Daniel J. Ragone, Jr., M.D., P.A.
Diplomate of the American Board of Physical Medicine and Rehabilitation
REHABILITATION & SPORTS MEDICINE

Dear Patient:

Welcome from the staff of Dr. Ragone:

In order for our doctors to perform a comprehensive assessment on this visit, we must have all the information pertinent to your condition. **Please bring the written results of all diagnostic studies (MRI, CT Scans, etc.), and lab results. No films necessary and No Discs.**

The enclosed registration forms should be completed before you arrive at the office. Please bring your health insurance cards and all referral/pre-certification forms that may be required by your health insurance carrier. If this is an Auto or Workman's Compensation claim, we will also need your Auto or Workman's Compensation case number, as well as the name, address and telephone number of your claims representative. For Auto and Workman's Compensation, we will also require your health insurance information and pre-certification forms, in the event that your claim is rejected.

If you do not have all of this information at the time of your visit, we will reschedule your appointment. Please make every effort to bring all information and have forms completed in their entirety. If you have any questions, please call the office. If for any reason you are unable to keep your appointment, please notify our office at least 48 hours prior to the appointment. Your help in this matter is appreciated.

Sincerely,

Dr. Ragone and Staff

HEALTH QUESTIONNAIRE FORM

PATIENT NAME: _____DATE: _____

DATE OF BIRTH: _____ GENDER: M / F AGE: _____ Rt / Lt HANDED

PREFERRED LANGUAGE: (CIRCLE) ENGLISH SPANISH SIGN LANGUAGE OTHER:_____

RACE: (CIRCLE) WHITE BLACK HISPANIC ASIAN

ETHNICITY: (CIRCLE) LATINO NON-LATINO **E-MAIL ADDRESS:_____**

_____

PLEASE FILL OUT THIS QUESTIONNAIRE IN ITS ENTIRETY.

It will assist us in understanding the full impact that your pain condition has made upon your life, and help us in planning your recovery.

MEDICAL HISTORY:

Are your complaints a result of a motor vehicle, a work related, or a slip and fall accident? YES NO

If yes, what was the date of injury? _____

Where are you experiencing your pain?_____

When did your pain first appear? _____

_____

What makes your pain better?_____

_____

What makes your pain worse? _____

_____

Please describe the circumstances, if any, in which your pain began. (Example: gradual onset, injury, accident, illness) _____

_____

List all of the physicians/clinicians and their specialties that have been involved in the treatment of your pain. List approximate dates of treatment (beginning to end) and check "yes" if you are still treating with them and "no" if you have discontinued treatment with them.

PHYSICIAN	SPECIALTY	PERIOD OF TREATMENT	CURRENTLY TREATING
_____	_____	_____	( ) YES ( ) NO
_____	_____	_____	( ) YES ( ) NO
_____	_____	_____	( ) YES ( ) NO
_____	_____	_____	( ) YES ( ) NO

DJR_____

Patient's Name _____ Date _____

Please circle all areas that you have pain and rate the level of pain.

Head No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Neck No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Shoulders No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Arms No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Hands No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Chest No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Mid-back No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Low-back No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Abdomen No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Legs No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Feet No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

Is your pain? ☐ Occasional or ☐ Continuous

What time of day is your pain worse? (check all that apply)

☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime

DJR_____

Patient's Name _____ Date _____

HEALTH QUESTIONNAIRE FORM

Please circle all which best describes your pain right now:

1. No pain	7. Aching	13. Tender
2. Penetrating	8. Throbbing	14. Burning
3. Miserable	9. Shooting	15. Exhausting
4. Unbearable	10. Stabbing	16. Tiring
5. Nagging	11. Gnawing	
6. Numb	12. Sharp	

Are you using any assistive devices such as canes, walkers or braces? (circle) Yes or No

Did you have your flu shot? (check box)

- ☐ No - I don't get flu shots
- ☐ Yes - at my primary care physician
- ☐ Yes - at a retail pharmacy

DJR_____

PATIENT'S NAME _____ DATE _____

REVIEW OF SYSTEMS (check all that apply)

1. Constitutional Symptoms ( ) No Problems
( ) weight loss ____lbs., period of time _____
( ) weight gain ____lbs., period of time _____
( ) recurrent fever
( ) general weakness
( ) fatigue

2. Skin ( ) No Problems
( ) dry skin
( ) recurrent rashes
( ) eczema
( ) itching
( ) changes in skin color
( ) changes in hair or nails

3. Hematologic / Lymphatic ( ) No Problems
( ) swollen glands
( ) low blood count (anemia)
( ) easy bruising
( ) easy bleeding
( ) slow to heal after cuts
( ) history blood transfusion(s)
( ) enlarged glands
( ) phlebitis
( ) HIV positive
( ) on blood thinners

4. Head / Face ( ) No Problems
( ) headaches
( ) history head injury no residual problems
( ) history head injury with residual problems of _____
( ) facial pain
( ) TMJ right – left
( ) Tic douloureux right left _____

5. Eyes ( ) No Problems
( ) nearsighted
( ) farsighted
( ) wear glasses
( ) wear contact lenses
( ) cataracts at present time right left
( ) conjunctivitis right left
( ) glaucoma right left
( ) double vision
( ) blurred vision

6. Ear / Nose / Mouth

Ears ( ) No Problems
( ) hard of hearing right left
( ) hearing aids right left
( ) frequent ear aches right left
( ) chronic ear discharge right left
( ) vertigo
( ) ringing in ears right left

Nose / Sinuses ( ) No Problems
( ) sinus discharge
( ) nasal discharge
( ) repeated nosebleeds
( ) deviated nasal septum
( ) chronic sinus problems
( ) chronic stuffy nose
( ) hay fever
( ) nasal polyps

Mouth / Throat ( ) No Problems
( ) teeth ___loose ____none
( ) dentures ___full ___partial
( ) bleeding gums
( ) dry mouth
( ) sore throat
( ) hoarseness
( ) vocal cord polyps
( ) trouble swallowing

7. Chest / Breasts ( ) No Problems
( ) breast masses
( ) breast surgery
( ) chest surgery
( ) other explain _____
_____

8. Respiratory ( ) No Problems
( ) smoker _____packs per day
( ) recurrent cough
( ) chronic bronchitis
( ) emphysema
( ) chronic obstr. pulmonary dis.
( ) bronchial asthma
( ) tuberculosis
( ) wheezing

9. Cardiac / Peripheral- Vascular

Cardiac ( ) No Problems
( ) heart trouble
( ) swelling of feet
( ) high blood pressure
( ) chest pain
( ) heart attack
( ) bypass surgery
( ) angioplasty
( ) mitral valve prolapse
( ) heart murmur
( ) valvular surgery
( ) heart failure
( ) shortness breath w/ walking

Periph.-Vasc. ( ) No Problems
( ) poor circulation-arm R L
( ) blood clots-arm R L
( ) varicose veins R L
( ) poor circulation legs R L
( ) blood clots legs R L
( ) vascular surgery _____

10. Hepatic-Biliary / Gastro / Abdominal
( ) any liver disease
( ) hepatitis Active___Inactive___
( ) history jaundice due to liver disease

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PATIENT'S NAME _____ DATE _____

REVIEW OF SYSTEMS – PAGE 2

( ) history jaundice due to gallbladder disease
( ) gallbladder problems

Gastrointestinal ( ) No Problems
( ) loss of appetite
( ) abdominal pains
( ) problems w/ gas
( ) heartburn
( ) recurrent nausea
( ) recurrent diarrhea
( ) recurrent constipation
( ) ulcer
( ) hiatal hernia
( ) regurgitation
( ) reflux
( ) indigestion
( ) history of vomiting blood
( ) blood in stools
( ) loss of control bowels

11. Urinary ( ) No Problems
( ) frequent urination
( ) difficulty with urination
( ) burning with urinating
( ) inability to control urination
( ) loss of control
( ) blood in urine
( ) kidney stones

12. Genital / Reproductive

Male ( ) No Problems
( ) discharge
( ) pain in testicles
( ) lumps in testicles
( ) hydrocele
( ) sexually transmitted disease(s)
( ) sexual dysfunction

Female ( ) No Problems
( ) menstruation Regular ____ Irregular____
first day last menstrual period_____
( ) premenstrual syndrome since _____
( ) recurrent vaginal discharge
( ) number pregnancies_____miscarriages____
abortions_____
( ) cesarean section(s) number _____
( ) on hormones
( ) history cancer of uterus-ovaries
( ) sexual dysfunction
( ) sexually transmitted disease(s)

13. Endocrine ( ) No Problems
( ) excessive thirst or urination
( ) heat intolerance
( ) cold intolerance
( ) change in hat or glove size
( ) thyroid trouble under active____ overactive____
( ) sugar diabetes – since_____
insulin dependent Y or N
( ) disease of pituitary gland
( ) disease of adrenal gland

14. Musculoskeletal ( ) No Problems
( ) muscle cramps
( ) stiff joints
( ) swelling of joints
( ) generalized arthritis
( ) rheumatoid arthritis
( ) fibromyalgia syndrome
( ) osteoporosis
( ) neck pain
( ) upper back pain
( ) low back pain
( ) heel spurs
( ) gout
( ) difficulty w/ walking
( ) cold upper extremities R L
( ) cold lower extremities R L
( ) pain in feet

15. Neurological / Psychiatric

Neurological ( ) No Problems
( ) frequent or recurrent headaches
( ) fainting
( ) blackouts
( ) stroke
( ) dizzy spells
( ) gait difficulties
( ) seizures
( ) epilepsy
( ) tremors
( ) neuropathy
( ) weakness
( ) paralysis

Psychiatric ( ) No Problems
( ) problems w/ concentration
( ) confusion
( ) problems w/ thinking/thought process
( ) problems w/ memory
( ) depressed
( ) anxious
( ) seeing a psychiatrist/ mental health
if yes, name_____

16. Allergies / Immunologic

Allergies ( ) No Problem
( ) drug allergies_____
_____
( ) food allergies _____
_____
( ) environmental allergies_____
_____

Immunologic ( ) No Problems
( ) Immunologic disorders_____
( ) AIDS
( ) lupus

DJR_____

Patient's Name _____ Date _____

HEALTH QUESTIONNAIRE FORM

Past Medical History

Do you have or have you ever had…? (Circle all that apply)

Diabetes	Lung Problems	Migraine Headaches
Heart Problems	Kidney Disease	Rheumatoid Arthritis
Stroke	Gout	Systemic Lupus
Rheumatic Fever	Stomach Problems	Osteoarthritis
Bleeding Problems	Gall Bladder Problems	Pancreas Problems
Anemia	Diverticulosis	Osteoporosis
Cancer	Hepatitis	Joint Disease
Chemotherapy	Jaundice	Insomnia
Radiation Therapy	Crohn's/Ulcerative Colitis	Peripheral Neuropathy
Seizure Disorder	Chronic Infections	High Cholesterol
Drug Addiction	Alcohol Addiction	
Thyroid Disease	Blood Clots	
Vomiting Blood	Other: (Please Explain) _____	
High Blood Pressure	_____	

Hospitalizations / Surgery: (Please include all for illness, injury and/or accident)

_____	_____	_____
Reason	Date	Location
_____	_____	_____
Reason	Date	Location
_____	_____	_____
Reason	Date	Location
_____	_____	_____
Reason	Date	Location
_____	_____	_____
Reason	Date	Location

DJR_____

Patient's Name _____ Date _____

HEALTH QUESTIONNAIRE FORM

Please list all medications (both prescribed and over-the-counter) that you **currently use:**

_____ _____ _____

_____ _____ _____

_____

_____

_____

PHARMACY ADDRESS, PHONE AND FAX NUMBERS:

_____

Ph #_____ Fx# _____

Please list all medications (both prescribed and over-the-counter) that you currently use for **PAIN**.

_____ _____ _____

_____ _____ _____

Please list all medications (both prescribed and over-the-counter) that you have tried for your pain, but no longer use? List date when last used.

_____ _____ _____

_____ _____ _____

Have you ever had surgery to treat your pain? ( ) YES ( ) NO

If yes, please list the surgeon, date and type of surgery, whether the surgery helped your pain and how long you had relief.

SURGEON'S NAME	TYPE OF SURGERY	DATE	PAIN RELIEF	RELIEF DURATION
_____	_____	_____	( ) YES ( ) NO	_____
_____	_____	_____	( ) YES ( ) NO	_____
_____	_____	_____	( ) YES ( ) NO	_____

List **ALL MEDICATION ALLERGIES** and describe the nature of the allergic reaction:

MEDICATION	NATURE OF REACTION
_____	_____
_____	_____
_____	_____

Patient's Name _____ Date _____

HEALTH QUESTIONNAIRE FORM

Family History

	Age	Alive? Y or N	Major Illness/Cause of Death
Mother	____	Y or N	_____
Father	____	Y or N	_____
Maternal Grandmother	____	Y or N	_____
Maternal Grandfather	____	Y or N	_____
Paternal Grandmother	____	Y or N	_____
Paternal Grandfather	____	Y or N	_____
Siblings:			
brother	____	Y or N	_____
brother	____	Y or N	_____
sister	____	Y or N	_____
sister	____	Y or N	_____
Children:			
daughter	____	Y or N	_____
daughter	____	Y or N	_____
son	____	Y or N	_____
son	____	Y or N	_____

DJR_____

Patient's Name _____ Date _____

HEALTH QUESTIONNAIRE FORM

Social History

Are you: Single Married Widower Divorced Separated

Do you have children? Y or N How many? _____

Do you: Live alone Live with significant others

Are you currently employed? Y or N

If not working, how long has it been since you stopped? (Please specify in how many days, weeks, months or years)

_____

What is your primary occupation? If you are not working, what was your primary occupation? (Please be as specific as possible)

Occupation:_____

_____

Do you drink alcohol? Yes or No If yes, how often?_____

Do you smoke cigarettes? (circle) YES : how often? # ___pack / day ___ years NO
when did you quit: _____

Have you ever smoked 100 or more cigarettes in your life? Yes or No

Do you use smokeless tobacco? Yes or No

Are you exposed to second hand smoke? Yes or No

DJR_____

Patient's Name _____ Date _____

HEALTH QUESTIONNAIRE

Which statements describe your current employment situation? Circle all that apply.

Currently working	Student
On paid leave	Homemaker
On unpaid leave	Unemployed, unable to find work
Disabled and/or retired because of my pain problem	Unemployed due to pain problems
Disabled due to health problem not related to my pain	Other – please specify: _____

Are you already on or planning to apply for any of the following programs? (Place an "X" next to any that apply)

	Already on it	Applied for it	Planning to apply
SOCIAL SECURITY	_____	_____	_____
PRIVATE DISABILITY	_____	_____	_____
WORKER'S COMPENSATION	_____	_____	_____
OTHER: _____ (Please specify)	_____	_____	_____

Do you think that the fault for your pain condition is: (circle all that apply)

Yours Your employer Co-Worker Another person Nobody

Have you hired a lawyer because of your pain condition?

_____ No, I have not hired a lawyer

_____ Yes, I have and the matter is in litigation

_____ Yes, I have and the matter has been settled

DJR_____

FAMILY DOCTOR

Doctor's Full Name _____

Address _____

_____

_____

Phone Number _____

Fax Number _____

To the best of my knowledge, the information in these pages is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Representative Relationship to Patient

DJR_____

Daniel J. Ragone, Jr., M.D., P.A.
3829 Church Road
Mount Laurel, New Jersey 08054
Phone: 856-222-9713
Fax: 856-222-9714

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper optimal treatments needed to restore your health; therefore if you have any questions or concerns about our payment policies do not hesitate to ask our billing department.

We ask that **ALL PATIENTS** read and sign our Financial Policy prior to any treatment.

We will be happy to bill your insurance company on your behalf, **but you must be prepared to take an active role in the payment of your bill. If we are having difficulty receiving payment for service rendered we may ask that you call your insurance company as well.**
I hereby instruct and direct my Insurance Company to pay by check made out and mailed to Dr.Ragone as the above address.
In special instances we may accept assignments of insurance benefits. However, you must understand that:

- Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.
- All charges are your responsibility if your insurance company pays or not. Not all services are covered benefits in all contracts.
- It is also your responsibility to determine whether this practice is participating or an in-network provider with your insurance carrier prior to making your appointment.
- Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. We accept cash, check, and credit card.
- If the insurance does not pay your balance in full within 45 days, we ask that you contact the insurance carrier to question the delay.
- If the insurance company does not pay in full within 60 days, we require you pay the balance due or arrange a payment schedule.
- Balances older then 90 days may be subject to additional fees and interest charges of 1-1/2% per month.
- Returned checks: A $25.00 returned check fee will be charged to you. We will no longer accept payment in the form of a check from you for future payments. You will be expected to pay your co pays and/or deductibles by cash or credit.
- I authorize the release of my medical care information to the Health Care Financial Administrator and/or any other insurance carrier, attorney, and/or their agents that may be necessary to determine benefits payable for my health care related services.
- All invoices referred for collection to an outside agency, will be subject to the cost of collection and reasonable attorney fees.
- You do have access to your own health records but there will be a minimal copying fee depending on the length of the record.
- There is an administrative fee of $10.00 per form for form completions and a fee of $20.00 per letter for special dictations. Please allow us at least 72 hours for completion of these services.

Please note that unless cancelled at least 24 hours in advance, you may be charged a missed appointment fee. Minimum fee being $25.00. Please call in advance if you have to reschedule.

Thank you for choosing us as your health care provider. We appreciate your trust in us as we appreciate the opportunity to serve you.

Patient Signature: _____

Date: _____

Daniel J. Ragone, Jr., M.D., P.A.
Diplomate of the American Board of Physical Medicine and Rehabilitation

PAYMENT POLICY

This office will make every effort to bill your insurance company for payment. However, we would appreciate your cooperation with the following:

All co-pays are due at the time of your visit.

1. Referrals **must be** presented before your visit. Payment for services denied by insurance due to lack of referral will become the patient's responsibility and obligations must be satisfied before subsequent visits can be scheduled.

2. Those services denied by your insurance as **billable non-covered** may be your responsibility.

3. We cannot carry your balance over an extended period of time. We are not able to extend "credit" to our patients. All balances remaining after insurance payment are payable in full within thirty days of billing.

4. We value you as a patient and will continue to act as your advocate in billing your insurance company and hope you will make every effort on your part to assist us in obtaining reimbursement.

Again, thank you for your continued cooperation.

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow –up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third –party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to Review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices form time to time and that I may contract this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payments or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give my permission for this office to leave a message on my answering machine and/or with family members.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient _____

Date: _____

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