THE Reading Neck & Spine Center

David J. Abraham, MD
Spine Surgeon

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 Physcian: _______________

Insurance Information

Primary Carrier	Secondary Carrier
Ins. Co. _________________________________	Ins. Co. _________________________________
Address_________________________________	Address _________________________________
_________________________________	_________________________________
Subscriber _______________________________	Subscriber _______________________________
Relationship to Patient ____________________	Relationship to Patient ____________________
Subscriber DOB _____/_____/_____	Subscriber DOB _____/_____/_____
Subscriber SS# _____ - ____ - _____	Subscriber SS# _____ - ____ - _____
ID# __________________ Group# ___________	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)____

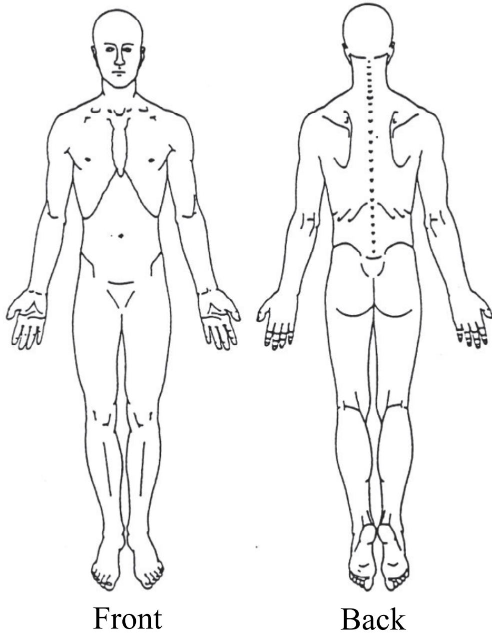
____

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? _____

	Medication	Dosage	Frequency	Duration
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.

THE Reading Neck & Spine Center

Prescription Renewal Policy

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

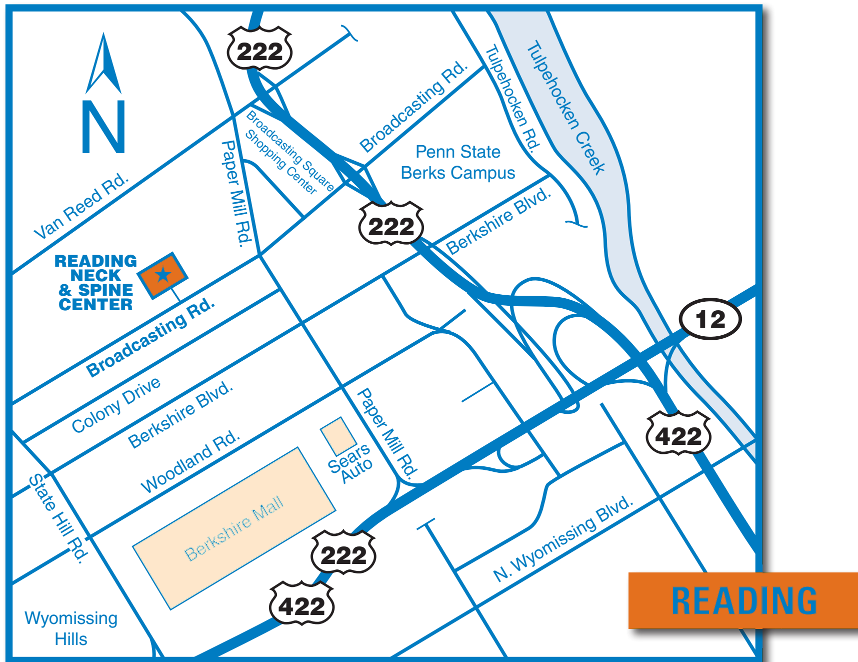
- Requests for prescription refills will only be handled during the following hours: Monday through Thursday 8:00 AM – 4:00 PM. We do not refill prescriptions on Friday.
- All refills and requests require 72 hour notice.
- Requests for narcotic medications cannot be called in to a pharmacy. You will 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.

THE
Reading Neck & Spine Center

LOCATIONS



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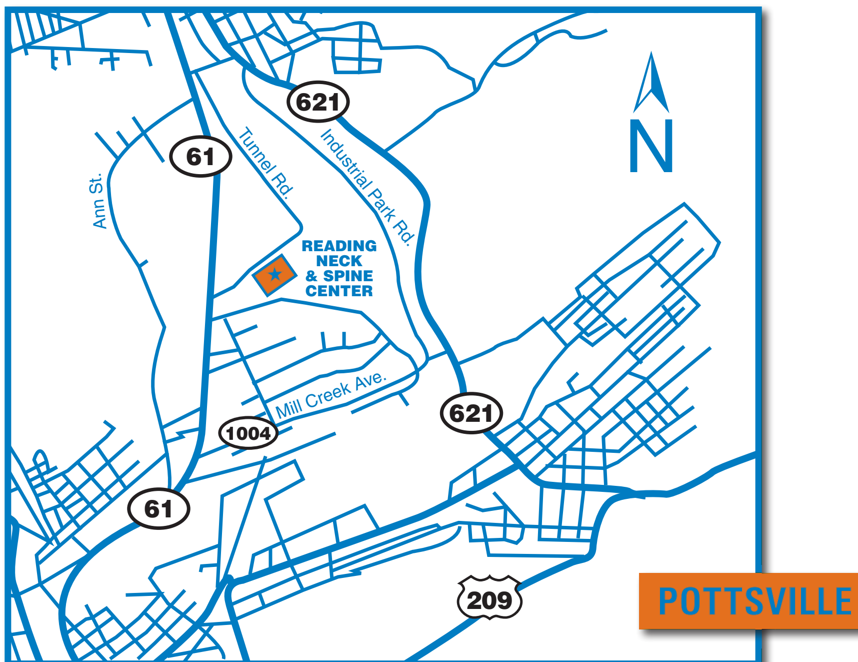

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