PHYSICIANS PAIN CENTER

PATIENT INFORMATION

LAST: _____ FIRST: _____ MI: _____

DATE OF BIRTH: _____ SEX: __M __F SOCIAL SECURITY # _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED OTHER _____

EMPLOYMENT: FULL-TIME PART-TIME RETIRED DISABLED OTHER _____

HOME #: (___) _____ CELL #: (___) _____ WORK #: (___) _____

EMAIL ADDRESS: _____ **

***** Necessary to set up your secure patient portal for <u>you</u> to be able to access your medical records online.***

We use an outside vendor to make reminder calls for your appointments, they do this via text messages, emails or phone calls.

If you do NOT want to receive text messages please check the box ( ).

EMERGENCY CONTACT NAME: _____ PHONE #: _____

HOUSE ADDRESS: _____

_____

_____

MAILING ADDRESS (IF DIFFERENT): _____

_____

_____

REFERRING PHYSICIAN: _____ PHONE: _____

Please complete this page in its entirety. Also, be prepared to provide the receptionist at check-in with your insurance card(s) and driver's license or other form of picture identification so that the appropriate copies can be made for your records.

PHYSICIANS PAIN CENTER

INSURANCE/BILLING INFORMATION

PATIENT'S NAME: _____ **DATE:** _____

PRIMARY INSURANCE: Circle one: Medicare Group Health Auto Work Comp Other

If you can bring a copy of the card for us to copy you do not need to complete this section.

INSURANCE CARRIER: _____

MEMBER'S NAME: _____ RELATIONSHIP: _____

MEMBER'S ID#: _____ GROUP #: _____ GROUP NAME: _____

EFFECTIVE DATE: _____ MEMBER'S DATE OF BIRTH: _____

SECONDARY INSURANCE

INSURANCE CARRIER: _____

PHONE: _____ MEMBER'S NAME: _____ RELATIONSHIP: _____

MEMBER'S ID#: _____ GROUP #: _____ GROUP NAME: _____

EFFECTIVE DATE: _____ MEMBER'S DATE OF BIRTH: _____

If we are seeing you and billing under any of the coverage types listed below: We must have complete information in order to obtain accurate benefit coverage and or authorization for you to be seen. Please complete all information.

( ) WORKERS COMPENSATION:

CASE MANAGER/ADJUSTOR: _____ PHONE: _____

EMPLOYER AT TIME OF INJURY: _____ PHONE: _____

ADDRESS: _____

FILE/CLAIM NUMBER: _____ DATE OF INJURY: _____

CLAIMS MAILING ADDRESS: _____

LEGAL REPRESENTATION: YES NO (circle one) if yes see below

_____

( ) AUTO:

CARRIER/INSURANCE NAME: _____

CLAIMS MAILING ADDRESS: _____

INSURED NAME: _____ CLAIM #: _____

DATE OF ACCIDENT: _____ Medical Benefits Exhausted: YES NO (circle one)

ATTORNEY: Yes or No (circle one) if yes see below

_____

( ) ATTORNEY INFO: (Please provide Name, address, phone, and fax) _____

_____

( ) Other Insurance Info: _____

_____

PLEASE PROVIDE INSURANCE CARDS and PICTURE ID FOR COPYING

PHYSICIANS PAIN CENTER

MEDICARE SECONDARY PAYOR QUESTIONNAIRE

ONLY PATIENTS COVERED BY MEDICARE MUST COMPLETE THIS FORM IN ITS ENTIRETY

PATIENT NAME _____ DATE: _____
MEDICARE NUMBER _____

1. Is the patient covered by an HMO plan? Circle One: YES NO If yes, Name: _____
2. Is the patient covered by Veterans Administration or Black Lung Medical Benefits? YES NO
3. Is this service for treatment of a work-related injury or illness? YES NO If yes, complete A and B.
   A. Give Name and Address of Workers' Compensation Agency: _____
   B. Give Name of the Workers' Compensation Carrier and your employer.- _____
4. Is illness due to an injury? YES NO If yes, answer A or B.
   A. If auto, give name, address and policy number of the automobile insurer. _____
   B. If patient is filing a liability suit, provide name and address of attorney. _____
5. Is the patient employed (Medicare disabled beneficiaries under age 65 or over the age of 65) and covered under a group health plan? YES NO
   Date of Retirement: _____
   Is the patient married? _____
   Is the spouse currently working? _____
   Does the spouse have group health insurance? _____
   Does the patient have coverage under a spouse/ parents group health? ____
6. Is the patient entitled to benefits solely on the basis of end stage renal disease? Y N
7. Has the patient received a kidney transplant? Y N
8. Has the patient been undergoing kidney dialysis for more than 12 months? Y N
9. If you answered yes to any of the above questions and/or you have a supplemental insurance policy, you will need to provide the information below.

Secondary Insurance Company: Name: _____
Address: _____
Policy Number: _____ Name of Insured: _____
Date of Birth of Insured: _____

Is this insurance a Medicare supplemental policy? YES NO

Patient signature: _____ Date: _____

PHYSICIANS PAIN CENTER

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for the Physicians Pain Center to furnish medical care and treatment to me or _____ (minor) which is considered necessary and proper in diagnosing or treating his/her physical and mental conditions.

Patient/Guardian: _____ ***Date:*** _____

BENEFIT ASSIGNMENT OF INFORMATION

I, the undersigned, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other coverage that is designated to cover medical treatments to The Physicians Pain Center. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

PATIENT/GUARDIAN: _____ **DATE:** _____

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill. We require that you pay all COPAYS, CO-INSURANCE, or DEDUCTIBLES at the time service is rendered. If your insurance carrier does not remit payment within 120 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for the services billed by us, you recognize an obligation to promptly remit the same to the Physicians Pain Center.

MEDICARE PATIENTS – This office accepts traditional Medicare assignment. Medicare patients are fully responsible for the yearly deductible and 20% co-payment. Federal law requires that we collect these amounts. If you have a secondary insurance to Medicare, we will be happy to submit this for you.

INSURANCE PATIENTS – The percentage of coverage by your insurance company may be based on your insurance company's own reduced fee schedule for medical services and may be less than actual charges, resulting in lower coverage for you. We have no control over this situation. Lower payment is a direct result of the plan selected by you or your employer

WORKERS COMPENSATION – The above does not apply for those patients with Worker's compensation. However, be advised as a Workers' Compensation patient, you may be held responsible for your charges in the event your claim is controverted.

NO INSURANCE – We know, at times, patients do not have insurance. If this is the case, cost of our services will be discussed prior to your appointment. All payments for services will be due at the time of your appointment.

I realize all payments are due within 30 days of receiving a statement and failure to keep my account current may result in the physicians/providers being unable to provide additional services. In the case of default on payment of my account, I agree to pay collection fee costs, court costs, and reasonable attorney fees incurred while attempting to collect my account balance or any future outstanding account balances.

PATIENT/RESPONSIBLE PARTY SIGNAURE: _____ **DATE:** _____

PATIENT NAME (PRINTED): _____

PHYSICIANS PAIN CENTER

Name: _____ *Date:* _____

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Please list below anyone that you wish to authorize to receive what is classified as Protected Health Information (PHI) on your behalf. This may include clarification of your treatment, prescriptions, treatment plan and or any orders you may have received. IE You ask us to speak to your spouse/daughter/neighbor/ etc. to clarify anything related to your treatment, we would need to have their name listed below and if you want to restriction what information can be disclosed.

You may revoke or change this form at any time by requesting to modify the list.

( ) I do not wish to list any persons at this time.

Name: _____ *Relationship:* _____

Contact Number: ( ) _____ *( ) Cell ( ) Home ( ) Work*

Address: _____

No Restrictions: _____ *Restricted to:* _____

Name: _____ *Relationship:* _____

Contact Number: ( ) _____ *( ) Cell ( ) Home ( ) Work*

Address: _____

No Restrictions: _____ *Restricted to:* _____

Name: _____ *Relationship:* _____

Contact Number: ( ) _____ *( ) Cell ( ) Home ( ) Work*

Address: _____

No Restrictions: _____ *Restricted to:* _____

The Physicians Pain Center

Initial Questionnaire
Please answer **all** questions as this helps us tailor a treatment plan for you

Name: _____ Date of Birth _____ Age ____ Date: _____

Referring Physician: _____ Primary Care Physician _____

Current Problem: When did it start? _____

How did it start? Gradual / Sudden / No Obvious Reason / Other _____

Motor-Vehicle Accident? No Yes When? _____ Workers' Compensation? No Yes When? _____

Other? _____

Describe Your Pain Below (use back of paper if needed):

Where does it start? _____ Does it go anywhere? _____

_____

_____

_____

_____

Are you psychologically affected by the pain? Mildly / Moderately / Severely

On a scale of 0 to 10 (0 being pain and 10 being the worst pain you ever experienced), what is

Your pain now? _____ What is your average pain score? _____

What is your pain with medications? _____ Without medications? _____

Which medications help the most? _____

Is the pain worsening? YES NO

Please circle **ONE** word in each group that describes your pain if applicable:

1. Flickering Quivering Pulsing Throbbing Beating Pounding	2. Jumping Flashing Shooting	3. Pricking Boring Drilling Stabbing Lancinating	4. Sharp Cutting Lacerating Crushing	5. Pinching Pressing Gnawing	6. Tugging Pulling Wrenching
7. Hot Burning Scalding Searing	8. Tingling Itchy Smarting Stinging	9. Dull Sore Hurting Aching Heavy	10. Tender Taut Rasping Splitting	11. Tiring Exhausting	12. Sickening Suffocating
13. Fearful Frightful Terrifying	14. Punishing Grueling Cruel Vicious Killing	15. Wretched Blinding	16. Annoying Troublesome Miserable Intense Unbearable	17. Spreading Radiating Penetrating Piercing	18. Tight Numb Squeezing Tearing Drawing
19. Cool Cold Freezing	20. Nagging Nauseating Agonizing Dreadful Torturing	21. Brief Momentary Transient	22. Rhythmic Periodic Intermittent	23. Continuous Steady Constant	

Name: _____

What activities make the pain better? _____ Worse? _____

How frequently do you have the pain? _____

When is the pain the best? _____ Worse? _____

What would you like to do but cannot due to the pain? _____

What can you still do (with the pain)? _____

How far can you walk? _____ How much can you lift? _____

Do you sleep well at night? Yes No Why? _____

Do you use a cane, brace, wheelchair or other device because of this problem? _____

What kind of treatment have you had for this pain? _____

Did/Does the treatment work? _____ For how Long? _____ How much improvement? _____

Circle the tests you have had for this problem and list the date and location of the test(s):

X-RAYS	Date _____	Where _____
MRI	Date _____	Where _____
EMG/NCV	Date _____	Where _____
Other	Date _____	Where _____

Current Medications: ***(Please include all medications including over-the-counter medications, vitamins, or other supplements)***

Medication	Dosage	Frequency	Prescribed by

Past Pain Medications and the reason you discontinued them:

_____ Why stopped? _____

_____ Why stopped? _____

_____ Why stopped? _____

_____ Why stopped? _____

Name: _____

Past Medical History: (Please Circle and Describe)

Heart Disease	Y N	_____	
Hypertension	Y N	_____	
Heart Attack	Y N	_____	
Lung Disease	Y N	_____	
Asthma	Y N	_____	
COPD	Y N	_____	
Emphysema	Y N	_____	
Liver Disease	Y N	_____	
Hepatitis	Y N	_____	
Kidney Disease	Y N	_____	
Urinary Problems	Y N	_____	
Sexual Dysfunction	Y N	_____	
Cancer	Y N	_____	
Seizures	Y N	_____	
Stroke	Y N	_____	
Stomach problems	Y N	_____	
Ulcers	Y N	_____	
Reflux	Y N	_____	
Thyroid	Y N	_____	
Diabetes	Y N	_____	
Glaucoma	Y N	_____	
Neuropathy	Y N	_____	
HIV	Y N	_____	
Blood problems	Y N	_____	
Rheumatoid Arthritis	Y N	_____	
Osteoporosis	Y N	_____	
DJD	Y N	_____	
Psychiatric problems	Y N	_____	
Depression	Y N	_____	
Anxiety	Y N	_____	
Fibromyalgia	Y N	_____	
Chronic Fatigue	Y N	_____	
Other		_____	

Have you had a Pneumonia Vaccination: Y N if so when (year) : _____

Have you had a bone density Study: Y N if yes when: _____ **where:** _____

Past Surgical History:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Drug Allergies: ( ) NKDA

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Please describe and give dates of past accidents (motor-vehicle, work-related or other):

Accident _____ Date _____

Accident _____ Date _____

Accident _____ Date _____

Are you receiving Compensation? Y N What _____

Are you involved in a lawsuit? Y N What _____

Are you considering a lawsuit? Y N What _____

Social History:

Marital Status: (Circle One) Single Married Divorced Living with someone

Number of children with ages: _____

Highest level of education: _____ Degree _____

What is your current occupation? _____ Past Occupation? _____

Are you working now? _____ Do you enjoy work? _____

Do you smoke? Y N How much? _____ How long? _____

Did you previously smoke? Y N How much? _____ How long? _____

Do you drink alcohol? Y N How much? _____ What? _____

Do you smoke marijuana? Y N How much? _____

Do you use cocaine? Y N How much? _____

Do you use crack? Y N How much? _____

Do you use intravenous drugs? Y N How much? _____

Do you have a history of dependency on medications? Y N What? _____ When? _____

Have you ever made a suicide attempt? Y N _____

Have you ever been subjected to abuse? Y N _____

Family Medical History:

Mother: History: _____

Alive? YES NO Age _____, Deceased? YES NO Age: _____

Father: History: _____

Alive? YES NO Age: _____, Deceased? YES NO Age: _____

Sister(s): _____

Alive? YES NO Age: _____, Deceased? YES NO Age: _____

Brother(s): _____

Alive? YES NO Age: _____, Deceased? YES NO Age: _____

Other Comments: _____

_____

_____

_____

_____

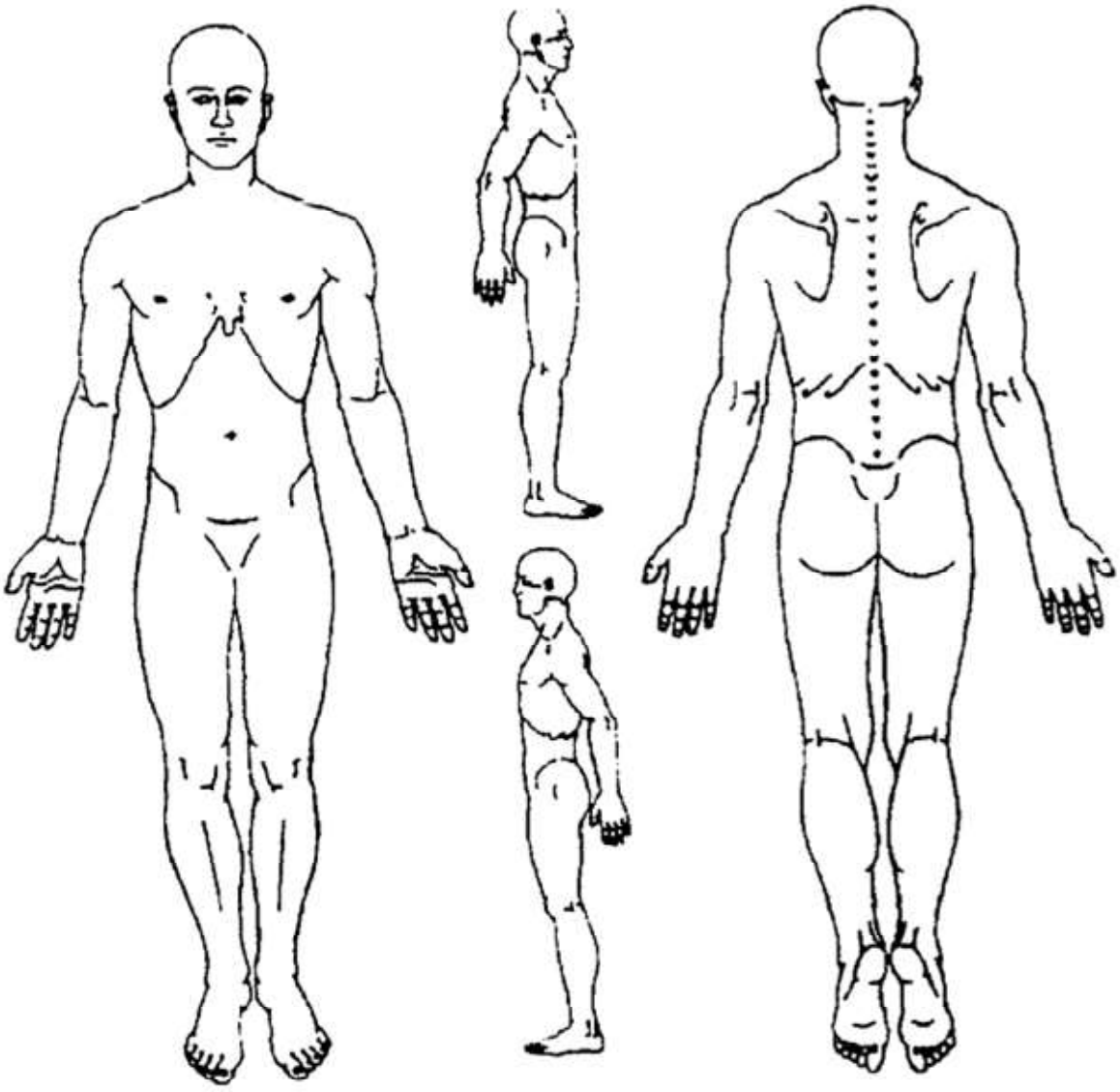
_____ _____ _____

Patient's Signature Print Name Date

_____ _____ _____

Signature of Person completing this form, (If other than the patient) Print Name Date

NAME:



Please indicate on this diagram where your pain is located by shading in the painful area(s).