
Employed: ❑ Full-Time ❑ Part-Time ❑ N/A Employer:_____
Student: ❑ Full-Time ❑ Part-Time ❑ N/A School:_ _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Phone: _____

MEDICAL INSURANCE INFORMATION:

Primary Insurance

_____

Member ID number _____ **Group #** _____

Employer _____

Name of Insured (if different from above): _____ **Date of Birth:** _____

Guarantor's Social Security#_____

Relationship to Patient: ❑ **Parent** ❑ **Spouse** ❑ **Partner** ❑ **Other**

Address (if different from patient)

_____
Street *City* *State* *Zip*

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SECOND MEDICAL INSURANCE INFORMATION:

Secondary Insurance _____

Member ID number _____ Group # _____

Name of Insured (if different from above): _____ Date of Birth: _____

Guarantor's Social Security# _____

Relationship to Patient: ❑ Parent ❑ Spouse ❑ Partner ❑ Other

Address (if different from patient)

_____

Street *City* *State* *Zip*

AUTO ACCIDENT RELATED INJURY:

Auto Insurance _____ Date of accident: _____/_____/_____

Claim # _____ Policy # _____

Claims Address _____

Adjuster name: _____ Home: _____

Fax _____

Attorney Name: _____ Phone: _____

Address _____ Fax: _____

WORKER'S COMP:

Worker's Comp Insurance _____ Date of injury _____/_____/_____

Claim# _____

Claims

Address _____

Adjuster name _____ Phone _____

Fax _____

Attorney Name _____ Phone _____

Address _____ Fax _____

Aditi Menon, MD

187 Millburn Ave, Suite 101, Millburn, NJ 07047

Phone: 973-382-5002 Fax: 973-924-0882

Reason for visit/Symptoms:_____

History:

When did your pain first start? *(approximate date, be specific as you can)*: _____

What were circumstances surrounding how pain began? _____

_____

Was it the result of an accident or injury? Yes No Is there any litigation involved? Yes No

Does the pain radiate from this part of your body to another area(s)? If yes, where? _____

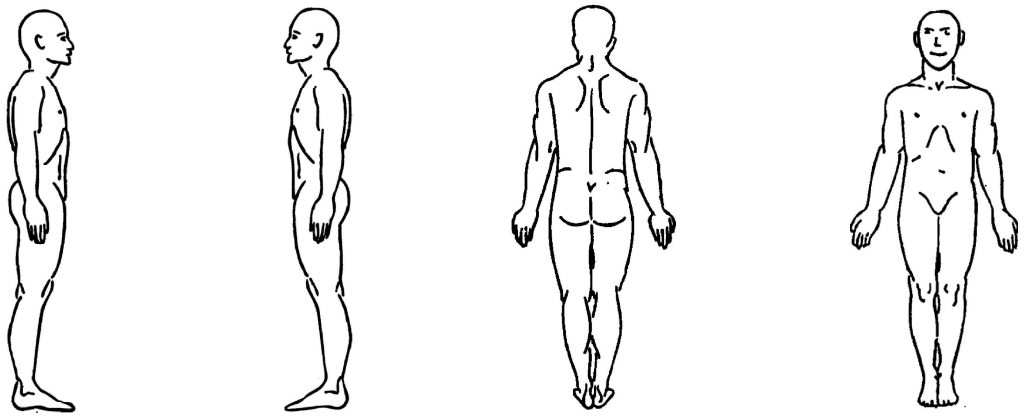
_____

Do you have numbness and tingling? If yes, which areas?_____

Please circle/notate the words that best describe your pain:

ACHING	HOT	SHOOTING	SHARP	COLD
BURNING	NUMB	SEVERE	STABBING	TINGLING

Please indicate where your pain is below:



On a scale of 1-10 with 1 being no pain and 10 being the worst possible pain, please circle your pain scale right now:

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 with 1 being no pain and 10 being the worst possible pain, please circle the most pain you have been in over the past two weeks:

1 2 3 4 5 6 7 8 9 10

Please circle if your pain is:

Constant Intermittent Brought on by Aggravating Factors

Is there a time of day when your pain is usually: *Better?* AM or PM *Worse*? AM or PM

Are there activities that make your pain worse? (walking, sitting, climbing stairs, etc.)?_____

_____

What positions/treatments seem to offer some relief for your pain? _____

Diagnostic Tests:

Please circle any diagnostic test you have had for this condition:

MRI CAT SCAN EMG XRAY OTHER_____

Please circle any treatment you have had for pain and duration of treatment:

Acupuncture Chiropractor Heat/Cold Massage Physical Therapy Other:

Pain Medications or Supplements tried for this condition (indicate names):

What Injections have you had for this condition and be specific on type/body region/dates:

Surgeries/Procedures for this condition (indicate type):

All Current Medications and Supplements:

Please list all medications currently being taken for pain and any other prescription medications or supplements you are taking for *any* condition. Or alternatively please attach a detailed list to this packet.

Medication/Supplement	Amount(Mg)	Frequency	What is it for?	Who prescribed?

Allergies:

Please list any known allergies (food/meds/environmental) you have and the reaction they cause.

☐ Check if you have no known drug allergies

Allergy (medication, food, etc.)	Reaction

Past Medical History _____

_____

Past surgeries/injections/procedures Please list with the years:

_____

_____

Family History: _____

_____

Social History:

Marital Status: Single Married Divorced Widowed Committed Relationship

Work Status: Working Not Working Retired Disabled

Do you smoke? Yes No If so how much?_____

Do you drink alcohol? Yes No If so how many drinks/week?_____

Do you take any recreational drugs? _____

Do you use an assistive device to get around? Cane Walker Wheelchair Scooter

Review of Symptoms:

Do you **CURRENTLY** have problems with any of the following? Please circle

Headaches
Heart Palpitation
Chronic cough
Heartburn
Chest Pain
Wheezing
Fever
Diarrhea
Bowel/Bladder Incontinence
Rashes
Rapid mood swings
Depression
Hair loss/dry skin
Confusion/Brain fog
Unintended wt loss/gain
Numbness/Tingling/burning
Excessive Fatigue
Shortness of Breath
Constipation
Swelling
Difficulty Sleeping
Blurred Vision
Hearing Changes
Currently Pregnant
Weakness
Multiple joint pain
Loss of Libido
Other:_____

Patient Signature:_____ Date:_____

Aditi Menon, MD

187 Millburn Ave, Suite 101, Millburn, NJ 07047

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INFORMED CONSENT FOR OFFICE PROCEDURES

I hereby request and authorize: **Dr. Aditi Menon** to perform on me (or on the patient named below, for whom I am legally responsible) the following procedure:

____ Trigger point injection to the following areas: cervical / thoracic / lumbar /specific region/level: _____

____ Joint Injection of: _____

____ Greater occipital nerve block (RIGHT / LEFT / BILATERAL)

____ Tendon injection: (RIGHT/LEFT/BIL) _____

____Platelet Rich Plasma (PRP) injection

____ Other :_____

Response to treatment varies with each individual. Much depends on the extent of injury, whether the injury is acute or chronic, as well as your bodies healing ability. We caution patients of the possibility to expect some increased discomfort for the first 24-48 hours which may be related to injection site pain or the procedure itself. This is part of the body's own healing response, & is generally exhibited by an inflammatory reaction which is the natural response of the body. It is the inflammation that causes temporary discomfort. Depending on particular procedure, you may treat this response with alternating applications of heat & ice (minimal to none for PRP) or oral supplements as XFlame, Tumeric, Tylenol. For certain procedures (PRP, prolozone) we ask patients to avoid the use of NSAIDs such as ibuprofen during this time, as this inflammation is desirable & part of the healing process.

I understand and am informed that there are some risks to treatment, including but not limited to infection, allergic reaction and local inflammation as well as a possible increase in pain as described above. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have had an opportunity to discuss with Dr. Menon and/or with other office or clinic personnel the nature and purpose of this procedure. I understand that results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Patient Name _____ Patient or Guardian Signature_____ Date _____

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ASSIGNMENT OF BENEFITS

Patient Name_____

1. I, the undersigned, hereafter referred to as "the patient," do hereby assign all of my rights and interests to _____ hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.
2. I assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. However, upon consent of both parties, same shall be revocable.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement made on my behalf.
5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.
6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance provider.
7. To prevent the insurance carrier and/or the vendor designated by the insurance carrier from refusing to accept my Assignment or submitting a challenge to my Assignment as being invalid, I execute this Special Power of Attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name. I understand and acknowledge that the attorney chosen by the medical provider is to represent me individually on any claim for outstanding treatment with the medical provider in any appropriate forum. This Assignment serves as a limited retainer agreement between me and the attorney chosen by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. I have been advised that if an arbitration and/or lawsuit is filed in my name individually, failure to include an outstanding medical provider's bills whom I have not executed an Assignment of Benefits with could make me liable for payment to that provider. In consideration, this medical provider has agreed to accept as payment in full, the amount awarded and/or settled and will not seek additional payment from other insurance carriers.
8. Please be aware that some Blue Cross Blue Shield checks and explanation of benefits may be sent directly to patient. Patient must sign back of check and send to the office within 14 days of receiving it.

Signature of the patient _____ **Date** _____

Print name: _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____