

# Pain Management and Anesthesiology of NJ

Mikhail Solomonov M.D.

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THE FOLLOWING MULTI-PAGE QUESTIONNAIRE IS A VERY IMPORTANT TOOL THAT IS USED TO ASSESS YOUR PAIN CONDITION AS WELL AS THE APPROPRIATE TREATMENTS FOR YOUR PROBLEM.

1. PLEASE READ AND FILL'OUT EVERY SINGLE ITEM IN THIS PACKAGE, INCLUDING THE DEMOGRAPHIC AND FINANCIAL INFORMATION ON THE FIRST THREE PAGES. PLEASE ALSO INCLUDE YOUR SIGNATURE WHERE REQUESTED. FAILURE TO COMPLETE OR SIGN THIS FORM COULD RESULT IN A DELAY IN YOUR APPOINTMENT.
2. PLEASE BRING THE COMPLETED FORM ALONG WITH ANY PERTINENT FILMS, REPORTS, DOCTOR NOTES, ETC. FOR YOUR INITIAL CONSULTATION.
3. AN INFORMED PATIENT MAKES BETTER DECISIONS ABOUT TREATMENT OPTIONS OFFERED BY HIS OR HER PHYSICIAN.

THANK YOU VERY MUCH IN ADVANCE FOR YOUR COOPERATION.

Pain Management and Anesthesiology of NJ  
Mikhail Solomonov, M.D.  
Phone: (973)998-7868 Fax: (973)998-7883

### GENERAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer's Name & Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Employer & Work Number: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Emergency Contact Person Not Living With You: \_\_\_\_\_

Emergency Contact's Relation To You: \_\_\_\_\_ Phone: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance Name: \_\_\_\_\_

Claim Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

ID#: \_\_\_\_\_ Group: \_\_\_\_\_

Subscriber Relation To Patient: Self  Spouse  Child  Other

Secondary Insurance Name: \_\_\_\_\_

Claim Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

ID# \_\_\_\_\_ Group: \_\_\_\_\_

Subscriber Relation To Patient: Self  Spouse  Child  Other

## ACCIDENT/INJURY & LITIGATION INFORMATION

### Is Your Condition Due To:

Work Related Injury or Accident (Workers Compensation)? Yes  No

Date of Injury/Accident: \_\_\_\_\_

Case Manager's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

WC Insurance Co. Name: \_\_\_\_\_ Claim # \_\_\_\_\_

Please describe the details of your work related injury or accident (what happened?):

**Automobile Accident?** Yes  No  Date of Accident: \_\_\_\_\_

Please describe the details of your work related injury or accident (what happened?):

**Other Type of Accident?** Yes  No  Date of Accident: \_\_\_\_\_

Please describe the details of your work related injury or accident (what happened?):

**Is litigation (Lawsuit) Pending?** Yes  No

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_

Please describe the current status of your legal case or settlement:

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## **AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Pain Management and Anesthesiology of NJ to release any Information pertaining to my case, to my physician, insurance company, adjuster, or attorney of applicable in the case.

\_\_\_\_\_  
SIGNATURE OF PATIENT GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
INITIALS

\_\_\_\_\_  
DATE

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## **PATIENT RECORD RELEASE FORM**

PERMISO PARA REVELAR LOS EXPEDIENTES DE PACIENTE

DOCTOR'S OFFICE OR HOSPITAL  
OFICINA DE HOSPITAL O DEL DOCTOR

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:  
LE AUTORIZO Y SOLICITO POR ESTE MEDIO REVELAR A:

## **Pain Management and Anesthesiology of NJ**

Complete medical records (including, but not limited to doctors notes, all radiological reports, Laboratory reports etc.) concerning my illness and/or treatment during: Mis expedients medicos (que incluyen, pero no limitado a las notas de los doctors, informes radiologicos, reports de Laboratorio etc.) referents a mi enfermedad y/o tratamiento durante:

PATIENT'S NAME (print): \_\_\_\_\_  
NOMBRE DE PACIENTE

PATIENT'S SIGNATURE: \_\_\_\_\_  
FIRM DE PACIENTE

DATE OF BIRTH: \_\_\_\_\_  
FECHA DE NACIMIENTO

WITNESS: \_\_\_\_\_  
TESTIGO



## PMA of NJ

### Advance Directive Patient Agreement

According to CMS directive 416.50 (a) (2) and the NJ State Law, every patient having a surgical procedure at **PMA of NJ** has the right to utilize an Advance Directive Document or create a new Advance Directive Document as per NJ State Law. If an individual does not have an Advance Directive Document or the paper work to complete an Advance Directive, it will be provided to you upon request by

## PMA of NJ

The NJ Advance Directive is a document that protects the patient's right to refuse medical treatment that the patient does not want or to request treatment that they may want in the event that the patient loses the ability to make decisions themselves.

Part I Proxy Declaration: This part allows the patient to name a health care representative to make decisions about their health care including decisions about life-sustaining treatments if they are no longer able to speak for themselves.

Part II NJ Instruction Declaration: This is the NJ State's living will. It allows the patient to state their wishes regarding health care decisions in the event that they can no longer make their own decisions.

The Advance Directive Document will go into effect at **PMA of NJ** when the operating surgeon/proceduralist makes the determination that the patient is no longer able to communicate their health care decisions.

These documents are legally binding only if the individual is a competent adult over the age of 18.

- YES**, I have an Advance Directive Document that I would like **PMA of NJ** to follow on the day of my procedure. I will provide a copy to the facility.
- NO**, I do not have an Advance Directive Document and I am not interested in obtaining one or using one on the day of my procedure.
- I do not have an Advance Directive Document but I would like to have one provided to me by the facility.** I would like to follow its mandates on the day of my procedure and will provide a completed copy to **PMA of NJ**.

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Witness \_\_\_\_\_

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## **ASSIGNMENT OF BENEFITS**

I Authorize and direct my insurer or payor to pay directly to the above, Pain Management and Anesthesiology of NJ, and the physicians, any or all benefits, that would otherwise be payable to me (or the patient, if signed by a responsible party), up to the amount of my bill, accruing to me in connection with my treatment at Pain Management and Anesthesiology of NJ.

I request that payment of authorized medicare, medigap or other health insurance policy benefits for services furnished to me by Pain Management and Anesthesiology of NJ be made on my behalf to Pain Management and Anesthesiology of NJ. In the event Payments are made to Pain Management and Anesthesiology of NJ and me as joint payees, I agree to cooperate with Pain Management and Anesthesiology of NJ to ensure that the center/practice receives all amount due to Pain Management and Anesthesiology of NJ.

I hereby authorize Pain Management and Anesthesiology of NJ to pursue any means necessary to collect all charges on my Account including follow up calls, appeals, arbitration, and civil suit, if allowable under law. In the event that Pain Management and Anesthesiology of NJ or physician elects to bring an appeal, lawsuit or petition for arbitration against the insurance carrier, I hereby assign to them my rights, title and interest under any insurance policy under which I am entitled to proceed for benefits, if allowable under law. This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim of any unpaid or underpaid bills for treatment rendered at Pain Management and Anesthesiology of NJ.

**Patient or Responsible Party** \_\_\_\_\_

(Signature)

**Patient or Responsible Party** \_\_\_\_\_

(Print Name)

**Witness** \_\_\_\_\_

**Date** \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) Is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically; on paper, or orally, are kept properly confidential. This, Act gives you, the patient, significant • new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misused personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information.

We may use and disclose your medical records for the following purposes only: treatment, payment, and health care operations.

- TREATMENT means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.  
PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- HEALTHCARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities auditing functions, coat-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and .distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provider appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written; request, except to the extent that we already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Pr4ctices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may 'request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office of the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice Or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer. For more information about HIPPA or to file a complaint: The US Dept of Health & Human Services, Office of Civil Rights, 200 Independence Ave, SW, Washington, D.C. 20201, phone 202-619-0257 toll free 1-877-696-6775.

Please acknowledge receipt of this information with your signature below. Thank you.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# COMPREHENSIVE MEDICAL QUESTIONNAIRE

**Referring Physician:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

**Please list the names of any healthcare professionals who have been involved in the evaluation and/or treatment(s) of your pain condition**

**(Please print names):**

Orthopedic Surgeon: \_\_\_\_\_ Physiatrist/Rehabilitation specialist: \_\_\_\_\_

Spine Surgeon: \_\_\_\_\_ Chiropractor: \_\_\_\_\_

Neurologist: \_\_\_\_\_ Acupuncturist: \_\_\_\_\_

Neurosurgeon: \_\_\_\_\_ Pain Medicine specialist: \_\_\_\_\_

Rheumatologist: \_\_\_\_\_ Other: \_\_\_\_\_

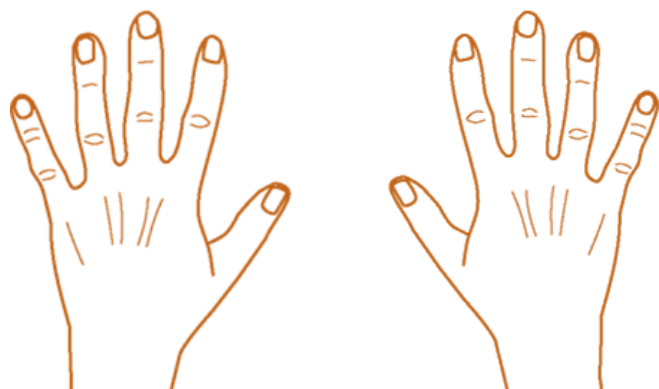
## **Pain History**

1. PLEASE DESCRIBE YOUR PAIN PROBLEM. Where is your pain? Where does the pain spread or radiate? (Example- "Low back pain that radiates down the back of my left leg to my heel"):

*PLEASE USE DIAGRAM ON THE NEXT PAGE TO DEMONSTRATE WHERE YOUR PAIN IS.*

Date: \_\_\_\_\_ Patient: \_\_\_\_\_

PLEASE USE THE DIAGRAM BELOW TO DEMONSTRATE WHERE YOUR PAIN IS LOCATED BY CHECKING THE AREAS THAT ARE PAINFUL.



2. When did your pain begin? (Please be as specific as possible (example: "4 months ago"))

---

3. How did your pain begin? (please Check and describe below)

Date of accident/ Illness

Pain just Started By Itself

Injury or Accident at Work

Injury or Accident At Home

Motor Vehicle Accident

Following Surgery

Following Illness

Other Reason (Specify): \_\_\_\_\_

#### 4. Pain Quality

##### HOW WOULD YOU DESCRIBE THE PAIN?

Burning

Sharp

Cutting

Throbbing

Cramping

Numbness

Dull

Aching

Pressure

Soreness

Pins and Needles

Shooting

Other \_\_\_\_\_

##### In general, during the past month has your pain been (Please Check One)

Worsening

Improving

Unchanged

#### 5. Timing of Pain

##### How often do you have your pain? (Please check one)

Constantly (100% of the time)

Nearly constantly (60% of the time)

Intermittently (30% to 60% of the time)

Occasionally (Less than 30% of the time)

**6. Which activities or body positions ( e.g. walking, bending, et.) bring on or WORSEN your pain?**

Which activities or body positions (e.g. sitting, lying down, etc.) seem to **IMPROVE** your pain?

**7. Which symptoms are associated with your pain? (Check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Weakness of arm (s) – Left/Right/Both | <input type="checkbox"/> Depression                                       |
| <input type="checkbox"/> Weakness of leg (s) – Left/Right/Both | <input type="checkbox"/> Weight gain (How many lbs. past 6 months? _____) |
| <input type="checkbox"/> Numbness of arm (s) – Left/Right/Both | <input type="checkbox"/> Difficulty sleeping                              |
| <input type="checkbox"/> Numbness of leg (s) – Left/Right/Both | <input type="checkbox"/> Impotence  |
| <input type="checkbox"/> Weakness of arm (s) – Left/Right/Both | <input type="checkbox"/> Decreased sex drive                              |
| <input type="checkbox"/> Loss of bladder or bowel control      |   |
| <input type="checkbox"/> Cool, pale skin                       |   |
| <input type="checkbox"/> Discolored or mottled skin            |   |
| <input type="checkbox"/> Pain with only light touch            |   |

**8. RATE YOUR PAIN**

(0-10 WHERE 0 IS NO PAIN AND A 10 IS THE WORST POSSIBLE PAIN)

I would rate my pain today a 0 1 2 3 4 5 6 7 8 9 10

I would rate my worst pain a 0 1 2 3 4 5 6 7 8 9 10

I would rate my pain when under control as a 0 1 2 3 4 5 6 7 8 9 10

I could accept or live with a level of pain at a 0 1 2 3 4 5 6 7 8 9 10

**9. ACTIVITIES AND YOUR PAIN**

During the past month, check the activities that you avoided/ or were affected because of the pain:

- |  |  |
|--|--|
| <input type="checkbox"/> Performance at work         | <input type="checkbox"/> Performing household chores |
| <input type="checkbox"/> Doing yard work or shopping | <input type="checkbox"/> Socializing with friends    |
| <input type="checkbox"/> Participating in recreation | <input type="checkbox"/> Having sexual relations     |
| <input type="checkbox"/> Physically exercising       | <input type="checkbox"/> Other _____                 |

**10. Which TREATMENTS have been used for your pain? (Check all that apply)**

	<b>Helpful?</b>	<b>When did you receive this treatment?</b>
<input type="checkbox"/> Pain Killers	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Anti-Inflammatory Meds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Bed rest	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> TENS (electrical stimulation)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**PRIOR TREATMENTS (continued):**

	<b>Helpful?</b>	<b>When did you receive this treatment?</b>
<input type="checkbox"/> Chiropractic Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Traction	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Cortisone Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Epidural Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Other Nerve Blocks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Psychotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Other _____		

**Please list any medications that you have taken in the past for your condition which has/have NOT helped to reduce or relieve your pain:**

**11. PATIENT MEDICAL HISTORY CONDITION**

**Other**

- |                  |                               |  |  |   |
|------------------|-------------------------------|--|--|---|
| Endocrine        | <input type="checkbox"/> None | <input type="checkbox"/> Diabetes: Insulin           | <input type="checkbox"/> Diabetes: Non-Insulin | <input type="checkbox"/> Thyroid              |
| Eyes             | <input type="checkbox"/> None | <input type="checkbox"/> Glaucoma: Narrow Angle      | <input type="checkbox"/> Glaucoma: Wide Angle  |   |
| Cardio           | <input type="checkbox"/> None | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Valve Problem        |
|                  |                               | <input type="checkbox"/> Heart Surgery               | <input type="checkbox"/> Angina                | <input type="checkbox"/> Arrhythmia           |
| Circulation      | <input type="checkbox"/> None | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Chronic Edema         | <input type="checkbox"/> Varicose veins       |
| Neurological     | <input type="checkbox"/> None | <input type="checkbox"/> CVA/Stroke                  | <input type="checkbox"/> Seizures              |   |
| Respiratory      | <input type="checkbox"/> None | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Asthma                | <input type="checkbox"/> COPD                 |
| Gastrointestinal | <input type="checkbox"/> None | <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Heartburn/Reflux      | <input type="checkbox"/> Liver Problems       |
| Genitourinary    | <input type="checkbox"/> None | <input type="checkbox"/> Urination Problems          | <input type="checkbox"/> Kidney Stones         | <input type="checkbox"/> Erectile Dysfunction |
| Musculoskeletal  | <input type="checkbox"/> None | <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Joint Replacement     |   |
| Psychiatric      | <input type="checkbox"/> None | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Claustrophobia       |
| Hematologic      | <input type="checkbox"/> None | <input type="checkbox"/> Low Platelets               | <input type="checkbox"/> Bleeding              | <input type="checkbox"/> Poor Clotting        |

**12. Please List any operations you have had in the past:**

Year	Type of Operation
------	-------------------

**ALLERGIES:**

**13. Please list your ALLERGIES TO MEDICATIONS or OTHER DRUGS:**

Name of Medication

Type or Reaction Experienced

**14. Are you allergic to Iodine contrast dye (e.g. IVP Dye)?**    Yes   No

**If you answered yes, what type or reaction did you have?** \_\_\_\_\_

**CURRENT MEDICATIONS:**

**15. Please list the medications which you currently take strictly for pain:**

Name of Medication

Dosage and Number of Pills Per Day

**16. Please list the medications which you currently take for other medical conditions:**

Name of Medication

Name of Medication

**17. Do you take Aspirin?**   Yes   No    **If you answered yes, when was your last dose?** \_\_\_\_\_





23. Do you currently smoke cigarette? Yes No How Much

Alcohol: Yes No How Much

24. Have you ever ben diagnosed with or treated for drug or alcohol abuse? Yes No

If yes, When? \_\_\_\_\_ Please describe \_\_\_\_\_

### **WORK HISTORY**

25. What is your employment status? ( please check one)

Retired

Able to work but currently unemployed

Homemaker

Not working, on worker's Comp, leave from my job since \_\_\_\_\_

Student

Not working, on Disability since (date) \_\_\_\_\_

Working Part Time

Working Full Time (Light Duty)

26. What is (was) your occupation or job Title? (Please describe)

27. Which of the following are regular requirements of your job? (Check all that apply to you)

Heavy lifting (over 30 pounds)

Light lifting (15-30 pounds)

Frequent stooping, Bending, Twisting

Standing for long periods of time (over one hour at a time)

Sitting for long periods of time (over one hour at a time)

Computer Work

Other Physical Requirements (describe) \_\_\_\_\_

**28. How much work have you missed as a result of your pain problem? (check one)**

- None
- I have missed \_\_\_\_\_ days of work due to my pain problem
- I have missed \_\_\_\_\_ weeks of work due to my pain problem
- I have missed \_\_\_\_\_ months of work due to my pain problem
- Not applicable to my situation
- Other: \_\_\_\_\_

**29. Please use the following space to address any other issues related to your pain condition not already covered in this questionnaire. Your comments and concerns are welcomed:**

**30. REVIEW OF SYSTEMS:** (please check the appropriate boxes) None

**Constitutional:** Weight loss Fever Chills Night sweats Other

**Skin:** Bleeding Rashes Moles Sores Other

**Eyes, Ears, Nose, Throat:** Recent changes in: Vision Hearing Smell Taste Other

**Respiratory:** Shortness of Breath Wheezing Productive cough Other

**Cardiovascular** Chest pain Palpitations Murmur Feet edema Other

**Gastrointestinal:** Nausea/Vomiting Diarrhea Constipation Abdominal pain Other

**Genital-Urinary:** Bloody urine Urinary discomfort Abnormal discharge Other

**Musculoskeletal:** Cramps Joint pain/Swelling Morning stiffness Weakness Other

**Central Nervous System:** Convulsion Dizziness Problem Sleeping Other

**Female:** Are you pregnant? No Yes, Last menstrual period - Date \_\_\_\_\_ Other \_\_\_\_\_

**Male:** Last Prostate exam - Date \_\_\_\_\_, PSA – Date \_\_\_\_\_, Results \_\_\_\_\_, Other \_\_\_\_\_

**HOW WERE YOU REFERRED TO THIS OFFICE?**

Doctor Patient Friend Yellow Pages Advertisement Other: \_\_\_\_\_