



David J. Abraham, MD
Spine Surgeon

Carl Burnett, D.O.
Non-Operative Spine Physician

Courtney Bates, CRNP

Dear New Patient:

You have an appointment scheduled on ____/____/____.

- Please arrive 10 minutes prior so that we can complete your registration.
- Your X-Ray appointment is scheduled for ____:____ AM/PM.
- Your appointment is scheduled for ____:____ AM/PM.

Please fill out the enclosed forms before arriving for your appointment along with your insurance cards and any co-pay which is due at time of service.

You **MUST** also bring the following (if applicable) to your appointment or your appointment will be rescheduled:

- Any recent EMG results, **ACTUAL CD OR FILMS OF ANY** X-rays, MRI scans, CT scans, or Bone scans.
- Any workman's compensation information.
- Any auto insurance information.
- Insurance referral if required by your insurance plan.

Please note: A new patient appointment may take up to two hours so please plan accordingly.

Thank you

The Reading Neck and Spine Center.

1270 Broadcasting Road • Wyomissing, Pennsylvania 19610
48 Tunnel Road, Suite 202 • Pottsville, Pennsylvania 17901
Phone: 610-372-1140 • Fax: 610-372-7684 • Toll Free: 1-877-774-6389
www.readingneckandspine.com

No Show Policy

When you schedule an appointment with one of our physicians that time is reserved exclusively for you. We do understand that on occasion unforeseen circumstances do arise and the need to cancel your scheduled appointment may be necessary. If you know that you will be unable to keep your appointment, we ask you to show consideration by calling our office 24 hours in advance. Providing our office with adequate notice will allow us to offer that appointment time to another patient who needs to see the physician.

A \$45 fee will be charged for a no show or for failing to give a 24-hour notice to cancel your appointment.

**These charges are not billable to your insurance and will ultimately be the responsibility of the patient. All no show charges will need to be paid before your next appointment with the physician. **

The Reading Neck and Spine Center
New Patient Information Record

Last Name _____ First Name _____ M.I. _____
Street Address _____ City _____ State _____ Zip _____
SS# _____ - _____ - _____ Home Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____
E-mail _____ @ _____
Sex: M / F Marital Status: M S W D Date of Birth ____/____/____ Age _____
Pharmacy _____ Pharmacy Phone _____ - _____ - _____

Patient's Occupation _____ Employer _____
Address _____ Work Phone _____ - _____ - _____

Spouse's Name _____ Spouse's Date of Birth ____/____/____
Spouse's Occupation _____ Employer _____
Address _____ Work Phone _____ - _____ - _____

How did you hear about our practice? (Please circle all that apply) Friends/Family Newspaper Lecture Physician: _____

Insurance Information

Primary Carrier

Secondary Carrier

Ins. Co. _____
Address _____
Subscriber _____
Relationship to Patient _____
Subscriber DOB ____/____/____
Subscriber SS# _____ - _____ - _____
ID# _____ Group# _____

Ins. Co. _____
Address _____
Subscriber _____
Relationship to Patient _____
Subscriber DOB ____/____/____
Subscriber SS# _____ - _____ - _____
ID# _____ Group# _____

I hereby authorize my insurance benefits to be paid directly to The Reading Neck and Spine Center realizing that I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

I hereby authorize release of my medical records, any x-rays, or other studies and any operative reports to be faxed to The Reading Neck and Spine Center at 610-372-7684.

Patient Signature _____ Date ____/____/____

Workers Compensation, Motor Vehicle Accident, Other
*****Must have this information filled out prior to visit.*****

Ins. Co. _____ Claim# _____
Address _____ Phone# _____ - _____ - _____
Date of Injury / Accident ____/____/____ Adjustor's Name _____

Complete Only If Patient Is A Minor

Name _____ Relationship _____ Address _____
Phone _____ - _____ - _____ Occupation _____ Employer _____
Employer's Address _____ Work Phone _____ - _____ - _____
Mother: Date of Birth ____/____/____ SS# _____ - _____ - _____
Father: Date of Birth ____/____/____ SS# _____ - _____ - _____

The Reading Neck and Spine Center

Patient's Name _____ Date ____/____/____

****If you would like any physicians to receive a copy of your medical report, this form must be completed with their correct mailing information.****

Referring Physician: (The physician who sent you to The Reading Neck and Spine Center)

Name _____

Name of Practice _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ - _____ - _____

Primary Care Physician:

Name _____

Name of Practice _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ - _____ - _____

Other Physician:

Name _____

Name of Practice _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ - _____ - _____

Name _____

Date ____/____/____

Height _____

Weight _____

Age _____

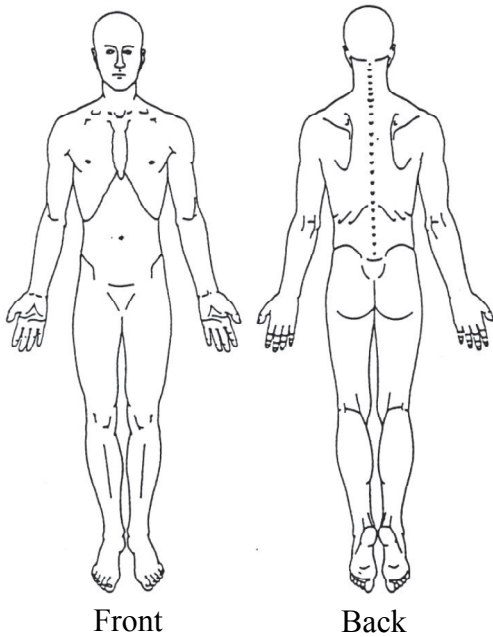
Reason for visit (please be specific) _____

Referring Physician _____

Family Physician _____

Please use the following diagram to map out any areas of pain or numbness that represents your current problem.

Please circle the area of pain:



Describe your pain: (circle all that apply)

Type:

Frequency:

Sharp

Constant

Dull

Intermittent

Burning

Shooting

What makes the pain:

Better:

Worse:

Name _____

Date ____/____/____

Past medical history (circle 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: _____
Psychological:	Depression	Anxiety	Panic disorder	Other: _____
Other:	High cholesterol	Reflux	Coronary disease	Other: _____
Other:	Other: _____	Other: _____	Other: _____	Other: _____

Past surgical history

Procedure _____ Surgeon _____ Year _____

Procedure _____ Surgeon _____ Year _____

Allergies

Family History (please circle and list relationship)

Cardiac:	Heart attack	Hypertension		_____
Pulmonary:	Asthma	COPD	Emphysema	_____
Endocrine:	Diabetes	Hypothyroid		_____
Neurologic:	Stroke	Aneurysm	Tumor	_____
Cancer:	Lung	Breast	Intestinal	_____
Other:	_____	_____	_____	_____

Social History:

Occupation _____

Tobacco _____ Alcohol _____
(Packs per day) (Drinks per day)

Review of systems (do you experience problems with any of the following)

Headache	Dizziness	Memory	Numbness	Other _____
Glasses	Contacts	Blurriness	Double Vision	Other _____
Deafness	Ringing	Swallowing	Hoarseness	Other _____
Chest pain	Skip beats	Rapid beat	Edema	Other _____
Cough	Cough blood	Wheezing	Short of breath	Other _____
Constipation	Diarrhea	Incontinence	Bleeding	Other _____
Pain	Weakness	Arthritis	Cane/walker	Other _____
Weight gain	Weight loss	Fevers	Chills	Other _____
Bruising	Lesions	Birth marks	Nausea	Other _____
Bleeding	Transfusion	Hepatitis	Vomit	Other _____
Depression	Insomnia	Fatigability	Night sweats	Other _____
Urination:	Frequency	Incontinence	Burning	

Signature _____

Date ____/____/____

OFFICE USE ONLY

PF: <4HPI EPF:<4HPI, 1ROS DET: 4HPI, PERTINENT PFSH, 2-9 ROS COMP:ALL

Do your legs or arms feel weak or numb?	Yes	No
Any changes in your bowel or bladder habits?	Yes	No
Have you had any fevers, chills or sweats?	Yes	No
Any recent weight loss?	Yes	No
Do you have a history of cancer?	Yes	No

What have you used to help the pain? (circle all that apply)

Medication: Yes No If yes, what medication? _____

Physical therapy: Yes No If yes, did it help? Yes No

Chiropractic Manipulation? Yes No If yes, did it help? Yes No

Spinal Injections? Yes No How many? _____ Did they help? Yes Temporarily No

Have you had previous spinal surgery? Yes No

If yes, please list:

Procedure _____ Surgeon _____ Year _____

Procedure _____ Surgeon _____ Year _____

What tests have you had and when?

X-rays Yes No Date _____

Bone Scan Yes No Date _____

Myelogram Yes No Date _____

Discogram Yes No Date _____

CT Scan Yes No Date _____

MRI Yes No Date _____

What is your occupation? _____

Would you consider this to be: (please circle one)

Heavy labor Physically demanding without heavy lifting Sedentary

Are you currently out of work because of your back or neck problems? Yes No

If yes, how long have you been out of work? _____

Is your back or neck injury related to any of the following?

Workman's compensation? Yes No

A motor vehicle accident? Yes No

If yes, do you have a lawyer involved in your claim? Yes No

Do you live alone? Yes No

Are you married? Yes No

Do you have children? Yes No

Do you drink alcohol? Yes No

If yes, do you drink (please circle one) Daily Weekly Occasionally

How many drinks per week? _____

Do you smoke? Yes No

If yes, how long have you smoked? _____

How many packs per day? _____

Name _____

Date ____/____/____

Medication List

Have you tried any of the following NSAIDS? Advil Aleve Ibuprofen Naproxen Motrin Other? _____

	<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Duration</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____
11.	_____	_____	_____	_____
12.	_____	_____	_____	_____
13.	_____	_____	_____	_____
14.	_____	_____	_____	_____
15.	_____	_____	_____	_____
16.	_____	_____	_____	_____
17.	_____	_____	_____	_____
18.	_____	_____	_____	_____
19.	_____	_____	_____	_____
20.	_____	_____	_____	_____

The Reading Neck and Spine Center
1270 Broadcasting Road
Wyomissing, PA 19610
610-372-1140

Notice of Privacy Practices
Written Acknowledgment Form

I, _____, have received a copy of The Reading Neck
Patient Name (please print)
and Spine Center's Notice of Privacy Practices.

Patient Signature

____/____/____
Date

I authorize the disclosure of my personal health information to the following individuals:

My spouse

Spouse's name _____ Phone ____ - ____ - ____

Other

Name _____	Relationship _____	Phone ____ - ____ - ____
Name _____	Relationship _____	Phone ____ - ____ - ____
Name _____	Relationship _____	Phone ____ - ____ - ____
Name _____	Relationship _____	Phone ____ - ____ - ____

I wish to be contacted in the following manner: (please check all that apply)

Home Telephone ____ - ____ - ____

- You have my permission to leave a message with detailed information.
- Leave a message with a call-back number only.

Cell Phone ____ - ____ - ____

- You have my permission to leave a message with detailed information.
- Leave a message with a call-back number only.

Work Telephone ____ - ____ - ____

- You have my permission to leave a message with detailed information.
- Leave a message with a call-back number only.

Prescription Renewal Policy

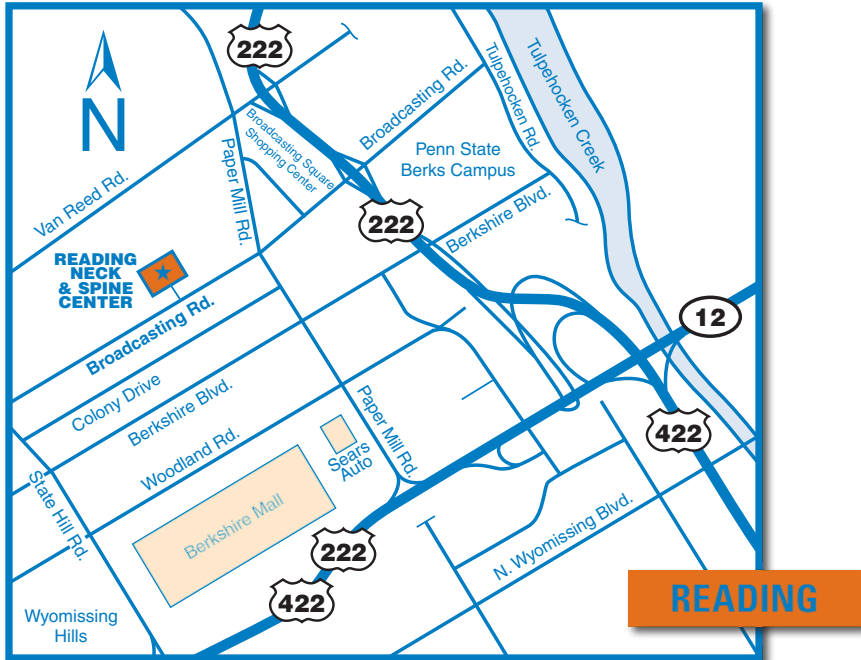
To ensure that you do not run short on your medication, it is important that you understand our prescription renewal policy.

- Requests for prescription refills will only be handled during the following hours: Monday through Thursday 8:00 AM – 4:00 PM. We do not refill prescriptions on Friday.
- All refills and requests require 72 hour notice.
- Requests for narcotic medications cannot be called in to a pharmacy. You will have to pick up the prescription in our office and take it to your pharmacy in order for it to be filled.
- Please review your personal prescription drug program carefully as new guidelines require special authorization for certain drugs and new formularies may eliminate the specific prescription drug you are now taking. These factors could play a role in the timelines of your prescription refill.

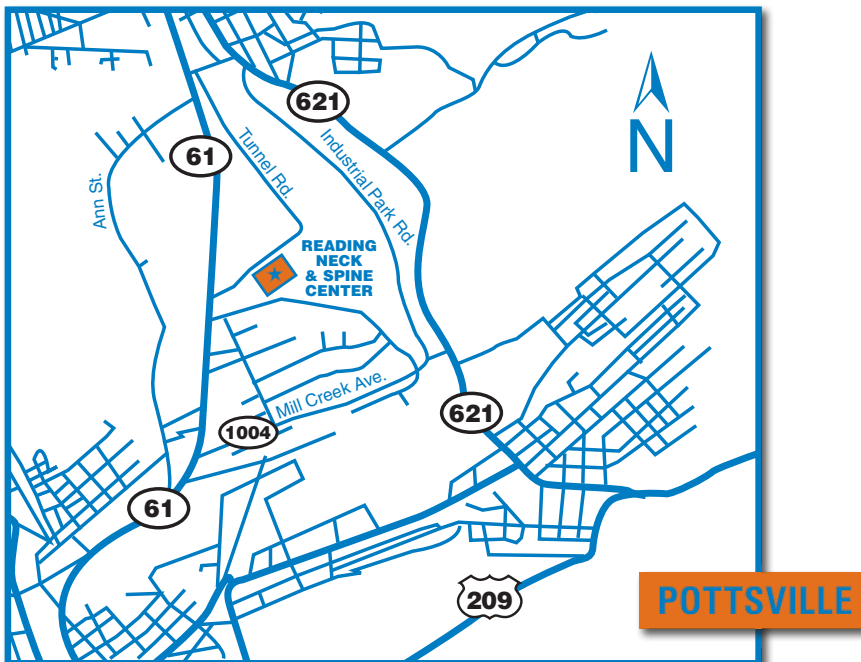
Thank you for your cooperation,

The Staff at The Reading Neck and Spine Center.

LOCATIONS



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Wyomissing, PA 19610
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1-877-SPINE-89



48 Tunnel Road • Suite 202
Pottsville, PA 17901