PREMIER ANESTHESIA AND PAIN MANAGEMENT

Patient Information Sheet Date ____/____/_____

NAME: LAST_____FIRST_____MIDDLE INTIAL_____

ADDRESS_____

CITY_____STATE_____ZIP_____

CELL PHONE (_____)_____-_____ HOME PHONE (_____)_____-_____

EMAIL_____ WORK PHONE (_____)_____-_____ EXT_____

PRIMARY CARE DOCTOR_____

REFERRING PHYSICIAN_____

DATE OF BIRTH_____/_____/_____ SEX ☐ F ☐ M SOCIAL SECURITY _____/_____/_____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

EMPLOYER NAME _____

ADDRESS_____

EMPLOYMENT STATUS: ☐ F/T ☐ P/T ☐ UNEMPLOYED ☐ RETIRED ☐ SELF EMPLOYED ☐ ACTIVE MILITARY

STUDENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ NOT A STUDENT

RESPONSIBLE PARTY:: ☐ SELF ☐ GUARANTOR RELATIONSHIP_____

EMERGENCY CONTACT

NAME: LAST_____FIRST_____RELATIONSHIP_____

HOME PHONE (_____)_____-_____ WORK PHONE (_____)_____-_____ EXT_____

PERMISSION TO LEAVE MESSAGE HOME: ☐ YES ☐ NO WORK: ☐ YES ☐ NO

PHARMACY: NAME _____ LOCATION _____PHONE_____

____I HAVE A DO NOT RESUCITATE ___ I HAVE A POWER OF ATTORNEY FOR MY MEDICAL DECISIONS

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER_____ ID#_____

CLAIMS ADDRESS_____ GROUP#_____

IF NOT SELF, POLICY HOLDER NAME_____ DOB_____SEX_____SSN_____

SECONDARY INSURANCE CARRIER_____ ID#_____

CLAIMS ADDRESS_____GROUP#_____

IF NOT SELF, POLICY HOLDER NAME_____DOB_____SEX_____SSN_____

I attest that the information above is true and current to the extent of my knowledge. I also hereby grant permission to **Premier Anesthesia and Pain Management,** to view my prescription history from external sources.

X_____ **Date:**_____

Patient, Parent or Guardian Signature

Premier Anesthesia and Pain Management P.A./Blue Valley ASC Patient Privacy Acknowledgement Form

I, _____, understand that the patient's health information is private and confidential. I understand that Premier Anesthesia and Pain Management, P.A./Blue Valley ASC work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that Premier Anesthesia and Pain Management, P.A./Blue Valley ASC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Premier Anesthesia and Pain Management, P.A./Blue Valley ASC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this acknowledgement. Premier Anesthesia and Pain Management, P.A./Blue Valley ASC may update this acknowledgement and "The Notice of Privacy Practices". If I ask, Premier Anesthesia and Pain Management, P.A. will provide me with the most current "Notice of Privacy Practices".) Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These right include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law, and requesting communication by specified methods of communications or alternative location.

My signature below indicates that I have been given the chance to review a current copy of Premier Anesthesia and Pain Management, P.A.'s/Blue Valley ASC "Notice of Privacy Practice".

Signed:_____ Date: _____
(Patient or Legally Authorized Representative)

AUTHORIZATION FOR RELEASING HEALTH INFORMATION

I hereby authorize Premier Anesthesia and Pain, P.A. to obtain or release my medical records and protected health information to coordinating care providers and third party payers. I also give permission to Premier Anesthesia & Pain, P.A./Blue Valley ASC to release my medical records and protected health information to the parties listed below:

Name _____ Relationship_____

Name _____ Relationship_____

I understand that records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. PROHIBITION OF DISCLOSURE: Alcohol and drug abuse information, if present has been disclosed from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR Part 2) prohibits recipients from making any further disclosure of this information except with specific written consent to the patient. HIV testing, ARC and/or AIDS related diagnosis is further prohibited from disclosure by state Regulations without the specific written consent of the patient. A general authorization for the release of information if held by another Party is not sufficient for this purpose. RE-DISCLOSURE: Notice is hereby given to the patient of legal representative signing this authorization that Premier Anesthesia and Pain Management cannot guarantee that the recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the recipient that law prohibits the re-disclosure of any health information regarding drug and or alcohol abuse, HIV and mental health treatment.

Signed:_____ Date: _____
(Patient or Legally Authorized Representative)

Patient Bill of Rights

As part of mandatory education, Premier Anesthesia and Pain, P.A./Blue Valley ASC educates and trains all staff about the importance of patient rights and patient responsibilities. We ensure our patients are informed of their rights and their role in supporting those rights. The patient has a right:

- To provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other health matter.
- To report unexpected changes in patient's condition to a responsible practitioner whether or not the patient clearly comprehends the course of treatment.
- To follow the treatment plan developed and communicate concerns regarding patient ability to comply with treatment.
- To understand the consequences of treatment alternatives and of noncompliance with the proposed treatment.
- To accept responsibility for outcomes if treatment is refused or instructions are not followed.
- To follow Interventional Spine and Pain Management Center rules and regulations affecting patient care and conduct.
- To be considerate of other patients and personnel regarding noise, smoking, property, and distractions.
- To assist the caregivers in assessment of pain. To report initial pain or unrelieved pain to caregivers as well as pain relief.
- To reasonable access to care.
- To care that is considerate and respectful of his or her personal values and beliefs.
- To be informed about and participate in decisions regarding his or her care.
- To participate in ethical questions that arise in the course of his or her care, including issues of conflict resolution, withholding resuscitative services, foregoing or withdrawal of life sustaining treatment, and participation in investigational studies or clinical trials.
- To security and personal privacy and confidentiality of information.
- To appropriate assessment and management of pain.
- To access protective services.
- To issue a concern or complaint and may do so at any time to clinical personnel or note findings on patient satisfaction surveys.
- To designate a decision-maker in case the patient is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- To know their patient rights.
- To have the staff educated about patient rights and their role in supporting their rights.

BLUE VALLEY ASC FINANCIAL POLICY

Your care at this facility will be comprised of two separately billed, parts: (1) Physician fee providing care (Premier Anesthesia and Pain) (2) Facility charge for advanced technology required to provide you with complete and cutting-edge care (Blue Valley ASC)

Our providers are in-network with most insurance companies. We strive to inform you if a provider is not in-network with your insurance company.

In contrast, our facility (Blue Valley ASC) is NOT in-network. As a result, when the facility bill is submitted it will be paid on an "out-of-network" basis. However, our "Out-Of-Network Policy" policy states that we will adjust the patient responsibility portion of the bill to match in-network co-insurance after the out-of-network deductible has been met.

Upon confirmation of your appointment, our staff will verify your insurance benefits and estimate your financial responsibility. We may choose to collect a portion of these costs prior to services being rendered. Our facility accepts flex spending, most major credit cards, and financing through CareCredit

*****BLUE VALLEY ASC IS OUT-OF-NETWORK YOU MAY RECEIVE A CHECK IN THE MAIL FOR CHARGES BY THE FACILITY. BY SIGNING BELOW YOU ACKNOWLEDGE THAT YOU AGREE TO ABIDE BY THE ABOVE POLICY AND UNDERSTAND THAT YOU WILL BE REQUIRED TO TURN ANY FUNDS SENT TO YOU DIRECTLY OVER TO THE FACILITY IMMEDIATELY TO AVOID BEING SENT TO COLLECTIONS.*

_____ _____

Patient Date

ATTORNEY LIEN AND PAYMENT AUTHORIZATION

LIEN NOTICE TO:

Attorney/Firm_____Phone:_____

Address_____

LIEN IN FAVOR OF _____ and Dr. Travis Foxx/Premier Anesthesia /Blue Valley ASC, 12800 Metcalf Ave., Overland Park, Kansas 66213.

TO ATTORNEY:

1. I have requested and Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC has agreed to render medical care/treatment to me for injuries sustained in the accident on _____City of _____ State of _____ for examination, diagnosis, treatment, prognosis of myself in regard to my accident.

2. I hereby give an IRREVOCABLE LIEN in favor of said Doctor and said facilities on any settlement, claim, judgment or verdict, as a result of said accident.

3. If you, my ATTORNEY, receive any proceeds from any Insurance Company for medical services rendered me by Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC, I request, authorize and instruct you to forward such payment for such medical services rendered me to Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC.

4. If I receive any payments from Insurance Company for medical services rendered by said Doctor, I will promptly deliver all such payments to Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC, and if I fail to do so, the balance is immediately net due and payable to Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC.

5. I fully understand that I am personally responsible to Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC for services rendered me and that this agreement is made solely for said Doctor/medical facility's additional protection and in consideration of awaiting payment from any Insurance Company for medical services rendered to me by Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC.

6. I understand that my responsibility of payment for medical services rendered by Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover.

7. I hereby waive signature, in favor of Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC on any check paid by said insurance.

8. I agree that a copy of this agreement is as valid as the original.

9. I agree for Dr. Travis Foxx/Premier Anesthesia/Blue Valley ASC to be paid in full before disbursement of monies to me.

10. I agree for this LIEN to be binding on any subsequent Legal Representative.

_____DATE_____

(Signature of patient)

ATTORNEY: The undersigned, being the attorney of record and/or authorized representative of the above patient, does hereby acknowledge receipt of the above clients' requests and lien, and agrees to comply with clients' request regarding fees, only from monies received for patient's account, for medical treatment and services rendered to the above patient. I am personally responsible ONLY for any "reports" or "copies of records" that I may request.

_____DATE_____

(Signature of attorney)

attylien

Via Certified Mail Return Receipt Requested #:_____

Provider/Patient Lien, Records Release and Payment Agreement

Lien Notice to Law Firm:_____

Lien is in favor of Dr. Travis Foxx, M.D. and/or Premier Anesthesia and Pain, P.A. and/or Blue Valley ASC (BVASC). THIS AGREEMENT, entered into this date by and between _____, hereinafter called "Patient," and Premier Anesthesia and Pain, P.A. and/or Blue Valley ASC (BVASC) and/or Dr. Travis Foxx, hereinafter called "Provider."

WHEREAS Patient desires to receive healthcare services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for the payment of such benefits, it is hereby agreed:

SECTION 1. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and that Provider may revoke this assignment at any time.

SECTION 2. Patient hereby grants Provider a lien against any proceeds resulting from any claim Patient has or may have against any party whose negligence may have caused Patient's injuries or illnesses. Patient also hereby grants a lien against the proceeds of any insurance policy or healthcare plan to which Patient is entitled as a result of services rendered to Patient by Provider. If said lien is insufficient to completely pay the patient's bill for provider's service, patient agrees that patient remains personally responsible for the unpaid portion of provider's bill. The remaining balance will be due immediately.

SECTION 3. Patient hereby directs all insurers and other persons responsible for Patient's healthcare costs to make all payments for healthcare services rendered by Provider directly to Provider.

SECTION 4. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this Agreement, Patient agrees to act as fiduciary agent for Provider and will immediately deliver said check, draft, or payment to Provider. Provider agrees to apply the proceeds from said check, draft or payments to Patient's debt for services rendered.

SECTION 5. Provider agrees to submit a copy of this Agreement with the initial claim form(s) which Provider submits to third party payers(s) and to Patient's Attorney as notice to the third party payer(s) and Attorney of the assignment and other agreements contained herein. A copy of this document will be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured at any time or will, upon request by Patient/insured, be mailed to a designated address.

SECTION 6. Patient hereby directs all insurers, attorneys or other persons responsible for Patient's healthcare costs to pay Provider in full before disbursement of any monies to Patient. Provider is NOT to be held to state lien laws outside the State of Kansas. Provider will be paid completely for billed charges prior to any outside state lien law application.

SECTION 7. Patient agrees to be responsible for insurance or health plan deductibles and co-payments for the cost of services not covered by said insurance or healthcare plan(s).

A. This Section is void if applicable insurance or health care plans do not provide coverage for services rendered by Provider.

B. This Section is void if prohibited by law or the terms of the Patient's insurance policy or health care plan.

C. Both Provider and Patient have the right to terminate the provisions of this Section at any time by providing written notice to the other. Such termination will have no effect on assignments, assumptions, or payments due, prior to said notice of termination.

SECTION 8. In the event that any Section or provision of the Agreement is legally void, invalid, or unenforceable, all other Sections and provisions of this Agreement will remain in full force and effect.

SECTION 9. The agreements contained in this document may not be revoked by Patient without the express written consent of the Provider, with the exception of the provision of Section 7.

SECTION 10. In the event Provider employs an attorney to enforce the terms of this agreement, collect any amounts due, or defend any claim or counterclaim brought by Patient, the Provider shall in addition to any other sums the Provider in entitled to recover, shall also be entitled to recover his reasonable attorney's fees, reasonable hourly compensation for time expended by Provider or its agents, litigation expenses and court costs. The Provider shall be entitled to recover attorney's fees and expenses incurred if he prevails in defending any administrative claim brought by the Patient against the Provider. Interest on past due accounts will accrue at the rate of 8% per annum on all accounts that are (30) days past due.

IN WITNESS WHEREOF, this Agreement has been entered into the day and year set forth below.

_____ _____

Date Patient

_____ _____

Witness Provider

Premier Anesthesiology & Pain Management
New Patient Intake Form & Medical History

Pain Description

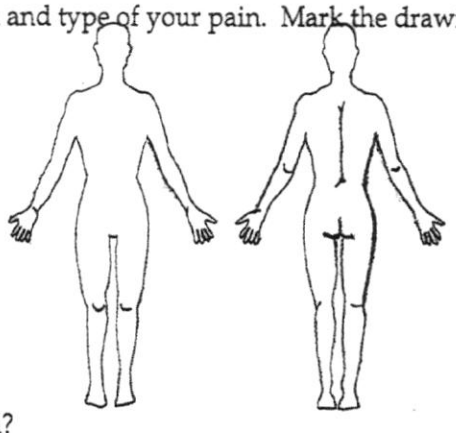
Please rate your pain on a scale of 1 to 10 when: Active _____ Resting _____

Check all the following that describe your pain:

□ Aching	□ Band-like	□ Burning/Hot	□ Cramping
□ Deep	□ Dull	□ Numb □Piercing	□ Tingling/Pins and Needles
□ Pressure	□ Shooting	□ Stabbing/Sharp	□ Spasming
□ Throbbing	□ Shock-like	□ Squeezing	□ Tiring/Exhausting

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



Where is your worst area of pain located?_____

Does this pain radiate? If so, to where?_____

Onset and Mechanism of Injury

Approximately how long have you been experiencing this pain? _____

How did your original injury occur?

□ N/A	□Altercation	□ Assault	□ Struck by falling object	□ Bending
□ Exercise	□ Lifting	□ Falling	□ Falling from height	□ Rotating
□ Trauma	□ Repetitive movements		□Other:_____	

What caused your current pain episode?

□ N/A	□ Altercation	□ Assault	□ Exercise	□ Heavy weight lifting
□ Injury at work	□ Motor vehicle accident		□ Multiple health/medical problems	
□ Surgery	□ Trauma	□ Other:_____		

How did your current episode begin? □ Gradually □ Suddenly

What word best describes the frequency of your pain? □ Constant □ Intermittent

Since your pain began, how has it changed? □ Decreased □ Increased □ Stayed the same

When is your pain the worst? □ Mornings □ During the day □ Evenings □ Middle of the night

Pain Interference

Check all of the following activities that your pain interferes with:

□ Nothing □ Driving □ Intercourse □ Leisure Activities
□ Personal Grooming □ Relationships □ Sleep □ Sports Activities
□ Walking □ Work duties: minimally/mildly/severely □ Other

Activity Level/ Work Status

Are you currently working? □ Yes □ No If not, are you on disability? □ Yes □ No

How far can you walk? _____minutes or _____miles

How long can you sit? _____ minutes. How long can you stand? _____ minutes

Do you have an exercise program you do at home? □Yes □No

If yes, please describe: _____

Can you lift anything? □ Yes □ No up to _____ pounds

Are you having trouble sleeping? □ Yes □ No Average number of hours of sleep per night:_____

Do you have problems with depression or feelings of hopelessness? □ Yes □ No

If yes, please explain:_____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical: □ Poor Circulation □ Cancer-Type_____ □ Chronic Joint Pain
□ Fibromyalgia □ Diabetes-Type_____ □Degenerative Disk Disease
□ HIV/AIDS □ Hyperthyroidism □ Joint Injury □ Osteoarthritis
□ Osteoporosis □ Rheumatoid Arthritis □ Spinal Stenosis □ Stroke
□ Tachycardia □ Tennis Elbow □ TIA □ Vertebral Compression Fracture

Head/Eyes/Ears/Nose/Throat: □ Headaches □ Migraines □ Head Injury □ Glaucoma

Cardiovascular/Hematologic: □ Atrial Fibrillation □Blood Clots □ Bleeding Disorders □ Anemia
□ Coronary Artery Disease □ Cong. Heart Failure □ Heart Attack □ High Blood Pressure
□ High Cholesterol □ Murmur □ Pacemakers Phlebitis □ Mitral Valve Prolapse

Respiratory: □ Asthma □ Bronchitis □ Emphysema/COPD □ Pneumonia Tuberculosis

Gastrointestinal: □ Bowel Incontinence □ Cirrhosis □ Constipation □ GERD (Acid Reflux)
□ Gastrointestinal Bleeding □ Hepatitis A/B/C □ Hernia □ IBS □ Ulcers

Musculoskeletal: □ Amputaion □ Bursitis □ Carpal Tunnel Syndrome □ Chronic Back/Neck Pain

Genitourinary/Nephrology: □ Bladder Infection □ Dialysis □ Kidney Disease/Stones □ Incontinence

Neuropsychological: □ Alcohol Abuse □ Alzheimer Disease □ Anxiety □ Bipolar Disorder
□ Depression □ Epilepsy □ Prescription Drug Abuse □ Multiple Sclerosis
□ Seizures □ Dystrophy/CRPS □ Sleep Disorders □ Schizophrenia
□ PTSD □ Neuropathy □Reflex Sympathetic Peripheral □ Other _____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and details.

Abdominal Surgery: □ Gallbladder Removal □ Appendectomy □ Other_____

Female Surgeries: □ Cesarean Section □ Hysterectomy □ Laparoscopy □ Ovarian
□ Other_____

Spine/Back Surgery: □ Discectomy (levels)_____ □ Laminectomy _____ □ Spinal Fusion (levels)_____

Heart Surgery: □ Valve Replacement □ Heart Stent □ Aneurysm Repair
□ Angioplasty □ Other_____

Joint Surgery: □ Shoulder □ Hip Replacement □ Knee Replacement □ Other_____

Common Surgeries: □ Hemorrhoidectomy □ Hernia Repair □ Thyroidectomy □ Tonsillectomy
□Vascular Stent □Other_____

Family History

Mark all appropriate diagnosis as they pertain to your biological MOTHER AND FATHER only.

	Mother	Father		Mother	Father
Arthritis	□	□	Kidney Problems	□	□
Cancer	□	□	Liver Problems	□	□
Diabetes	□	□	Osteoporosis	□	□
Heart Disease	□	□	Rheumatoid Arthritis	□	□
High Blood Pressure	□	□	Seizures	□	□
High Cholesterol	□	□	Stroke	□	□

Other medical problems:_____

□ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY □ I AM ADOPTED (No medical history available)

Social History

Height:_____ Weight:_____

Work Status: □ Full Time □ Part Time □ Retired □ Off work since:_____ □ Disabled since:_____

□ Light Duty, restrictions:_____ Restricting Physician:_____

Living Situation: □ Alone □ With Spouse □ With Significant Other □ Other:_____

Number of people living in your household:_____

Are you capable of becoming pregnant? □ Yes □ No *If so*, are you currently pregnant? □ Yes □ No

Highest level of education obtained: □ Grammar School □ High School □ College □ Post-graduate

Alcohol Use: □ Daily □ Socially □ Never □ History of Alcoholism □ Current Alcoholism

Tobacco Use: □ Current User □ Former User □ Never Used

Illegal Drug Use: Currently Using:_____ Formerly Used:_____ □ Never

Are you currently using someone else's prescription medication? □ Yes □ No

Have you ever abused narcotic or prescription medication? □Yes □ No *If yes*, which?_____

Are there any substance abuse issues in your house? □ Yes □ No

Review of Symptoms

Mark the following symptoms that you currently suffer from (Non-Diagnosed Conditions)

Constitutional : □ Chills □ Abnormal Bleeding □ Easy Bruising □ Unexplained Weight Gain
□ Fatigue □ Low Sex Drive □ Excessive Swelling □ Unexplained Weight Loss
□ Tremors □ Night Sweats □ Excessive Thirst □ Difficulty Sleeping
□ Fevers □ Insomnia □ Swollen/Tender Lymph Nodes

Skin: □ Rashes □ Sores □ Blisters □ Change in Moles □ Discoloration

Head/Eyes/Ears/Nose/Throat: □ Nosebleeds □ Dental Problems □ Hearing Problems □ Sinus Problems
□ Recent Vision Changes □ Recurrent Sore Throats □ Ringing in the Ears □ Earaches

Respiratory: □ Cough □ Wheezing □ Pulmonary Embolism
□ Shortness of Breath on Exertion/Effort □ Shortness of Breath at Rest

Cardiovascular: □ Bleeding Disorder □ Chest Pain □ Deep Vein Thrombosis
□ Swelling in the Feet □ Shortness of Breath During Sleep

Gastrointestinal: □ Abdominal Cramps □ Acid Reflux □ Constipation □ Hernia □ Vomiting

Genitourinary: □ Blood in Urine □ Decreased Urine Flow/Frequency/Volume
□ Increased Urination Frequency □ Flank Pain □ Painful Urination

Musculoskeletal: □ Back Pain □ Joint Pain □ Joint Stiffness □ Joint Swelling
□ Muscle Spasms □ Neck Pain

Neurological: □ Dizziness □ Headaches □ Numbness/Tingling □ Tremors
□ Numbness /Pain Hand(s) □Instability When Walking □ Seizures

Psychiatric: □ Depressed Mood □ Feeling Anxious □ Stress Problems □ Suicidal Thoughts
□ Suicidal Planning □ Thoughts of Violence

Prior Pain Treatments

Mark all of the following treatments you have had prior to today's visit for your current complaints:

□ Acupuncture □ Chiropractic □ Pain Medications □ Physical Therapy □ Psych Therapy

□ Epidural Steroid Injection(s) □ Trigger Point Injections □ Joint Injections □ Nerve Blocks

□ Radiofrequency Ablation □ Spinal Cord Stimulator- □ Trial or □ Permanent

□ Vertebroplasty/Kyphoplasty-Level(s)_____

□ Pain Pump If yes, date implanted?_____ □ Spine Surgery If yes, when?_____

□ Other:_____

□ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

□ MRI of the _____ Date:_____ Facility:_____

□ X-ray of the _____ Date:_____ Facility:_____

□ CT Scan of the _____ Date:_____ Facility:_____

□ EMG/NCV study of the_____ Date:_____ Facility:_____

□ Other diagnostic testing:_____

□ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS

Allergies

Do you have any known drug allergies? □ Yes □ No

Medication Name

_____

_____

_____

_____

If so, please list all medications you are allergic to

Allergic Reaction Type

_____

_____

_____

_____

Topical Allergies: □ Iodine □ Latex □ Tape

Are you allergic to shellfish? □ Yes □ No

Current Medication

Please list ALL medications you are currently taking. Attach an additional sheet if necessary.

Medication Name	**Dose**	**Frequency**	**Medication Name**	**Dose**	**Frequency**

Please Indicate which (if any) of the following blood-thinners you are taking:

□ Aggrenox □ Coumadin/Warfarin □ Effient □ Lovenox □ Plavix □ Pletal

□ Pradaxa □ Prasugrel □ Ticlid □ Other_____