New England Orthopaedic & Spine Surgery, LLC
Telephone 617-734-2450 Fax 617-734-7804

Chestnut Hill Location
830 Boylston Street, Suite 211
Chestnut Hill, MA 02467

Dedham Location
40 Allied Drive , Suite 108
Dedham, MA 02026

****We encourage you to visit our web-site****
www.neorthoandspine.com

Welcome to New England Orthopaedic & Spine Surgery, LLC! In an attempt to expedite processing of your medical history, demographic and insurance information, we are asking you to review and complete the attached forms ***at least one (1) week PRIOR*** to your scheduled appointment. ***Please MAIL the completed forms to: NE Orthopaedic & Spine Surgery, LLC 830 Boylston St Ste 211 Chestnut Hill, MA 02467 or FAX to 617-734-7804.***

Please call NE Baptist hospital Pre-Registration at 617-754-6000, M-F 8:00am-5:30pm in the event that you need x-rays on date of service. Please note this number is not for Pre-Registration for physician services.

It is imperative that you bring a photo ID and your insurance cards. If your health insurance requires a referral, the following guidelines are strictly followed:

1. We recommend you contact your primary care physician as soon as you schedule your appointment with our office.
2. Referral status is reviewed in advance of scheduled appointments. If we are unable to verify your referral, our office staff will notify you via telephone two days in advance that we will be postponing your appointment until we receive the referral.
3. Please understand that many patients require further radiographic, diagnostic testing, injections or surgical procedures. Without a referral in place, it limits our ability to assist you.
4. Be sure to bring your imaging studies/CD (MRI, CT-Scan, Xrays) and all other pertinent records to your visit.
5. Co-Payments are expected at time of service and we accept CASH, CHECK, MASTERCARD and VISA.
6. Children under the age of eighteen must be accompanied by an adult

As part of our treatment protocol, please respond to the following:
Have you previously had a work-related injury, auto accident or personal injury that involves the particular area or problem that you are seeking our services today? (*please circle one*) **YES** **NO**

If you answered "yes", please contact our office as soon as possible and speak with **John**, our third party coordinator and complete the information requested below. Even if you have not pursued a claim or reported the injury, it is imperative that you advise our staff of the events surrounding the accident/injury. Please remember that in the event of a third party claim, we are unable to bill your private insurance for services and we must secure authorization from third parties in advance of your appointment, otherwise your appointment may have to be postponed. We appreciate your understanding.

Date of incident/injury: _____
Brief summary of incident/injury: _____
Current status: _____
Attorney's name/address (if applicable): _____
Attorney's phone number (if applicable): _____

Signature _____ ***Date*** _____

DIRECTIONS TO OUR CHESTNUT HILL OFFICE: 830 Boylston St. Rte 9 Chestnut Hill, MA 02467

FROM THE NORTH (New Hampshire/Main/North Shore):
Route 93 or Route 95 South to Route 128 South. Once on Route 128, take EXIT 20 East (Route 9 East exit). Remain on Route 9 East for approximately 5 miles (you will pass the Atrium Mall on the right, Chestnut Hill Mall, Macy's/Star Market/CVS on the left). Our building is approximately 1 mile beyond Star Market on the right immediately adjacent to a large building (Brigham & Women's Medical Building). Our building states "New England Baptist Hospital Medical Building" on the exterior and is tan in color with a large grassy area in front, U.S. Petroleum gas station and fire station across the street). The entrance and parking lot are located immediately at the end of the building. Proceed up the driveway to the rear of the building where there is ample free parking.

FROM THE SOUTH (Cape Cod, Route 3/93/South Shore):
Route 128 North to Exit 20 East (Route 9 East exit). Remain on Route 9 East for approximately 5 miles (you will pass the Atrium Mall on the right, Chestnut Hill Mall, Macy's/Star Market/CVS on the left). Our building is approximately 1 mile beyond Star Market on the right immediately adjacent to a large building (Brigham & Women's Medical Building). Our building states "New England Baptist Hospital Medical Building" on the exterior and is tan in color with a large grassy area in front, U.S. Petroleum gas station and fire station across the street). The entrance and parking lot are located immediately at the end of the building. Proceed up the driveway to the rear of the building where there is ample free parking.

FROM THE WEST (Westboro/Framingham area):
Route 9 Eastbound. At the overpass for Route 128/95, follow Route 9 East for approximately 5 miles (you will pass the Atrium Mall on the right, Chestnut Hill Mall, Macy's/Star Market/CVS on the left). Our building is approximately 1 mile beyond Star Market on the right immediately adjacent to a large building (Brigham & Women's Medical Building). Our building states "New England Baptist Hospital Medical Building" on the exterior and is tan in color with a large grassy area in front, U.S. Petroleum gas station and fire station across the street). The entrance and parking lot are located immediately at the end of the building. Proceed up the driveway to the rear of the building where there is ample free parking.

FROM THE EAST (Downtown Boston/Waterfront area):
Follow Huntington Avenue (also known as Route 9 when you enter the Longwood Medical Area, which becomes Boylston Street in Brookline). At the intersection of Route 9 and Chestnut Hill Avenue (Reservoir will be on your left), proceed to the next set of lights. Our building is across from the U.S. Petroleum and fire station, however you cannot take a left at that light. Proceed to the next set of lights, making a U-turn. Our building states "New England Baptist Hospital Medical Building" on the exterior and is tan in color with a large grassy area in front, U.S. Petroleum gas station and fire station across the street). The entrance and parking lot are located immediately at the end of the building. Proceed up the driveway to the rear of the building where there is ample free parking.

PUBLIC TRANSPORTATION/MBTA:
Take the Green Line to the Kenmore Square stop. Proceed to street level. Take the Chestnut Hill bus (#60). Once on Route 9, wait for the intersection of Chestnut Hill Avenue and exit the bus in front of the Chestnut Hill fire station immediately prior to the U.S. Petroleum gas station. You will see our building on the left.

IMPORTANT: DO NOT FOLLOW STREET NUMBERS ON ROUTE 9 SINCE THEY CHANGE FROM TOWN TO TOWN. WE ARE BOYLSTON STREET IN CHESTNUT HILL, NOT BOSTON (near the Prudential/Hancock bldg).

DIRECTIONS TO OUR DEDHAM OFFICE: 40 Allied Drive Dedham, MA 02026

From Boston:
Take I-93 South (Southeast Expressway) to I-95 North (Route 128 North)
Take exit 14 (East St, Canton St)
Take second right onto Allied Drive. (Hilton will be on your right)

From Cape Cod:
Take Route 3 North to Route 128 North (which becomes I-95 North)
Take exit 14 (East St, Canton St)
Take second right onto Allied Drive (Hilton will be on your right)

From the North:
Take I-95 South (Route 128 South) to exit 14 (East St, Canton St)
Go around rotary and exit onto Allied Drive (Hilton will be on your right)

From the South:
Take I-95 North and exit onto Route 128 North. Take exit 14 (East St, Canton St)
Take second right onto Allied Drive (Hilton will be on your right)

New England Orthopaedic and Spine Surgery, LLC

Patient Information

First Name _____ Middle ____ Last Name _____ SSN _____
Address _____ Home Phone _____
City/State/Zip _____ Cell Phone _____
Email Address _____ Work Phone _____
Sex _____ DOB _____ Marital status _____
Race _____ Ethnicity _____ Language _____
Patient Employer _____ Occupation _____ Employment status _____
Employer Address _____ Phone _____
Emergency Contact _____ Relationship _____ Phone _____
Pharmacy Name/Address _____ Phone _____
Primary Care Physician _____ Phone _____
PCP Address _____ Fax _____
Referring provider Name _____ Phone _____
Referring provider Address _____ Fax _____
Who referred you to our practice?

Primary Insurance

Person Responsible for Account _____
Address (if different from patient) _____
Primary Insurance _____ Phone _____
Address _____
Subscriber _____ DOB _____ Relationship _____
Group # _____ ID # _____

Additional Insurance

Secondary Insurance _____ Phone _____
Address _____
Subscriber _____ DOB _____ Relationship _____
Group # _____ ID # _____

Workers Compensation / Motor Vehicle / Personal Injury Insurance (if applicable)

Insurance Name _____ Address _____
Adjuster _____ Phone _____ Fax _____
Claim # _____ Date of Injury _____
Nurse Case Manager _____ Phone _____ Fax _____
Utilization Review _____ Phone _____ Fax _____

Attorney Information (if applicable)

Attorney Firm Name/Address _____
Attorney Name _____ Phone _____ Fax _____
Reason for Attorney?

Assignment and Release

I request payment under the medical insurance program to be made directly to *New England Orthopaedic & Spine Surgery, LLC*. I hereby authorize *New England Orthopaedic & Spine Surgery, LLC* to furnish information to my insurance carrier(s), or its intermediaries in order to process claims. If services being rendered pertain to a workers compensation injury, I authorize *New England Orthopaedic & Spine Surgery, LLC* to furnish information to my employer, insurer or its intermediaries in order to process claims. I also understand that I am financially responsible for charges not covered by this authorization. I permit a copy of this authorization to be used in place of original.

I acknowledge that I have read the *New England Orthopaedic and Spine Surgery, LLC* Notice of Privacy Practices available at http://newenglandorthoandspine.com/privacy.aspx, which provides me with detailed information about how *New England Orthopaedic and Spine Surgery, LLC* may use and disclose my protected health information for the purposes of treatment, payment and health care operations. I also understand that if *New England Orthopaedic and Spine Surgery, LLC* amends or revises its Notice of Privacy Practices, an updated copy can be found on our website at http://newenglandorthoandspine.com/privacy.aspx or by calling 617-734-2450.

I have the right to request, in writing, that *New England Orthopaedic and Spine Surgery, LLC* restricts how they use and disclose my protected health information for the purposes of treatment, payment or health care operations and that the Practice is not required by law to grant my request. However, if the Practice does decide to grant my request, the Practice must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws.

I give permission to *New England Orthopaedic and Spine Surgery, LLC* to check my prescription eligibility and prescription history.

Signature _____ ***Date*** _____ ***Relationship*** _____

GENERAL MEDICAL QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

DOB: _____ Age: _____ Sex: [ ] F [ ] M Height: _____ Weight: _____

Primary Care Physician: _____

Referring Physician: _____

Reason for visit today: _____

_____

Tobacco use: [ ] current smoker How many per day? [ ]5 or less [ ]6-10 [ ]11-20 [ ]21-30 [ ]31 or more
[ ] former smoker How long has it been? [ ]< 1mo [1-3mo [ ]3-6mo [ ]6-12mo [ ]1-5yr [ ]5-10 yr [ ]>10 yr
[ ] never smoked

Alcohol use: [ ] YES [ ] NO If yes, how much? _____

Past Operations: _____

_____

_____

Past Illnesses: _____

_____

_____

Past Fractures: _____

_____

_____

Any history of the following:

[ ] Asthma	[ ] High blood pressure	[ ] Heart disease
[ ] Diabetes	[ ] Thyroid disease	[ ] Gout
[ ] Bleeding Problems	[ ] Sleep apnea	[ ] Liver disease
[ ] Stomach/Ulcer problems	[ ] Lung disease	[ ] Kidney disease
[ ] Glaucoma	[ ] Other _____	

[ ] Arthritis If so, where? _____ If known, what type? _____

List any family member with history of heart or lung disease, cancer or serious illness:

Relationship: Type:

Relationship: Type:

Relationship: Type:

Relationship: Type:

Relationship: Type:

Relationship: Type:

Relationship: Type:

Patient Name_____ Today's Date_____

Do you take aspirin? YES ( ) NO ( ) If yes, how much _____

Do you take anti-inflammatory medication? YES ( ) NO ( )

If yes, how much and for what diagnosis? _____

Have you had complications with previous anesthetics? YES ( ) NO ( )

Are you taking steroids such as cortisone? YES ( ) NO ( )

Current medications:

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

****Please list on additional page if other medications need to be listed.**

ALLERGIES:_____

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS

Fatigue	[ ] yes	[ ] no
Fever	[ ] yes	[ ] no
Chills	[ ] yes	[ ] no

NEUROLOGICAL

Weakness	[ ] yes	[ ] no
Tingling/Numbness	[ ] yes	[ ] no
Tremor	[ ] yes	[ ] no

CARDIOVASCULAR

High blood pressure	[ ] yes	[ ] no
Chest pain	[ ] yes	[ ] no
Shortness of breath	[ ] yes	[ ] no
Palpitations	[ ] yes	[ ] no
Swelling of extremities	[ ] yes	[ ] no
Heart "skipping"	[ ] yes	[ ] no
Fainting	[ ] yes	[ ] no

RESPIRATORY

Persistent cough	[ ] yes	[ ] no
Asthma or wheezing	[ ] yes	[ ] no
Chest congestion	[ ] yes	[ ] no

GASTROINTESTINAL

Nausea or vomiting	[ ] yes	[ ] no
Frequent diarrhea	[ ] yes	[ ] no
Rectal bleeding	[ ] yes	[ ] no
Bloody stool	[ ] yes	[ ] no
Abdominal pain	[ ] yes	[ ] no
Heartburn	[ ] yes	[ ] no
Vomiting blood	[ ] yes	[ ] no

HEMATOLOGIC/LYMPHATIC

Easy bruising	[ ] yes	[ ] no

MUSCULOSKELETAL

Joint pain	[ ] yes	[ ] no
Back pain	[ ] yes	[ ] no
Sciatica	[ ] yes	[ ] no

ENDOCRINE

Excessive sweating	[ ] yes	[ ] no
Heat/cold intolerance	[ ] yes	[ ] no
Excessive thirst	[ ] yes	[ ] no
Excessive urination	[ ] yes	[ ] no

UROLOGICAL

Frequent urination	[ ] yes	[ ] no
Urgent urination	[ ] yes	[ ] no

OPTHALMOLOGICAL

Change in vision	[ ] yes	[ ] no
Eye redness	[ ] yes	[ ] no
Eye pain	[ ] yes	[ ] no

PSYCHOLOGICAL

Depression	[ ] yes	[ ] no
Nervousness/anxiety	[ ] yes	[ ] no

ENT

Coughing blood	[ ] yes	[ ] no
Sore throat	[ ] yes	[ ] no
Nose bleeds	[ ] yes	[ ] no
Hearing trouble	[ ] yes	[ ] no
Difficulty swallowing	[ ] yes	[ ] no

SPINE TRIAGE FORM

Patient Name_____ **Date:** _____

Referring Physician Name/Address: _____

Chief Complaint: **Neck** [ ] Neck pain alone [ ] Neck and arm pain [ ] Arm pain alone **Back** [ ] Low back pain and/or buttock pain [ ] Back pain and leg pain [ ] Leg pain alone [ ] Mid back pain

Date of onset of present pain: _____

What do you think caused your present pain? _____

Injury first occurred at: **Y / N work** **Y / N motor vehicle accident** **Y / N other (Please Explain Below)**
Explain: _____

How long have you had pain? [ ] less than 1 wk [ ] less than 4 wks [ ] 1-3 mos [ ] more than 3 mos

Have you had similar attacks in the past? [ ] no [ ] 1 or 2 [ ] 2 to 5 [ ] 5 or more

If you have leg pain:	**Is the back pain worse than the leg pain?**	[ ] yes	[ ] no
	Is the leg pain worse than the back pain?	[ ] yes	[ ] no
	Are the leg pain and back pain about equal?	[ ] yes	[ ] no
If you have arm pain:	**Is the neck pain worse than the arm pain?**	[ ] yes	[ ] no
	Is the arm pain worse than the neck pain?	[ ] yes	[ ] no
	Are the arm pain and neck pain about equal?	[ ] yes	[ ] no

Do you have numbness, pins and needles or a tingling sensation?

In the foot / leg / thigh (circle)	[ ] yes	[ ] no
In the hand / forearm / finger (circle)	[ ] yes	[ ] no

Any other symptoms you feel are related but not described? [ ] yes [ ] no
If yes, explain: _____

Is there anything you have done to make the pain better? [ ] yes [ ] no
If yes, explain: _____

Have you had previous back/neck treatment? [ ] yes [ ] no
Date of treatment: _____ **Result:** _____

Do you participate in any specific/general exercise? [ ] yes [ ] no
If yes, explain: _____

Have you been able to continue work? [ ] yes [ ] no
If not, out of work/modified duty from _____ **to** _____

Are you under the care of a doctor (specialist)? [ ] yes [ ] no
If so, was surgery recommended? [ ] yes [ ] no
If no surgery, what was the treatment? [ ] Physical therapy [ ] Medications [ ] Injections

Have you engaged the services of an attorney? [ ] yes [ ] no

Previous treatment listed below (include date/location/results):
[ ] X-rays: _____
[ ] Myelogram: _____
[ ] CT scan: _____
[ ] MRI: _____
[ ] EMG: _____
[ ] Epidural, Nerve or Facet block: _____
[ ] Spine surgery: _____

Results of previous surgery? [ ] worse [ ] same [ ] improved [ ] normal

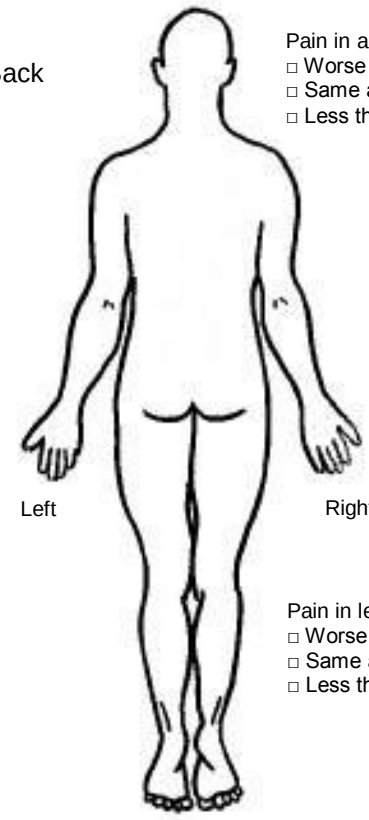
PAIN DRAWING AND SCALE REVIEW

Using the symbols given below, mark the areas on your body where you feel the described sensations and include all affected areas. Just to complete the picture, please draw in your face.

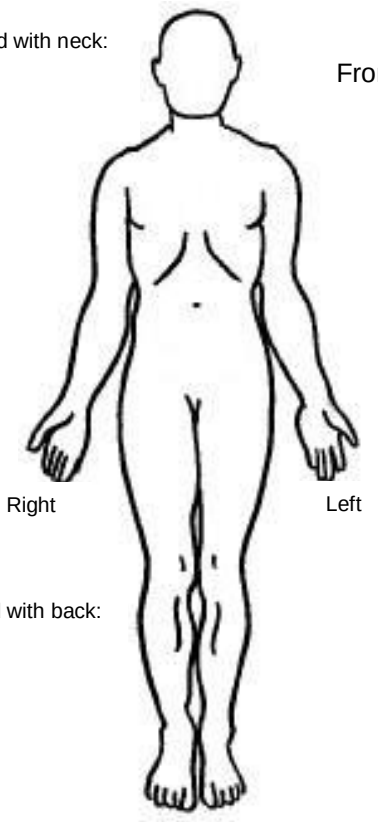
Aching	Numbness	Pins and needles	Burning	Stabbing	Other
▲▲▲	= = =	o o o	x x x	/ / /	● ● ●

Back

Pain in arm(s) compared with neck:
□ Worse than
□ Same as
□ Less than



Front



Pain in leg(s) compared with back:
□ Worse than
□ Same as
□ Less than

Location of pain or symptoms (indicate on drawing also using above symbols)

_____

_____

_____

How bad is the pain on a scale of 1 (best) to 10 (worst)?

1 2 3 4 5 6 7 8 9 10 (circle)

How often is pain present? _____

Is pain referred? _____

Sensation? _____

ACTIVITIES: Is your pain aggravated by any of these?

[ ] coughing or sneezing	[ ] sitting in a chair	[ ] bending forward to brush teeth
[ ] when you wake up	[ ] in the middle of the night	[ ] lying flat on your back
[ ] lying flat on your stomach	[ ] lying with knees bent	[ ] walking a distance

THE GENERAL MEDICAL QUESTIONNAIRE, PAIN DRAWING AND SPINE TRIAGE FORM HAVE BEEN REVIEWED/AUTHENTICATED BY THE PATIENT AND PHYSICIAN AS INDICATED BY SIGNATURES BELOW.

_____ _____

Patient signature Date Physician signature Date