

Fax cover sheet. **Fax to: 973-972-2825**
From an Incoming Coccyx Patient

Page 1 of _____

To: **Patrick M. Foye, M.D.**, (and staff)
Director, Coccyx Pain Service
Associate Professor of Physical Medicine & Rehabilitation,
UMDNJ: New Jersey Medical School, 90 Bergen Street, DOC-3100, Newark NJ 07103
Phone: 973-972-2802. Fax: 973-972-2825
www.TailboneDoctor.com (FYI: Provide your email at this website to receive more info.)

From (Patient name, please **PRINT**): _____

Patient's **Fax #**: _____

Patient's **Phone #**: _____

Today's Date: _____ -- _____ -- _____

You MUST **Fax** this **COMPLETED** paperwork to our office **BEFORE** an appointment will be made.

AFTER completing and Faxing in this form, (and a copy of your insurance card, front and back)
THEN call 973-972-2802 for an appointment. The sooner you send this, the sooner your appointment.

Patients: PLEASE BRING the following items to your initial appointment:

- **Insurance card(s).**
- **HMO Referral:** If you have an HMO, bring a Referral.
- **Co-pays** (payments due at time of visit).
- **Identification** (your driver's license or passport)
- **Actual images** (films or computer CD) from relevant X-rays, MRI, CT scans, etc.
- **A copy of ALL forms that you have faxed in advance:**
(Bring these in case the Fax we receive is not fully legible or is misplaced).
 - **"Questionnaire for Coccyx Patients"**, fully completed in advance.
 - **Pain Diagram.**
 - **Registration form** (providing your name, address, insurance information, etc)
 - **Copies of official radiology reports** from relevant X-rays, MRI, CT scans, etc.
 - **Copy of your Insurance Card** (Copy of both the **Front and Back** of the card)

"CONFIDENTIAL" FAX COVER SHEET (If Health information is attached.)

"Confidential Protected Health Information Enclosed": Protected Health Care Information is personal and sensitive information related to a person's health care. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. This fax may contain privileged and confidential information. It is intended only for the use of the individual(s) or entity(ies) named above. If the reader of this message is not the intended recipient, you are hereby notified that any review, dissemination, distribution or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email or fax and destroy all copies of the original message.

UNIVERSITY REHABILITATION ASSOCIATES
(Patient Registration Form)

Please verify the completed information for accuracy and provide all missing information. If an item does not apply, write N/A.

1. Name _____ 2. Date Of Birth ____ / ____ / ____ 3. Sex: -Male -Female
4. Home Phone (____) ____ - ____ 5. Cell Phone # (____) ____ 6. Pager # (____) ____
7. Social Security # ____ - ____ - ____
8. Address _____ City _____ State _____ Zip _____
9. Parent/Guardian _____ Address (if different) _____

9. To assist with your care, medical/appointment information can be left at your phone #s unless you cross out this line.
10. In case you are in a life threatening situation would you like to be kept on life support? Yes No Undecided
11. Race _____ 11. Marital Status -Single -Married -Legally Separated -Divorced -Widowed
12. Are you an organ donor? -Yes -No 13. Religion _____ Church _____
14. Your maiden name _____ 15. Mother's maiden name _____

16. PATIENT'S EMPLOYER

17. Work Status: -Full-time -Part-time -Retired -Unemployed 18. Employment Date ____ / ____ / ____
19. Department _____ 20. Occupation _____ 21. Phone (____) ____ - ____
22. Address _____ City _____ State _____ Zip _____

NEAREST RELATIVE

23. Name _____ 24. Relationship to the patient _____
25. Home Phone (____) ____ - ____ 26. Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____
27. Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT (not living with you)

28. Name _____ 29. Relationship to the patient _____
30. Home Phone (____) ____ - ____ 31. Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____
32. Address _____ City _____ State _____ Zip _____

33. Is this a result of an **AUTO** accident? Yes- No- If yes, where in the vehicle were you? -Driver; -Passenger; Other _____
34. Is this a result of a **WORK**-related injury? Yes- No- _____
35. Date of accident ____ / ____ / ____ Time ____ : ____ 36. Has a claim been established? Yes- No-
37. Attorney name _____ 38. Attorney phone # (____) ____ - ____

INSURANCE INFORMATION

39. Company _____ 40. Phone (____) ____ - ____
41. Address: _____ City: _____ State: _____ Zip: _____
42. Policy # _____ 43. Group # _____ 44. Adjuster _____
45. Relation to insured Self Spouse Child Other
46. Insured _____ 47. Insured's SSN ____ - ____ - ____ 48. Insured's DOB ____ / ____ / ____

OTHER INSURANCE

49. Company _____ 50. Phone (____) ____ - ____
51. Address _____ City _____ State _____ Zip _____
51. Policy # _____ 52. Group # _____ 53. Adjuster: _____
54. Relation to insured Self Spouse Child Other
55. Insured _____ 56. Insured's SSN ____ - ____ - ____ 57. Insured's DOB ____ / ____ / ____

58. Referred by _____

If you have an HMO:

- It is the **patient's responsibility** to know whether a referral is needed to see our physician(s) and to bring it at the time of the visit.
- If no referral is brought in, a referral can not be obtained after the visit and bill for the visit can not be submitted later to the insurance company as per New Jersey State and federal guidelines.
- Although we will try to assist you in any way reasonably possible, it is also the patient's responsibility to know what is covered by his/her contract.
- **Co-pays are due at the time of the visit.**
- If patient does not supply referral and chooses to go out of network, they can not submit bill to insurance company.
Please sign and date _____ if you choose to self pay for office visit.

Outstanding deductible payments are expected at time of service unless special arrangements are made.

I certify that outpatient services were rendered to me at the place of service indicated on this date. I hereby authorize release of information needed to collect from my insurance carrier and authorize payment directly to University Rehabilitation Associates of any insurance benefits otherwise payable to me for this visit. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Patient's signature: _____ Date signed: ____ / ____ / ____

Physical Medicine and Rehabilitation
Occupational/Musculoskeletal Medicine
EMG and Nerve Conduction Studies
Independent Medical Exams (IMEs)
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General Physiatry (PM&R)
Sports Medicine



UMDNJ: New Jersey Medical School
University Rehabilitation Associates
90 Bergen Street, D.O.C. Suite 3100
Newark, N.J. 07103-2499
Tel: 973-972-2802
Fax: 973-972-2825

ASSIGNMENT OF BENEFITS FORM

Patient Name (*PRINT*): _____

I irrevocably assign to "University Rehabilitation Associates" (part of "University Physician Associates") all of my rights and benefits under any insurance contracts for payment for services rendered to me by University Rehabilitation Associates.

I irrevocably authorize all information regarding my benefits under any insurance policy (relating to any claims by University Rehabilitation Associates) to be released to University Rehabilitation Associates.

I irrevocably authorize University Rehabilitation Associates to file insurance claims on my behalf for services rendered to me.

I irrevocably direct that all such payments go directly to University Rehabilitation Associates.

I irrevocably agree to cooperate with the insurer, including, but not limited to, attending requested physical examination(s) and completing all necessary paperwork.

I irrevocably authorize University Rehabilitation Associates to act on my behalf and report any suspected violations of improper claims practices to the proper regulatory authorities.

In the event that my insurance company does not reimburse University Rehabilitation Associates, I understand that I will be held personally responsible for payment of all charges for services rendered, including co-insurance and deductible fees according to the terms of my policy.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Sign below:

Patient signature: _____ **Date:** _____

**This Page is a Reminder to
Make a Copy of Your INSURANCE CARD,
Both Front and Back.**

Send a Copy of Your INSURANCE CARD send it in with your other papers.

(Reminder #2: If you have not already done so, please enter your email address into the Yellow Box on the "Home Page" of the website: www.TailboneDoctor.com. That will send you an automatic email that has additional information about coming for your evaluation by Dr. Foye.)

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**QUESTIONS for Patients to *Complete In Advance* and *Bring* to Dr. Foye
(Questionnaire for Patients with ***COC CYX PAIN***)**

This helps us to take care of you. (Unanswered questions decrease our ability to help you.) Form Revised: 11-24-10

Patient Name: _____

Date form completed: _____, 2010. Date of scheduled appointment: _____, 2010.

Chief complaint: Is coccyx (tailbone) pain a primary area of concern? **Yes or No.** [if No, please explain].

Onset Date:

Referred by: (e.g., found me via internet?)

Patient's home city/state, and driving distance to this office:

E-mail address where patient wants personal medical emails from Dr. Foye: *PRINT CLEARLY:* _____

HISTORY: Age: _____ years old.

Gender (*circle one*): Male or Female.

Occupation (specify job title): _____

Please write a general narrative paragraph summarizing how the symptoms started and treatment so far:

Tailbone-related questions

Duration/onset date of tailbone pain:

TRAUMA: Any identifiable traumatic incident:

- Any *recent* coccyx trauma:
- Any *remote* (long ago) coccyx trauma:

EXACERBATING FACTORS (e.g. prolonged sitting, sitting on hard versus soft surfaces, pain when standing up after sitting):

What makes the pain worse??

Is your pain worse while **sitting**? Circle your answer: Yes or No or Unsure

Is pain with sitting worse when you lean partway backwards: Yes or No or Unsure

When you first get up from sitting, does your tailbone pain get worse for a few moments?

Circle your answer: Yes (pain gets worse) or No or Unsure

What **sitting surface** is worse for you? Circle your answer: **Hard** surface or **Soft** surfaces or **Other**:

Any other things that make the coccyx pain worse? (Explain:)

CUSHIONS tried (e.g., donut cushions, wedge cushions):

Have you tried "**donut**" cushions (i.e., with the whole in the middle)? Yes or No

Was it helpful? Yes or No

Have you tried "**wedge**" cushions (with a triangular "wedge" shape cut out of the back)? Yes or No

Was it helpful? Yes or No

If you tried **both** types, which cushion helped more? Circle one: wedge or donut or same or neither

SITTING TOLERANCE:

How long can you sit for the pain makes you change positions?: _____ minutes

SEVERITY of coccyx pain: (0-10 scale): At best: _____ /10. At worst: _____ /10. Average: _____ /10.

SPECIALISTS who you have already seen: Indicate if you have seen any of the following for this pain:

Primary care physician? Name(s):

"Pain management" doctor? Name(s):

Chiropractor? Name(s):

Surgeon? Name(s):

PM&R (Physical Medicine and Rehabilitation)? Name(s):

Physical therapy:

Other:

Interventional Pain Management INJECTIONS and response to these (e.g. whether helpful or not):

(e.g., caudal or other epidurals, local anesthetic blocks, steroid injections, etc. and asking whether these were blind versus

fluoroscopically-guided): **If done, try to BRING the procedure note (paper report) for Dr. Foye to review.**

TYPE OF INJECTION	Done? (Yes or No)	Date(s) (if done)	Did the injection help?
Coccyx injection with STEROID, blind (withOUT fluoroscopic guidance):			
Coccyx injection with STEROID, WITH fluoroscopic guidance):			
Ganglion Impar injection (sympathetic nerve block):			
EPIDURAL steroid injection:			
FACET joint injection:			
SACROILIAC joint injection:			
PIRIFORMIS muscle injection:			
Other lower back or pelvic injections (Pudendal nerve, etc) (specify)			

IMAGING STUDIES (Please obtain and **BRING** the official, written radiology reports for any tests):

Dr. Foye will want to see the **actual images** (on computer CD or actual films) **AND** see the **radiology reports**. Call your radiology facility to get a copy of the actual images and the official/typed radiology report (**important**).

	Done? (Yes or No)	Date (if done)	If done, can you bring the radiologist's paper report?	If done, can you bring the actual images (either films or on computer CD)?
Lumbosacral X-rays:				
Lumbar (or lumbosacral) MRI:				
Lumbar (lumbosacral) CT scan:				
Pelvic (or Coccyx) MRI:				
Pelvic (or Coccyx) CT scan:				
Coccyx X-rays:				
Coccyx X-rays, seated (dynamic):				
Bone scan:				

Is your insurance United, Cigna, or Oxford? Circle: Yes or No. (If yes, then X-rays at UMDNJ may be "out of network").

GI (Gastroenterology: which means abdomen/intestines/etc) symptoms

Circle any of the following symptoms that you have, and then explain if positive:

- pain with bowel movements (including coccyx pain with bowel movements):
- constipation
- diarrhea
- bright red blood per rectum
- melena [black, tarry stool]
- fecal incontinence
- rectal or anal pain or itching
- other (explain):

Note: for these symptoms, consider seeing a GI doctor (gastroenterologist).

GI (gastroenterology) workup (e.g., GI consult, colonoscopy, digital/finger rectal exam, etc.):

Have you seen any **GI specialist** (gastroenterologist)? **Circle your answer:** Yes or No or Unsure
 When is the last time that a physician performed a **rectal exam** (placing a finger inside your anus)? ____
 Did you ever have a **colonoscopy** (a scope of the large intestine) or sigmoidoscopy (lower colon)? ____
 If so, when was it? _____
 If so, has this test been performed **AFTER** the time that the tailbone pain started? Yes or No
 If so, please obtain a copy of the report, to provide to Dr. Foye for review.

Have you ever been told you have a "Pilonidal Cyst"? (Circle one: Yes or No)

If so, when was that?
 How was it treated? Surgery?
 Were you ever specifically told that you do NOT have a pilonidal cyst? (Circle one: Yes or No)

Skin (Dermatologic) symptoms:

Any **itching** over the skin near the coccyx or buttocks? Circle one: Yes - or - No
 Any **rash** over the skin near the coccyx or buttocks? Circle one: Yes - or - No
 Any **pressure sores** (e.g. bed sores)? Circle one: Yes - or - No
 Have you needed **creams/lotions**, to treat skin problems near the coccyx, anus, or buttocks? Yes / No

Urinary symptoms:

Any urinary **incontinence** (loss of bladder control for urinating)? Circle one: Yes - or - No
 Any **burning or pain** when urinating? Circle one: Yes - or - No
 Note: for these symptoms, consider seeing a Urologist or your primary doctor.

Urinary diagnostic workup (urology consult, urinalysis, etc., since onset of coccyx symptoms):

Have any of these urologic consults/tests been done????

If so, were they done since the onset of coccyx symptoms??

This box is for FEMALE patients only (MALE patients should cross out this whole box)

Female patients: intra-pelvic history:

Have you ever been diagnosed with uterine fibroids?

Have you ever been diagnosed with ovarian cyst?

Have ever been diagnosed with any other obstetric/gynecologic condition?

Female patients: obstetric history:

How many children have you had?

Were these children delivered through the vagina or were they through a cesarean section?

Were there any tailbone problems with any of these deliveries?

Female patients: OB/Gyn evaluation?

Have you seen your obstetrician/gynecologist since the time that you are tailbone symptoms started?

If so, did the OB/GYN think that any OB/GYN condition was causing the tailbone pain?

Note that we recommend OB/GYN evaluation for female patients with tailbone pain.

Female menopausal status (Please circle one: *Pre-Menopausal*, *Peri-Menopausal*, or *Post-Menopausal*)

Pain during (or after) sexual intercourse:

Does sexual intercourse make your tailbone pain feel worse? Circle one: Yes No Not Applicable

Pudendal nerve: Have you ever been told you have Pudendal nerve problems?

Yes No

Do you have pain, tingling, or numbness in the external genital region?

Yes No

Note: for these symptoms, consider seeing... Urologist (for males), or Ob/Gyn (for females)

Lower limb neurologic symptoms (e.g. any leg pain, or any leg numbness or weakness):

Do you have any pain that travels down into the leg? Yes or No. If so, how far down the leg?

Do you have any numbness or weakness in either leg?

Ischial bursitis: (e.g., lower/ ischial buttock pain due to leaning to either side to avoid sitting with pressure in the midline/coccyx):

Do you get pain at the bottom of either cheek of the buttocks (e.g. pain at the "sit bones")? Yes or No.

Body weight: (e.g., has there been any significant increase or decrease in body weight preceding the onset of the symptoms?)

Current height: _____ feet _____ inches

Current weight: _____ pounds

Was there any significant increase in weight before the coccyx symptoms started? _____

Was there any significant decrease in weight before the coccyx symptoms started? _____

Any other significant changes in weight? Circle one: No or Yes (explain):

Cancer history (e.g., especially prostate, ovarian, cervical, testicular, colon or any other cancers):

Have you ever been diagnosed with any cancer? Yes or No
If so, explain (what body region, when, and how was it treated):

Cancer history or risk factors: (e.g., any blood per rectum or abnormal vaginal bleeding? Any unexplained weight loss, fevers, or chills? Any of these should be promptly evaluated for your primary care physician and/or other specialists.)

Do you have any of these risk factors???? (**Circle** any above that are positive, or write in details):

Medications tried so far (to treat your coccyx pain) and your response to these (did it help?):

Circle any of the following that you have ALREADY tried using forward your coccyx-region pain:

Nonsteroidals: ibuprofen/Motrin/Advil, naproxen/Naprosyn, etc

Meds for nerve pain: Neurontin/gabapentin, Lyrica, Cymbalta, etc

Opioid painkillers: Percocet/Roxicet, oxycodone, OxyContin, Tylenol with Codeine (T#3),

Other pain meds: Tylenol. Tramadol (Ultram/Ultracet).

Topical meds: Lidoderm (lidocaine). Flector (diclofenac). Voltaren gel (diclofenac).

Other meds that you have tried:

CURRENT MEDICATIONS: (For *pain* medications, list the actual doses, but do NOT list doses for other meds)

Allergies: (Are you allergic to any medications?) No or Yes (List the allergies:)

Are you allergic to latex, iodine, shellfish or medical contrast? No or Yes (List the allergies:)

Past Medical History (previously diagnosed conditions):

List any medical conditions that you have had (such as high blood pressure, diabetes, etc.):

Surgical History: List any/all surgeries you have had and the approximate year of each surgery:

Have you undergone coccyx surgery (coccygectomy): No or Yes (List the date:)
and do your best to bring the surgical report.

Family History: List any diseases that run in your family: (e.g. diabetes, pelvic cancers, colon cancer):

Social History:

Do you smoke?: No or Yes

Do you drink alcohol?: No or Yes (if so: how many drinks in a typical week?):

Does your tailbone pain cause you difficulty with performing your job? No or Yes (explain):

If patient accepts or sends medical emails, patient accepts the inherent potential confidentiality risks of unencrypted emails. Patient agrees to see any involved or relevant Primary Care Physician, Gastroenterologist (GI), Urologist, OB/GYN, Surgeon, etc., for any relevant care related to those or other medical specialties.

Patient signature: _____ **Date:** _____

Name [Nombre y Apellido]: _____

Date [Fecha]: _____

Pain Drawing [Diagrama del dolor]

Only for the pain in the body region that you are being seen for today:

[Sólo para la region del cuerpo mas dolorosa hoy]

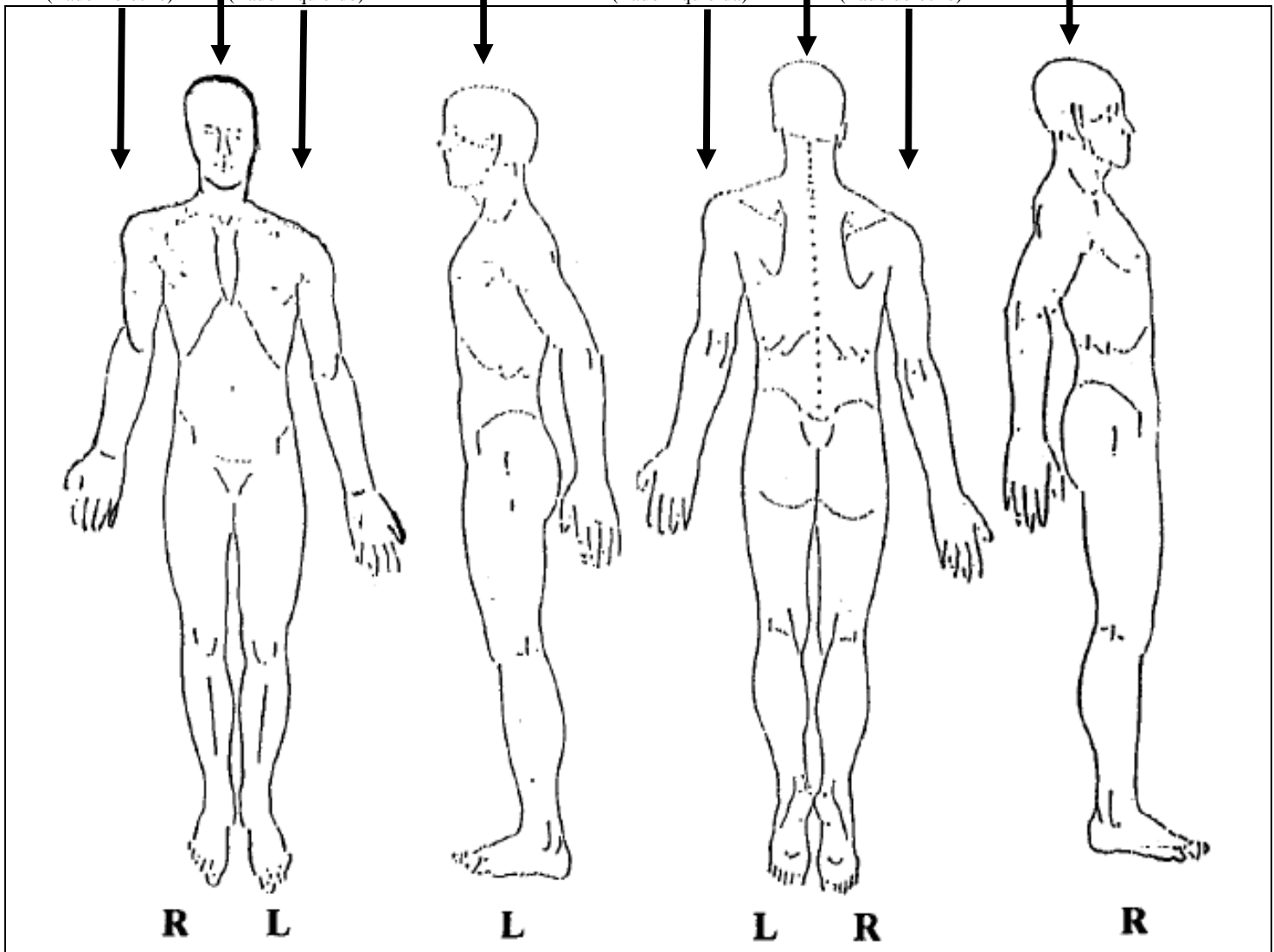
Choose the symbol(s) shown below that best describe the pain you are having (e.g. $\Delta \Delta \Delta$ means it is an aching [dull] type of pain).
 [Seleccione los símbolos que se muestran a continuación que mejor describen el dolor que está sufriendo. (Ejemplo: $\Delta \Delta \Delta$ significa que es dolencia).]

Aching [Dolencia]	Numbness [Entumecimiento]	Pins & Needles [Pinchazos]	Burning [Ardor]	Stabbing or Sharp [Punzadas]	Other [Otro]
$\Delta \Delta \Delta$	===	000	XXX	///	...

Draw onto the diagram below, using the symbol(s) you have chosen above, to show where your pain is located.

[Dibuje en el diagrama de abajo, usando los símbolos que ha elegido anteriormente, para mostrar donde se encuentra su dolor.]

FRONT [DE FRENTE]		LEFT	BACK [DE ESPALDAS]		RIGHT
RIGHT (Lado Derecho)	LEFT (Lado izquierdo)		LEFT (Lado Izquierda)	RIGHT (Lado derecho)	



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Phone **973-972-2802**
Fax: 973-972-2825

If you have a **GPS... Here's our address: 90 Bergen Street, Newark, NJ 07103. (Corner of Bergen Street and 12th Avenue).**

DIRECTIONS:

From New Jersey Turnpike, North or South:

- Take exit 15W to I-280 West to the Orange St. /6th St. exit.
- Make the first right onto Orange St. and proceed one block to First St. and turn right.
- Proceed through 5 lights. (First St. turns into Bergen St.)
- The 5th light will be the intersection of Bergen Street and 12th Ave. (We are on this corner.)
- Drive just past 12th Street and make left into main entrance of UMDNJ-Hospital
- **See bottom of page for rest of directions after entering main entrance of hospital:**
 - **Return Trip** (going home)
 - Exit Parking Deck on Bergen Street side
 - Make right onto Bergen Street.
 - Make right onto Central Ave
 - Left onto Norfolk Street. Continue until you see signs for 280 east and Turnpike.

From The Garden State Parkway, North or South:

- Take exit 145 to I-280 East.
- Stay in the 3 left lanes (Exit 13 on Left) for approximately 1.5 miles it will end on First St.
- Make a right turn on First Street.
- Proceed 4 lights. (First Street turns into Bergen St.)
- The 4th light will be the intersection of Bergen Street and 12th Ave. (We are on this corner.)
- Drive just past 12th St. and make left into main entrance of UMDNJ-Hospital
- **See bottom of page for rest of directions after entering main entrance of hospital:**
 - **Return Trip** (going home)
 - Exit Parking Deck on Bergen St.
 - Make a right onto Bergen St.
 - Proceed 5 lights and make left onto Route 280 west
 - Garden State Parkway will be about a mile on your right.

From Route 78, Eastbound

- Take exit 56 toward CLINTON Ave 0.8 mi
- Merge onto W Runyon St 0.1 mi
- Turn left at Elizabeth Ave 0.1 mi
- Turn left at E Bigelow St 0.6 mi
- Turn right at Bergen St. You will make a right into the entrance of UMDNJ-Hospital 1.6 mi
- **See bottom of page for rest of directions after entering main entrance of hospital:**

From Route 78, Westbound (from Newark International Airport)

- Take exit 55 toward Hillside/Irvington 0.1 mi
- Keep right at the fork to continue toward Fabyan Pl and merge onto Fabyan Pl 0.7 mi
- Turn right at Clinton Ave 0.8 mi
- Turn left at Bergen St You will make a right into the entrance of UMDNJ-Hospital 1.4 mi
- **See bottom of page for rest of directions after entering main entrance of hospital:**
 - **Return Trip** (going home)
 - Exit Parking Deck on Bergen St. side
 - Make right onto Bergen St.
 - 2nd light make right onto West Market
 - Right onto Norfolk St. Continue a few miles until you see signs for 78.

Directions after entering main entrance of hospital:

- Follow traffic circle into parking deck. This is the deck on the corner of Bergen Street and 12th Ave.
- Park your car (write down what floor). Take elevator to 2nd floor ("2nd" Floor is actually "Ground" Level).
- Walk out of the parking deck and walk 30 feet straight ahead to DOC building- it will have the number "90" on it.
- Elevators are on the right - take elevator to the 3rd floor.
- Proceed to Suite 3100.

**The exact Address is: 90 Bergen St. Newark, NJ 07103
D.O.C. Building (Doctor's Office Center), Suite 3100
Phone 973-972-2802**