Basic Information

Full name

First_____Middle_____Last_____

Sex: ☐Male ☐ Female ☐Unknown_____ Date of birth_____

Primary Phone: ☐ Home ☐ Mobile ☐ Work

Home_____Mobile_____Work_____

Email_____Social security number_____

Address Line 1_____Address Line 2_____

City_____State_____Zip code_____

Marital Status

☐ Married ☐ Single ☐ Separated ☐ Divorced

Driver's license state_____Driver's license #_____

Language_____

Emergency Contact

Relationship to Contact_____

Full name

First_____Middle_____Last_____

Primary Phone: ☐ Home ☐ Mobile ☐ Work

Home_____Mobile_____Work_____

Email_____

Address Line 1_____Address Line 2_____

City_____State_____Zip code_____

Additional Information

_____

Please list your preferred pharmacies in order of preference

Pharmacy Name_____

Pharmacy Address Line 1_____Address Line 2_____

City_____State_____Zip code_____

How did you hear about us?

_____

Allergies

_____

WORKERS' COMPENSATION & NO-FAULT INTAKE FORM

Work-related injury: ☐ YES ☐ NO

Auto accident ☐ YES ☐ NO

Date of Injury or accident:

State of Injury or accident:

Employer Information:

Name of employer:

Job title:

Address:

Phone number:

Email:

CLAIM INFORMATION

Insurance name:

Address:

Claim Number: Jurisdiction:

WCB Case number (If applicable):

Group number (If applicable):

Compensable Body Part(s) / Area(s) REQUIRED:

Referred By Dr.:

ADJUSTER INFORMATION

Name: Phone number:

Fax number: Email:

Nurse case manager:

Name Phone number:

Fax number: Email:

ATTORNEY INFORMATION

Name:

Address:

Firm name: Phone number:

Email: Fax number:

Date:

Patient's Signature:

Pain Problem Questionnaire

Please fill out this questionnaire to the best of your ability. Be sure to include a list of all your medications x-rays, MRI, or CT imaging related to your pain problem.

☐ Numbness

☐ Burning

☐ Stabbing

☐ Pins and Needles

☐ Ache/Tightness

When did the pain begin? Please mention the month and Year or the date if possible.

Month: Year:

Describe how your pain started

☐ Accident

☐ Lifting

☐ Surgery

☐ Following an Illness

☐ Unknown

Have you had any recent falls?

☐ Yes

☐ No

Please select the minimum intensity. (0 to 10)

Please select the maximum intensity. (0 to 10)

Since your pain has started, has the intensity of the pain.

☐ Varied

☐ Increased

☐ Decreased

☐ Remained the same

☐ Unknown

The Pain is

☐ Occurs under certain circumstances

☐ Is rarely present

☐ Is always present

☐ Is usually present

Please select all that describe your pain.

☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Shooting ☐ Stabbing

☐ Lightening shock ☐ Cutting ☐ Cramping ☐ Radiating ☐ Soreness

☐ Terrifying ☐ Tight ☐ Hot ☐ Tingling

Is there any Bowel/Bladder incontinence due to the pain?

☐ Yes

☐ No

Is there any sexual/erectile dysfunction due to the pain?

☐ Yes

☐ No

How many times a week do you pass a stool movement?

Aggravating Factors: Please select what makes your pain worse:

☐ Walking ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Twisting ☐ Exercise

☐ Stress ☐ Driving ☐ Eating ☐ Coughing ☐ Sneezing ☐ Sexual Activity

☐ Lying Down ☐ Use of Arms ☐ Use of Legs ☐ Climbing Stairs ☐ Bright Lights

☐ Loud Nose ☐ Bowel Movement ☐ Changes in Weather ☐ Anything touching skin

Alleviating Factors: Please select what makes your pain better:

☐ Walking ☐ Sitting ☐ Standing ☐ Lying down ☐ Heat

☐ Cold ☐ TENS Unit ☐ Medications ☐ Relaxation ☐ Exercises

☐ Socializing ☐ Recreational Activities

What specialists/Treatments have you seen or done for your pain? Please select that apply

☐ Acupuncturist ☐ Chiropractor ☐ Internist ☐ Massage Therapist

☐ Therapist ☐ Neurologist ☐ Physical Therapist

☐ Orthopedic ☐ Shots

Have you ever been seen by a Pain Clinic/Specialist before? Yes or No. If yes so where?

What type of treatment procedures did they do for you and when did they take place?

What X-Rays or Tests have you done? Please select all that apply.

☐ MRI ☐ Nerve Conduction Study ☐ CT scan

☐ Blood work ☐ Bone scan

Date:

Patient's Signature:

Family History

If any blood relatives have suffered any of the following, please check and indicate which relative.

Family Member

☐ Thyroid_____

☐ Migraine_____

☐ Arthritis_____

☐ Hepatitis_____

☐ Stroke_____

☐ Cancer_____

☐ Heart Disease_____

☐ Peripheral Vascular Disease_____

☐ HIV_____

☐ Drug/Alcohol abuse_____

☐ Glaucoma_____

☐ Anemia_____

☐ Chronic pain_____

☐ COPD_____

☐ Diabetes_____

PAST MEDICAL HISTORY					
☐	Difficulty sleeping	☐	Heartburn/Indigestion/Reflux	☐	Pneumonia in the past year
☐	Ears/Eyes	☐	Bowel Incontinence	☐	Shortness of Breath w/exertion
☐	Doubled/Blurred Vision	☐	Liver disease/ Hepatitis	☐	Cardiovascular
☐	Asthma	☐	Incontinence/ Difficulty Urinating	☐	High blood pressure
☐	COPD/Emphysema	☐	Prostate Enlargement	☐	Heart Attack
☐	Sleep Apnea	☐	Arthritis	☐	Pacemaker/AICD
☐	Diabetes	☐	Blood clots	☐	Valve disease
☐	Thyroid	☐	Abnormal Bleeding	☐	Congestive Heart Failure
☐	Stroke	☐	Depression/ Anxiety	☐	Cancer
☐	Migraine	☐	Hepatitis	☐	Heart Disease
☐	Peripheral Vascular Disease	☐	HIV	☐	Drug/Alcohol abuse
☐	Glaucoma	☐	Anemia	☐	Chronic pain
☐	Diabetes				
☐	Others				

PAST SURGICAL HISTORY					
☐	Appendectomy	☐	Cervical Surgery	☐	Breast cancer
☐	Back surgery	☐	Colon surgery	☐	Cardiac surgery
☐	Bariatric surgery/gastric bypass	☐	Colonoscopy	☐	Hernia surgery
☐	CABG	☐	Disc Replacement	☐	Hip surgery
☐	Carpal tunnel release surgery	☐	Elbow surgery	☐	Hydrocelectomy
☐	Cataract/lens surgery	☐	Eye surgery	☐	Kidney Surgery
☐	Cesarean section	☐	Fibia	☐	Knee surgery
☐	Hip replacement	☐	Finger surgery	☐	Kyphoplasty
☐	Hysterectomy	☐	Foot Surgery	☐	Laparoscopy
☐	Inguinal hernia repair	☐	Gallbladder surgery	☐	Liver biopsy
☐	Laminectomy	☐	Gastrectomy	☐	Lower back surgery
☐	Prostate surgery	☐	Gastric surgery	☐	Lumbar surgery
☐	Rotator cuff surgery	☐	Hand surgery	☐	Minus surgery

☐	Sinus surgery	☐	Heart stent	☐	Neck surgery
☐	Tonsillectomy/Adenoidectomy	☐	Heart Surgery	☐	Open heart surgery
☐	2- C section	☐	Back surgery	☐	Ovary surgery
☐	Abdominal surgery	☐	Bilateral Hip Replacement	☐	Removal Fallopian tube
☐	Ablation	☐	Bilateral knee surgery	☐	Shoulder surgery
☐	Angioplasty	☐	Bladder Cancer Surgery	☐	Tendon Release
☐	Angiography	☐	Bladder Surgery	☐	Thumb surgery
☐	Ankle surgery	☐	Bowel surgery	☐	Tumor removal
☐	Appendix	☐	Brain surgery		
☐	Arm surgery	☐	Breast Biopsy		
☐	Others				

SOCIAL HISTORY

☐	Frequently drink	☐	Disabled		
☐	Do not drink	☐	Currently not working		
☐	Illicit drug use	☐	Currently working		
☐	No illicit drug use	☐	Medical Marijuana		

Current Medication

☐		☐		☐	
☐		☐		☐	
☐		☐		☐	
☐		☐		☐	
☐		☐		☐	

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Eastern Pain Medicine, PC
Nagendra P. Upadhyayula, MD

Diplomatic American Board-Certified Anesthesiology
Board Certified in Pain Management

Prescription Medication Contract

I myself, and the staff of Eastern Pain Medicine have a common treatment goal: **To improve my ability to function**. In consideration of this goal, I may be treated with potent medications some of which are narcotics or tranquilizers. These medications are controlled substances and therefore monitored by Local, State, and Federal agencies. These medications are highly effective when taken as directed under medical supervision, but they also have the potential for misuse and abuse.

I therefore agree to abide by the following conditions:
I agree that all medications for the control of pain related to my pain condition shall be prescribed ***ONLY*** by my pain management physician. I agree to inform my pain management physician if I obtain a prescription either for pain control or anything related to my pain condition from any other source for any reason. If my referring physician or primary care physician prefers to write prescriptions for all my medications, including those prescribed for pain, I will inform my pain management physician of this, and he will then only make recommendations to my primary care / referring physician.

I understand that my medications are prescribed to be used by myself only and I agree not to "share" or give medications to anyone else; this is illegal, as well as dangerous for all parties concerned. I agree to use my prescriptions exactly as written including the prescribing dose, time, interval or frequency and route. If I take my medications more often and use up my medications sooner than prescribed, **I understand that they will NOT be refilled early.** I also agree not to use any medications for pain or my pain condition from any other source or to use medications given to me by any other person.

Permission to obtain urine specimen:

I understand that I may be asked to perform a random urine drug screen if I receive narcotics from this office. This is a mandatory screening that will be done to ensure appropriate medication levels, as well as to determine any misuse or abuse of the prescribed or illicit drugs. If I refuse to give a urine specimen upon request, I will no longer be provided with narcotic prescriptions. If illicit drugs and/or narcotics not prescribed by this office are detected, we will no longer continue writing narcotic prescriptions for you and we may exercise our right to discharge you from the practice.

- ☐ I receive medications from a different Doctor and don't wish to sign the contract.
- ☐ I have read this form and am in agreement with the terms and conditions of this contract.

Print: _____ Sign: _____ Date: _____

Consent to treat, use and disclose protected health information and acknowledgement of receipt of notice of privacy practices

1. Patient consent to treat:

I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the provider in the course of treatment.

2. Patient consent for use and disclosure of Protected Health Information

I, the undersigned patient, give my consent to the provider and his staff to use or disclose my protected health information (PHI) to carry out treatment, payment or health care operations. These individuals and entities can release, use or disclose my PHI to other health care personnel including, but not limited to, physicians, certified registered nurse anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physicians assistants, child life specialists, physical therapists, respiratory therapists, radiology therapists, audiologists, students in each of the above disciplines, and other such entities or persons as are deemed related to treatment, payment and health care operations, as determined in the sole discretion of the provider, his/her practice group and their respective agents.

3. Permission to release medical records to providers:

If another provider who is involved with treatment, payment, or health care operations relating to me, requests my medical records, I consent to the release of my entire medical record maintained by the provider to those other providers listed above. Please be advised that we may be required to discuss your care with any concerned party, such as other physicians involved in your care, family members, pharmacy and inquiring law enforcement agencies. This is for your safety to avoid any problems related to opioid use.

4. Permission to release billing information over the telephone:

I agree, as part of this consent for payment operations that the provider, his billing staff, billing agents or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number and/or health plan number.

5. Permission to call and leave voicemail messages:

I agree that the provider and his staff may call and leave a voicemail message at my home or other number I provide them with regarding medical appointments, billing or payment issues or other information related to treatment, payment or health care operations.

Initial:_____ Date:_____

I understand that lost, stolen and/or altered prescriptions or medications will *NOT* be replaced. I understand I will not adjust the dosage or timing of medications by myself.

Patient agrees to comply with all the following:

1. Fill in pain medications at the same pharmacy every time or notify the physician of the reason for the change.

2. To obtain pain medication from this office only. In case of needing to obtain medications from another source (i.e., Emergency surgery etc.) the patient will notify this office of this event as soon as possible.

3. To show up for all scheduled doctor visits (including subspecialty appointments).

4. To use medication only as prescribed. No more than a 30-day supply for controlled substances can be supplied at a time.

5. To follow all treatment plans as prescribed.

6. To be evaluated and followed by a psychiatrist, psychologist and/or social worker as deemed necessary.

THIS OFFICE RESERVES THE RIGHT TO REPORT ANY SUSPICIOUS OR UNUSUAL ACTIVITY TO THE NEW YORK STATE BUREAU OF CONTROLLED SUBSTANCES.

THE USE OF ILLEGAL DRUGS OR THE VIOLATION OF PAROLE OR PROBATION IS A VIOLATION OF THIS PRESCRIPTION MEDICATION CONTRACT.

I UNDERSTAND THAT FAILURE TO COMPLY WITH THIS AGREEMENT/CONTRACT MAY RESULT IN MY DISMISSAL FROM THE EASTERN PAIN MEDICINE OFFICE.

REFILLS

If a prescription refill is due, I understand I must call at least one week prior to running out to make an appointment.

If a prescription refill is due on a weekend or holiday, an appointment will be made on a business day prior to the weekend or holiday.

By signing below, I indicate that I agree with all the terms of the above contract. A copy of this agreement will be provided, **upon request,** to me for my own records.

*Patient's Signature (Parent or Guardian if minor):

_____

Witness: _____

*Physician: _____

*Date Signed: _____

Venefit™
Targeted Endovenous Therapy

PATIENT SELF-ASSESSMENT

Patient Self-Assessment
Please take this self-assessment to see if you might be a candidate for additional screening for potential varicose veins and / or chronic venous insufficiency.

History

Have you ever had varicose veins?	○ Yes	○ No

Signs and Symptoms
Do you experience any of the following signs and symptoms in your legs or ankles?

Do you experience leg pain, aching or cramping?	○ Yes	○ No
Do you experience leg or ankle swelling, especially at the end of the day?	○ Yes	○ No
Do you feel “heaviness” in your legs?	○ Yes	○ No
Do you experience restless legs?	○ Yes	○ No
Do you have skin discoloration or texture changes?	○ Yes	○ No
Do you have open wounds or sores?	○ Yes	○ No

Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed with venous reflux disease or chronic venous insufficiency?	○ Yes	○ No
Have you had any treatments of procedures for vein problems?	○ Yes	○ No
Do you stand for long periods of time, such as at work?	○ Yes	○ No

Self-Assessment Results
If you answered yes to one or more of the above questions, please contact us for a consultation to see if you may be candidate for venous reflux disease.

Name: _____

Contact number: _____

Email Address: _____