Haim D. Blecher, M.D.
Board Certified
Fellowship Trained Spine Surgeon

Dear Patient:

In efforts to make your visit as pleasant and time efficient as possible, we are enclosing the necessary forms to be completed for your appointment**.** All paperwork must be completed and mailed in the self-address envelope prior to your appointment. **Regardless of your appointment location, please mail all paperwork to our primary location in Princeton, NJ**. If you do not have the time to do so, please bring the completed paperwork with you to you appointment. Failure to do so can considerably delay your visit with the doctor.

If you have an extensive medical history and a large amount of medical reports and/or films, we kindly request that you either mail them or drop them off to our office at least one week prior to your appointment.

If you were involved in a motor vehicle accident all pertinent claim information must be furnished to our office prior to your appointment. This information is needed so that we can obtain the necessary pre-certifications/authorizations for your visit (such as insurance company name, address, phone number, claim number date of injury and adjuster's name). If you have a workman's compensation injury, your visit must be authorized by the workman's compensation carrier and your employer.

If you have any recent studies pertaining to your current injury, you must bring all studies to your appointment. Failure to do so will result in your appointment being either cancelled or rescheduled to the next available date. Studies include but are not limited to: MRI, CT Scan, Discograms, Myelograms, Bone Scans, X-Rays, EMG etc. If you have the studies without the reports, please request that copies be faxed to our office at 609-924-9212.

We request that you please arrive at least 15 minutes prior to your scheduled appointment to enable us to register you in a timely matter. Certain time slots are designated for our new patients. If you should have any questions, please feel free to call the office between the hours of 9:00am-5:00pm at 609-924-8060. The staff will be happy to answer any questions that you may have.

We thank you in advance for your cooperation.

APPOINTMENT ____

LOCATION ____

UNIVERSITY SPINE ASSOCIATES, P.A.

Haim D. Blecher, M.D.
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PATIENT INFORMATION

Please fill out entire packet.

Name____

Address ____

City, State, Zip ______________________________________

Home Phone ______________ Cell ____________________ Work_____________________

Are we permitted to leave a message on voice mail at all of these numbers? Yes or No

Date of Birth________________ Age _________SS# ___________________________

E-mail address ______________________________________

Gender: Male Female (circle one)

Marital Status: Single Married Divorced Widowed (circle one)

Employer ________________________ Occupation _______________________

Business Address _____________________________________

Who is your primary care physician? ____________________________

Address____

Phone __________________________ Fax __________________________

Would you like a copy of your progress notes sent to your primary care physician? Yes No

How were you referred you to our office? Physician ____________________________

Other (please specify) _________________________________

In case of a medical emergency whom would you like us to notify?

Name/Phone/Relationship _____________________________

Today's Date ____________________________________

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Patient Name_______________________________________Date____________

PLEASE READ THE FOLLOWING SECTIONS CAREFULLY.

YOUR SIGNATURES ARE REQUIRED PRIOR TO SEEING THE PHYSICIAN.

Please be aware that University Spine Associates, P.A. does not contract with most commercial insurance carriers. **Haim D. Blecher, M.D. is an out of network provider with most commercial insurance companies**. As a courtesy to you, if you so choose, University Spine Associates, P.A., will submit the bill for services rendered to your insurance company. Each insurance policy has different deductibles and out of network benefits. You must be aware that there may be a balance for payment on services rendered that may include but is not limited to your co-insurance and deductible. You are responsible for this balance. In the event your insurance carrier sends payment directly to you for services rendered by University Spine Associates, P.A. please forward the payment University Spine Associates, P.A. with the explanation of benefits.

By signing below, I am aware that University Spine Associates, P. A. is an **out of network provider** and I understand the above paragraph that describes my financial responsibility.

Signature ___________________________________**Date** __________________

Printed Name ____

If you are not the patient what is your relation? _____________________________

I hereby authorize my physician at University Spine Associates, P.A. to release any information obtained in the course of my examination that my insurance company may request. I also authorize assignment of my medical benefits to my physician at University Spine Associates, P.A. This assignment of benefits allows our office to collect directly from your insurance company.

Signature ___________________________________**Date**__________________

Printed Name ____

If you are not the patient what is your relation? _____________________________

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Patient Name____Date______________

Primary Insurance

Insurance Policy Holder's Name ____

Relationship to Patient ____

Subscriber's Employer ____

Carrier________________________________ Phone ____________________

Address____

Policy ID______________________________ Group ____________________

Subscriber's Birth Date ____________ Subscriber's SS#______________________

Does your insurance require pre-authorization for office visits or testing?

Yes ______________ No ____________________ Uncertain ____________________

Secondary Insurance

Insurance Policy Holder's Name ____

Relationship to Patient ____

Subscriber's Employer ____

Carrier________________________________ Phone ____________________

Address____

Policy ID______________________________ Group ____________________

Subscriber's Birth Date ____________ Subscriber's SS#______________________

256 Bunn Drive, Suite 3B ● Princeton, NJ 08540 ● Tel: (609) 924 8060 ● Fax: (609) 924 9212
www.universityspine.com

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Patient Name_______________________________________Date____________

Worker Compensation or Motor Vehicle Information

If your injury is Workers Compensation or Motor Vehicle related, please specify by circling below and completing this page. If not please circle Not Applicable and go to the next page.

Worker Compensation Motor Vehicle Not Applicable

Carrier________________________________ Claim# ____________________

Claims Office Address ____

____

Adjuster/Case Manager Name____

Adjuster's Phone/Fax # ____

Date of Injury ____

Employer Name____

Are you represented by an attorney? Yes or No (circle one)

Please provide attorney name/address/phone/fax below

____

____

____

____

Are you presently working? Yes or No (circle one)

If not, when was your last day of work? ______________________________

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Patient Name____Date_______________

Symptoms and Conditions

What is your main complaint? ____

What symptoms have you been having? ____

____

How long have you been having these symptoms? _______________________________________

____

Have you been seen by another doctor for this condition? Yes or No (circle one)

Please describe your past treatment for this condition:

Please List Previous Spine Surgeries

Type ____

Date_________________ Surgeon ____

Please List Previous Surgeries (other than Spine Surgery)

Type ____

Date_________________ Surgeon ____

Type ____

Date_________________ Surgeon ____

Physical Therapy

Place & Therapist ____

Name____ Date _______________

Pain Management/Injections

Doctor ____

Type of Injection ______________________________________ Number of Injections _________

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Patient Name____Date______________

Medical Conditions, Medications, Allergies and Studies

Please list all your medical conditions ____

____

____

____

____

Please list all medications you are currently taking

Medication_______________________ Dosage ____________Duration__________________

Medication_______________________ Dosage ____________Duration__________________

Medication_______________________ Dosage ____________Duration__________________

Medication_______________________ Dosage ____________Duration__________________

Pharmacy Name & Phone ____

Known Allergies ____

Please list any test/studies you have had in the past pertaining to this visit such as MRI, CT Scans, X-Rays

____ Date ______________

____ Date ______________

____ Date ______________

____ Date ______________

____Date ______________

Please list what test/studies you have with you today for doctor to review

____

____

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Patient Name____Date______________

Review of Symptoms Please check below all that you are currently experiencing

General
- □ Recent Weight Change
- □ Fever
- □ Fatigue
- □ Memory Loss/Confusion
- □ Depression
- □ Night Sweats
- □ HIV infection or AIDS
- □ Arthritis

Head and Neck
- □ Eye Disease or Injury
- □ Wear Glasses/Contacts
- □ Blurred or Double Vision
- □ Glaucoma
- □ Hearing Loss
- □ Ringing in Ears
- □ Earaches or Drainage
- □ Sinus Problems
- □ Nose Bleeds
- □ Mouth Sores
- □ Bleeding Gums
- □ Bad Breath or Taste
- □ Sore Throat /Voice Change
- □ Swollen Glands in Neck
- □ Snoring
- □ Facial Pain
- □ Allergies

Heart and Cardiovascular
- □ Heart disease
- □ Chest pains
- □ Hypertension
- □ Angina
- □ Anemia
- □ Pacemaker
- □ Swelling of ankles, hands

Musculoskeletal
- □ Joint Pain
- □ Joint Stiffness/Swelling
- □ Muscle Weakness
- □ Back Pain
- □ Difficulty walking

Neurological
- □ Headaches
- □ Head Injury
- □ Numbness
- □ Black-Outs
- □ Paralysis
- □ Tremors
- □ Seizures
- □ Strokes

Respiratory System
- □ Hoarseness
- □ Chronic Cough
- □ Throat Clearing
- □ Heart Burn
- □ Spitting up blood
- □ Shortness of Breath
- □ Asthma/Wheezing
- □ Bronchitis
- □ Emphysema
- □ Tuberculosis
- □ Lung Cancer

Endocrine
- □ Diabetes
- □ Thyroid Imbalance
- □ Glandular/Hormone
- □ Menstrual disorders
- □ Heat/Cold intolerance
- □ Excessive thirst

Hematological/Lymphatic
- □ Anemia
- □ Phlebitis
- □ Transfusion
- □ Swollen glands
- □ Slow to heal after cuts
- □ Easily bruised

Gastrointestinal
- □ Difficulty /Pain Swallowing
- □ Constipation
- □ Jaundice
- □ Hepatitis
- □ Liver disease
- □ Kidney disease
- □ Diverticulosis
- □ Gallbladder disease
- □ Diarrhea

Urologic
- □ Difficulty on urination
- □ Frequent urination
- □ Blood in urine
- □ Prostate problems

Skin and Breasts
- □ Rash or itching
- □ Change in skin color
- □ Change in hair or nails
- □ Varicose Veins
- □ Breast pain
- □ Breast lump
- □ Breast Discharge

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