

**Medical History**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ **Left** or **Right** Handed Occupation: \_\_\_\_\_  
(circle one)

**Reason for Visit:** \_\_\_\_\_

Approximate date of onset: \_\_\_\_\_ If injury, how did it happen: \_\_\_\_\_

**Known Health Problems:** (Please list) \_\_\_\_\_

**All Surgery or Operations:** \_\_\_\_\_

Please list all **prescription and non-prescription medications** you are taking. If none please write “None”

**Medication:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

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**Medication Allergies:** (if none write “None”) \_\_\_\_\_ **Women: Any chance of pregnancy?** Yes  No

**Do you smoke?** (How much per day) \_\_\_\_\_ **Alcohol Consumption:** Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Size \_\_\_\_\_

**Substances:** Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)  
Next to each substance that you’ve circled, indicate if you used it **Occasionally** “O” **Frequently** “F” **Continuously** “C”

Alcohol \_\_\_\_\_ Barbiturates \_\_\_\_\_ Cocaine \_\_\_\_\_ Heroin \_\_\_\_\_ Amphetamines \_\_\_\_\_ Marijuana \_\_\_\_\_ Painkillers \_\_\_\_\_

Other: \_\_\_\_\_

**Are you presently using any of the drugs or substances below?** (Circle all that apply)

Alcohol Barbiturates Cocaine Heroin Amphetamines Marijuana Painkillers Other: \_\_\_\_\_

Have you ever been treated for or had a professional recommend treatment for alcohol or substance abuse? Yes  No

**In your opinion, do you have or have you ever had a problem with alcohol or other drugs?** Yes  No

Please **describe the type of work** that you do: \_\_\_\_\_

If you feel **any other activities** may relate to your problem, please describe: \_\_\_\_\_

**Conditions:** (Check all conditions you have or have had in the past)

- |                                                     |                                               |                                            |                                             |
|-----------------------------------------------------|-----------------------------------------------|--------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Thyroid or Goiter | <input type="checkbox"/> Herpes             |
| <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Anorexia          | <input type="checkbox"/> Bronchitis         |
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Bleeding or Clotting | <input type="checkbox"/> Prostate Problem  | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Pacemaker or Defibrillator | <input type="checkbox"/> Disorder             | <input type="checkbox"/> Appendicitis      | <input type="checkbox"/> Cataracts          |
| <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Gout              | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Mumps              |
| <input type="checkbox"/> Asthma or Emphysema        | <input type="checkbox"/> Ulcer/Reflux         | <input type="checkbox"/> Polio             | <input type="checkbox"/> Chicken Pox        |
| <input type="checkbox"/> Aids or HIV                | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Scarlet Fever     | <input type="checkbox"/> Miscarriage        |
| <input type="checkbox"/> Liver Disease or Hepatitis | <input type="checkbox"/> Suicide Attempt      | <input type="checkbox"/> Shingles          | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Chemical Dependency  | <input type="checkbox"/> Hernia            | <input type="checkbox"/> Mononucleosis      |
| <input type="checkbox"/> Cancer: TYPE: _____        | <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Tonsillitis       | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Breast Lump       |                                             |

**Review of Systems:** (Check all conditions you have or have had in the past)

**GENERAL**

- Unexplained Changes in Weight     Fever or Chill Sweats     Change in Voice     Tiredness

**HEAD**

- Headache     Head Injury     Visual Problems     Hearing Problems     Vertigo (Dizziness)     Ear Pain  
 Tinnitus (Ringing in Ears)     Sinus Problems     Dental Problems     Any Mental Complaints

**NEUROLOGICAL**

- Head Pain     Head Trauma/Injuries     Seizures/Epilepsy     Tingling (Pins & Needles)     Loss of Consciousness     Tremors/Shaking     Pinched Nerve     Difficulty Walking     Weakness/Paralysis  
 Numbness/Loss of Sensation     Memory Problems     Disorientation     Difficulty Speaking  
 Difficulty Swallowing     Double Vision     Loss of Vision     Difficulty Writing     Difficulty Reading

**MUSCULAR / SKELETAL**

- Muscle Aching     Weakness     Joint Swelling     Joint Pain or Stiffness     Neck Pain     Arthritis  
 Low Back Pain     Injuries: (Specify) \_\_\_\_\_

**SLEEP**

- Insomnia     Snoring (Excessive)     Daytime Drowsiness (Excessive)

**CARDIAC/VASCULAR/HEART**

- Chest Pain     Palpitations     Heart Murmur     Fainting     Swollen Feet/Legs     Blood Vessel Problems

**LUNGS**

- Coughing/Wheezing     Shortness of Breath     Coughing Up Blood

**GASTRO-INTESTINAL**

- Change in Appetite     Digestion Problems     Gas     Nausea     Vomiting     Constipation  
 Diarrhea     Abdominal Pain

**GENITAL/URINARY**

- Difficulty Urinating     Incontinence (Loss of Urine)     Kidney Stones     Urinary Infections     Impotence  
 Other Sexual Problems     Women: Irregular Periods

**SKIN/HAIR**

- Change in Hair     Skin or Scalp Lesions     Rash     Dryness     Itching

**ENDOCRINE/HEMATOLOGICAL ALLERGY IMMUNE**

- Sensitivity to Temperature     Unusual Thirst or Hunger     Excessive Urination     Bloating  
 Swollen Glands     Pale Color     Multiple Allergies     Frequent Colds/Infections

**Family Medical History:**

Known Health Problems

Age (or age at death if deceased)

**Father:** \_\_\_\_\_

\_\_\_\_\_

**Mother:** \_\_\_\_\_

\_\_\_\_\_

**Sister:** \_\_\_\_\_

\_\_\_\_\_

**Brother:** \_\_\_\_\_

\_\_\_\_\_

**Child:** \_\_\_\_\_

\_\_\_\_\_

Patient Initials: \_\_\_\_\_

Reviewed by physician: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

# Pain Drawing

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Examiner: \_\_\_\_\_

## Tell Us Where You Hurt

**Please read carefully:**

Mark the areas on your body where you feel you pain. Include all affected areas. Mark areas of pain radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

**Ache** >>>>

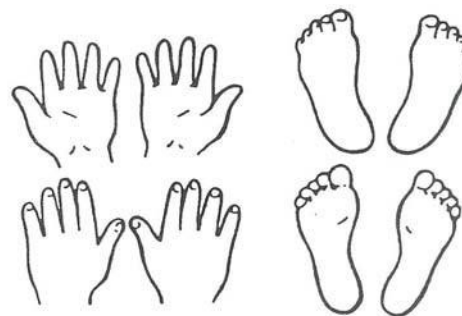
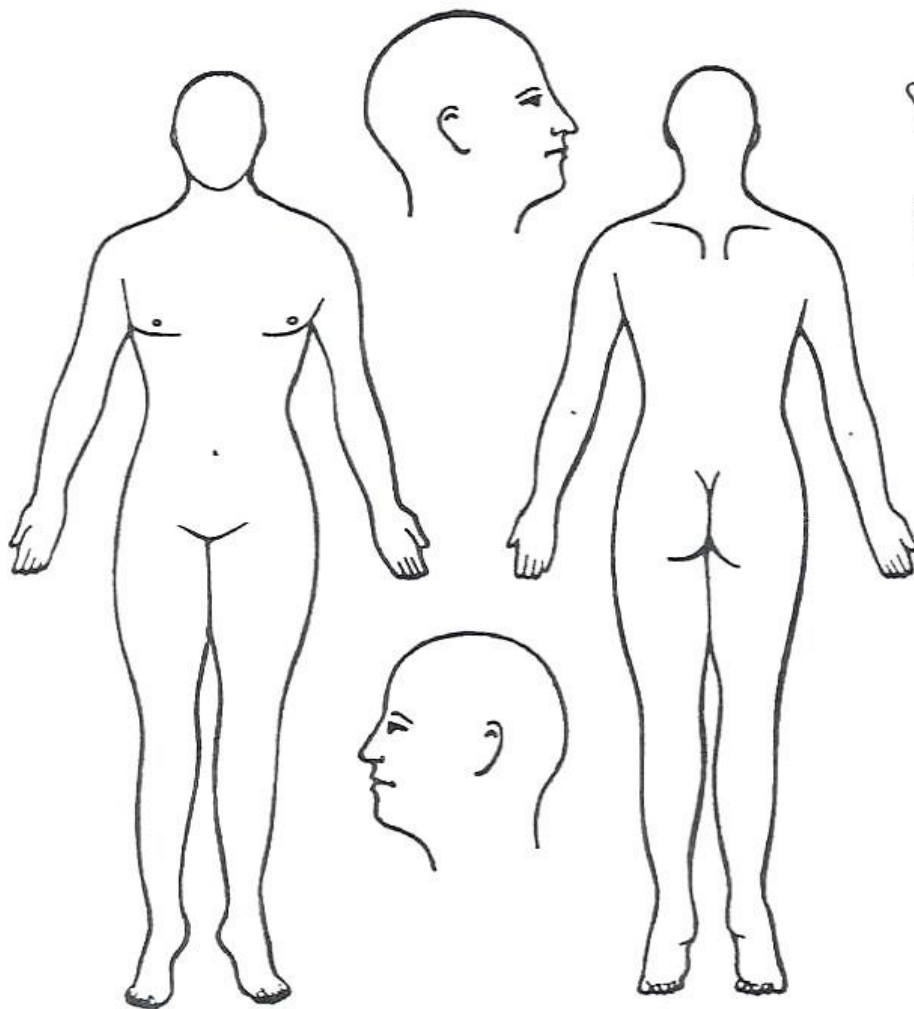
**Numbness** =====

**Pins and Needles**      0 0 0 0  
                                         0 0 0 0

**Burning** x x x x

**Stabbing** // // //

**Throbbing** ~ ~ ~ ~



### Severity of Pain

List the region of pain. Circle the severity number.  
1=least pain, 10=greatest pain

- ex:           NECK            
          0 1 2 3 4 5 6 7 8 9 10
1. \_\_\_\_\_  
          0 1 2 3 4 5 6 7 8 9 10
  2. \_\_\_\_\_  
          0 1 2 3 4 5 6 7 8 9 10
  3. \_\_\_\_\_  
          0 1 2 3 4 5 6 7 8 9 10
  4. \_\_\_\_\_  
          0 1 2 3 4 5 6 7 8 9 10
  5. \_\_\_\_\_  
          0 1 2 3 4 5 6 7 8 9 10

**WELCOME TO ROBERT J. FRIEDMAN, M.D., P.A.****AUTHORIZATION AND FINANCIAL AGREEMENT****Insurance Coverage**

HPC has made prior arrangements with several insurance companies. We will bill those plans with which we have an agreement and will only require you to pay the applicable co-payment or deductible at the time of service. If you have insurance coverage with a plan that we are not participating with, HPC will file insurance claims for you to your insurance for medical services. These patients are required to pay HPC in advance for the estimated cost of services and procedures.

Your insurance policy is a contract between YOU and your insurance company. All health plans are different and cover different services. In the event your insurance company determines a service to be "not covered or not medically necessary" or over the usual and customary charge, you will be responsible for the complete charge.

If you are a Medicare recipient with Supplemental or Secondary insurance that covers the Medicare 20% or Deductible, WE WILL FILE AS A COURTESY. If your Supplemental/Secondary insurance does not reimburse HPC within sixty (60) days, it will become your responsibility. If you have no supplement, or your supplement is with a company that we know does not "crossover" automatically from Medicare, you will be responsible for the 20% at the time of service.

**Laboratory Testing**

Patients requiring laboratory testing are sent to an outside lab facility that your insurance requires. These lab tests are done at and by its facility and HPC is not responsible for any billing related to those services. If you have any questions about lab or diagnostic test billing, it is your responsibility to contact these facilities direct, not us.

**Minor Patients**

For all services rendered to minor patients, we will look to the adult accompanying the patient for payment. This parent or guardian will be listed as the guarantor in our system.

**Our Office Charges for the Following**

Telephone calls from the doctor at the patient's request will fall under our TeleHealth Agreement. If you feel you may need these services in the future, please notify our Staff and an Agreement will be made available to you for your review and signature. TeleHealth consults are typically non-covered by insurance and would be your responsibility. Any and ALL forms to be filled out at your request will incur a fee of \$10 and up; Patient's requesting a prescription refill by phone in lieu of office visit will cost \$25.00. Returned check fees are \$50.00.

**Before and After Hour Appointments**

Patient appointments before 8:30am and after 5:00pm will incur a charge of \$50 for New Patients and \$30 for Follow-Up appointments. This charge is not covered by insurances and is the patient's responsibility. You will be required to pay this fee in addition to any applicable copays or deductibles.

**Cancellation Policy**

With the understanding of the significant expenditures for equipment, treatment supplies, staffing, scheduling, and other costs, once appointments are scheduled the patient is responsible for keeping that appointment. Patients who cancel or miss an appointment without prior 48 hour notice will be charged a fee. Extenuating circumstances will be considered on an individual basis. The charges are as follows: Office Visits: New Patients: \$ 150.00; Follow-up appointments \$ 60.00; Procedures \$130.00 If your appointment is canceled or rescheduled by HPC, you will not be charged for the canceled appointment. If you arrive at the office more than 30 minutes late, this will be considered a no-show in most instances. **Exceptions may be made for acute illness or other emergency only at the sole discretion of HPC.** This charge is not covered by insurances and is the patient's responsibility.

*I authorize the patient's insurance company, attorney, or Medicare to pay direct to Robert J. Friedman, MD any medical expenses payable under the terms of the contract. I have read and understand the financial policy of Robert J. Friedman, M.D., P.A. and agree to be bound by its terms. Photocopies of this form will be valid. I also agree that any balance not covered will be paid by me. I understand that should this account be referred to an agency or attorney for collection that I will be responsible for all collection and court costs and attorney's fees. Delinquent accounts beyond 90 days are subject to the maximum interest allowed by law. I further authorize the physician in charge of the care of the patient to administer such medical care as may be deemed advisable in the diagnosis (and treatment) of this patient. I certify that the information I have reported with regard to my insurance coverage is true and accurate. If my insurance company has not paid or denied my claim in 30 days, I give Robert J. Friedman M.D. my consent to seek assistance and lodge complaints to the Insurance Commissioner's office on my behalf. I agree to the policies of this office and wish to be seen.*

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

