Pain Care Physicians

Thank you for choosing Pain Care Physicians, PA. We welcome you as a new patient to our practice. Please complete this packet in its entirety to ensure that we have all of the necessary information to treat you effectively.

www.PainCarePhysicians.com

PATIENT INFORMATION		
Patient Name: (Last) (First) (Middle Initial):		
Gender: ☐ Male ☐ Female	SSN:	DOB:
Marital status (circle): M S D W	Driver's License Number/State:	
Address:		Apt:
City:	State:	Zip:
Primary Phone Number:		

DEMOGRAPHIC INFORMATION
Ethnicity: Central American – Cuban – Dominican – Hispanic or Latino/Spanish – Latin American/Latin – Latino – Mexican – Not Hispanic or Latino – Puerto Rican – South American – Spaniard
Race: American Indian – Asian – Asian Indian – Black or African American – European – Filipino – Japanese – Korean – Native Hawaiian or Other Pacific Islander – White – Other
Language: English – Spanish – Other:

EMERGENCY CONTACT INFORMATION		
In case of emergency, please list someone who can be contacted.		
☐ (1) ( )	Relation:	home/work/cell/other
☐ (2) ( )	Relation:	home/work/cell/other
☐ (3) ( )	Relation:	home/work/cell/other

PREFERRED PHARMACY INFORMATION		
More information regarding pharmacy preference can be located in the Opioid Agreement (presented at consultation visit)		
Name:	Phone:	Fax:
Address:		

PREFERRED CLINIC LOCATION
☐ (1) 2315 W Ben White Blvd Austin, TX 78704
☐ (2) 1301 Wonder World Drive Suite 306 San Marcos, TX 78666
☐ (2) 3101 Hwy 71 E Suite 210 Bastrop, TX 78602

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Please read and initial the following stating that you understand and agree to abide by the terms of our policies

Assignment of Benefits

_____I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health/medical plans, to issue payment check(s) directly to Pain Care Physicians, PA for medical services rendered to myself and/or my dependents regardless of my insurance. In the event that I receive the insurance payment directly, I realize that I will be billed personally until this balance is paid in full.

Authorization to Release Information

_____I hereby authorize Pain Care Physicians, PA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims. I further understand that my insurance and/or third party payer may require a copayment or coinsurance that is to be paid on the date that services are rendered. I agree to pay all such charges incurred immediately upon presentation of a financial statement. A photocopy of this assignment is to be considered as valid as the original. This order will remain in effect until revoked in writing.

_____I have requested medical services from Pain Care Physicians on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

Consent to Treat

_____I consent to treatment at Pain Care Physicians, PA and understand that I am responsible for all charges incurred by me and all charges not allowed by my insurance company. I authorize release of any medical information to process my claims. I authorize payment of any assigned benefits to Pain Care Physicians, PA, Anand Joshi, MD, Bennjamin Fronk, MD, Jason Carroll, DO, and associates.

Financial Policy

_____I have read and understand the Patient Financial Policy of Pain Care Physicians, PA.

Notice of Privacy Practices

_____I have read and understand the Notice of Privacy Practices of Pain Care Physicians, PA.

Patient Signature: _____

Patient Name (printed):_____ Date: _____

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MEDICAL HISTORY
Referring Physician (name and phone number):
Primary Care Physician:
What is your main reason causing you to be referred for treatment?
Describe your symptoms in detail:
When and how your symptoms begin? Please describe in detail all the treatments you have had for this condition. Please write as much as possible in this space and attach additional pages if necessary.

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HEALTH SUMMARY
Are you allergic to shellfish? ☐ Yes ☐ No
List your medication allergies: ☐ No Known Allergies
List your non-medication allergies: ☐ No Known Allergies
Are you allergic to anesthesia or anesthetics? ☐ Yes ☐ No
Are you allergic to latex? ☐ Yes ☐ No
If you answered yes, what was your reaction?

Current Medications: Please list all medications that you have taken in the last 12 months.

Also list vitamins and supplements

Name:	Dose/Strength:	Frequency:	Last Taken:

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PAST MEDICAL HISTORY	
Please list major medical history in the following areas:	
Cardiovascular (i.e. high cholesterol, high blood pressure)	☐ None
Pulmonary (i.e. asthma, sleep apnea.)	☐ None
Gastrointestinal (i.e. acid reflux, IBS.)	☐ None
Renal/Genitourinary (i.e. renal stones, urinary tract infections.)	☐ None
Musculoskeletal/Connective Tissue (i.e. fractures, rheumatoid arthritis.)	☐ None
Endocrine (i.e diabetes, thyroid.)	☐ None
Neurological/Genetic (i.e. migraine headaches, seizures.)	☐ None
Hematologic (i.e. iron deficiency, blood disorders.)	☐ None
Immunology/Dermatology (i.e. chicken pox, sinusitis.)	☐ None
Cancers	☐ None
Psychiatric	☐ None
FEMALE PATIENTS ONLY	
☐ Please indicate if you are currently or planning to become pregnant.	

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SURGICAL HISTORY

Spine Surgery: Have you had spine surgery? ☐ Yes ☐ No

If yes, please list.

Other Surgeries: Please list any surgeries that you have had. (i.e. appendix, tonsils.)

PAST TREATMENT HISTORY- SPECIALISTS

List all previous pain management, chiropractor, physical therapists, neurosurgeon, orthopedic doctors you have seen in the last 5 years (name and phone number):

FAMILY HISTORY

Please list any and all major-medical history and disorders present in your family. Please list the medical condition and your relation to the person. Including anesthesia/anesthetic problems.

Condition	Relation

SOCIAL HISTORY

Alcohol: ☐ Never Current or past history of: Type of alcohol:	**Tobacco:** ☐ Never Current or past history of: Type of tobacco:
Quantity and frequency:	Quantity and frequency:

Substance Abuse: (Including marijuana) ☐ Never ☐ Would rather discuss with provider

Current or past history of:

Type of substances:

Quantity and frequency:

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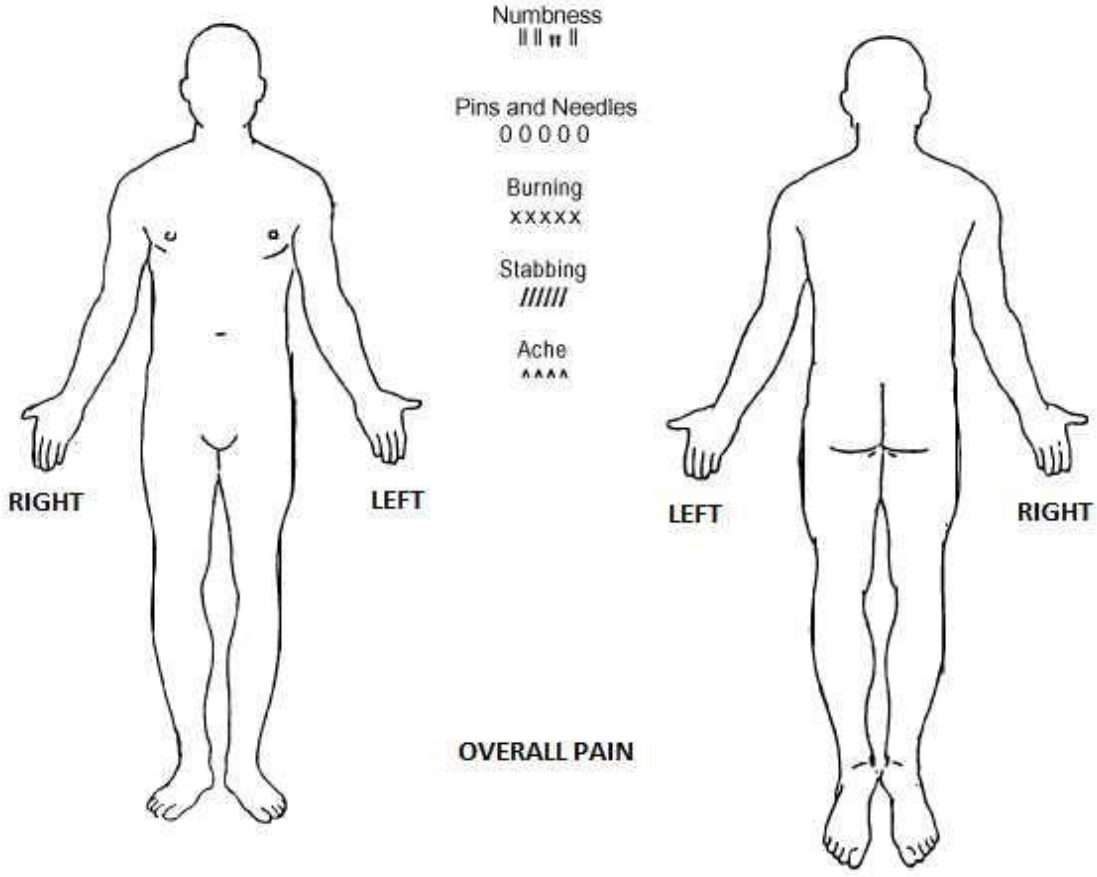
Pain Diagram Instructions: Mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc.). If you feel any of the following sensations, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.



WITH PAIN MEDICATION

(NO PAIN) 1-------2-------3-------4-------5-------6-------7-------8-------9-------10 (MOST PAIN)

WITHOUT PAIN MEDICATION

(NO PAIN) 1-------2-------3-------4-------5-------6-------7-------8-------9-------10 (MOST PAIN)

Current treatments or therapies: Please describe current treatments or therapies (include any exercise habits you may have, type, and frequency).
Please describe the character of any pain symptoms:
Please circle each word that applies to your symptoms: Unable to describe Constant – Intermittent Mild – Moderate – Severe Aching – Stabbing – Burning – Sharp – Cramping – Dull – Tearing – Throbbing – Electrical Tingling – Stiffness – Numbness – Weakness – Skin Sensitivity – Spasms

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Patient Name:_____ **Date of Birth:**_____

Review of Systems

Please review the below symptoms and **check** all that apply to your health status and specify further where indicated. If none of the symptoms listed apply to you, please select "none".

General Symptoms	☐ None	☐ Fatigue	☐ Fever	☐ Chills	☐ Recent Trauma
	☐ Unintentional Weight Loss/Gain		☐ Allergies/Hypersensitivities		☐ Lumps or Masses
	Specify or Other:				
Head & Neck	☐ None	☐ Eye Pain	☐ Facial Pain	☐ Glaucoma	☐ Blurry/Double Vision
	☐ Glasses	☐ Contacts	☐ Sensitivity or Pain to Light Exposure		
	Specify or Other:				
Cardio-vascular	☐ None	☐ Rapid or Irregular Heartbeat		☐ Leg or Foot Cramping or Swelling	
	☐ Shortness of Breath		☐ Loss of Consciousness (fainting)		
	Specify or Other:				
Pulmonary/ Respiratory	☐ None	☐ COPD	☐ Cough (Chronic or Acute)		☐ Sleep Apnea
	☐ Coughing up Blood/Sputum		☐ Difficulty Breathing/Wheezing		
	Specify or Other:				
Gastro-intestinal	☐ None	☐ Constipation	☐ Vomiting	☐ Nausea	☐ Abdominal Pain
	☐ Heartburn/Acid Reflux		☐ Black/Tarry Stool		☐ Blood in Stool
	Specify or Other:				
Genito-urinary	☐ None	☐ Current or Frequent UTI		☐ Difficulty or Painful Urination	
	☐ Increased or Decreased Urination			☐ Loss of Bladder Control	
	☐ Impotence	☐ Blood in Urine	☐ Kidney/Flank Pain		
	Specify or Other:				
Endocrine	☐ None	☐ Infertility	☐ Hair Loss	☐ Blood Sugar Abnormalities	
	☐ Intolerance to Heat or Cold		☐ Excessive Hunger or Thirst		
	Specify or Other:				
Neurology	☐ None	☐ Dizziness	☐ Numbness	☐ Headaches	☐ Slurring of Speech
	☐ Seizures	☐ Memory Loss	☐ Difficulty Walking		
	Specify or Other:				
Musculo-skeletal	☐ None	☐ Neck Pain	☐ Back Pain	☐ Loss in Range of Motion	
	☐ Muscle Aches/Stiffness		☐ Warmth or Redness to Joints or Muscles		
	☐ Joint Pain/Stiffness (indicate) -		☐ Hip/Knee	☐ Foot/Ankle	☐ Shoulder/Arm/Elbow
	Specify or Other:				
Hematology	☐ None	☐ Anemia	☐ History of Blood Transfusion		☐ Easy Bruising
	☐ Clotting Difficulties or Excessive/Easy Bleeding			Specify:	
Mental Health	☐ None	☐ Depression	☐ Confusion	☐ Stress	☐ Personality Change
	☐ Anxiety	☐ Poor Memory	☐ Poor Concentration		☐ Suicidal Thoughts
	☐ Mood Swings/Manic Episodes		☐ Substance Abuse		
	Specify or Other:				
Sleep Patterns	☐ None	☐ Inability to Complete Tasks		☐ Fogginess of Thought	
	☐ Daytime Sleepiness		☐ Inability to Sleep		
	Specify or Other;				
OB-GYN	☐ None	☐ Pregnant	☐ Date of Last Menstrual Cycle:		
	☐ Onset of Menopause		☐ Change in Menstrual Patterns		
	Specify or Other:				

MA INITALS_____

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Pain Care Physicians

Date:
Name:
DOB:

BRIEF NEW PATIENT QUESTIONNAIRE:

1. Please fill out a new patient packet from our website (www.paincarephysicians.com)
2. Have you seen a pain management doctor in the past 10 years?
    - If yes,
        i. What was the name of the doctor and practice? _____
        ii. Was your prior doctor board certified in Pain Management?
        iii. How satisfied were you with that doctor?
            1. Answer: (high/medium/low/none)
        iv. Reason for not returning _____
        v. Please obtain prior pain management treatment records for us.
3. Have you been prescribed a pain medication in the past five years?
    - If yes, please name the drug(s) which have been tried_____.

4. Please tell if you have an expectation that our practice would prescribe pain medications?
    - Answer: (high/medium/low/none)
    - If yes, do you have an idea which drug medication(s) work(s) best?
        i. _____.
        ii. _____.
    - If any of your pain medicines are controlled substances, how likely is the success of you being able to STOP the controlled substance medications within 90 days?
        i. Answer: (high/medium/low/none)

5. Please tell us how interested are you in getting steroid injections for pain?
    - Answer: (high / medium /low /none)
    - If yes, do you have an idea which injection works best?_____
6. Please tell us how interested are you in getting regenerative injections for pain? (ie prolotherapy, platelet rich plasma, stem cells, etc)
    - Answer: (high / medium /low /none)
    - If yes, do you have an idea which injection is most interesting?_____
7. Please tell us how interested are you in getting implantation procedures for pain? (ie spinal cord stimulator, occipital stimulator, morphine spinal pump, etc).
    - If yes, do you have an idea of which procedure would be most suitable? _____

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Contact Numbers

Patient Name: _____
DOB_____/_____/_____

When necessary for us to contact you regarding health information, please indicate (in order of preference) the phone numbers we may use. Please check yes or no, if we can leave a detailed voicemail with medical information.

1. _____ home/work/cell Voicemail? ☐ Yes ☐ No
2. _____ home/work/cell Voicemail? ☐ Yes ☐ No
3. _____ home/work/cell Voicemail? ☐ Yes ☐ No

HIPAA Privacy Authorization Form

I, hereby authorize Pain Care Physicians to release any and all medical information and test results that pertain to me, to the following individuals.

Name:_____Phone #:_____Relation:_____

Name:_____Phone #:_____Relation:_____

Name:_____Phone #:_____Relation:_____

I authorize Pain Care Physicians to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Pain Care Physicians in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____
Signature of Patient Date

Release for Correspondence of
Medical Information by Electronic Communication

"THI" NOTICE DE"CRIBE" HOW MEDICAL INFORMATION ABOUT YOU MAY BE U"ED AND DI"CLO"ED, AND HOW YOU CAN GET ACCE"" TO THE INFORMATION. PLEA"E READ CAREFULLY"

Patient Information:

Name:	
Address:	
Email Address:	
Cell Number:	

Purpose of this form:

Pain Care Physicians offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff. Secure messaging can be a valuable communication tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is, therefore, intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the secure Patient Portal works:

A secure web portal is a kind of web page that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site.

How to participate in our Patient Portal:

You can compose, pick up, and reply to secure messages or view information sent to you through a Web site hosted by our electronic records company. Once this form is agreed to and signed, we will send you an email notification that tells you how to register for the first time. This notification will give you the URL (Internet address) of the Web site where you can log in. By clicking on the URL you will activate your Internet browser, which will open the Web site. You will then be able to log in using the user name and password provided. Next you will be able to look in your "message box" and see any new or old messages or view other parts of your electronic record. Because the connection channel between your computer and the Web site uses "secure socket layer" technology, you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

You can view more clinic-specific information or access the portal through www.gotomyclinic.com/paincarephysicians.

Patient Initials_____

Protecting your private health information and risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission, however, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account; so that only you or someone you authorize can see the messages you receive from us.

If you pick up secure messages from a Web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the Web site and change it.

We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible and will never sell or give away any private information, including email addresses, without your written consent.

Conditions of participating in the Patient Portal:

Access to this secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate this service we will notify you as promptly as we reasonably can. You agree to not hold Pain Care Physicians or any of its staff liable for network infractions beyond their control.

Before you were given this form, we provided you with our Policy and Procedures for using this web portal. We need you to understand and comply with these, and by signing this form below you will acknowledge that they were explained to you and that you agree to comply with them. If you do not understand, or do not agree to comply with our Policy and Procedures, do not sign the form. If you have any questions we will gladly provide more information.

Encrypted Email Communication:

Pain Care Physicians offer encrypted email communication as a service to patients who wish to receive their medical records via secure email. Please initial if you would like to receive encrypted emails

Patient Acknowledgement:

I hereby agree to allow Pain Care Physicians to correspond by any electronic communication to provide health-related benefits and services that may be of interest to the above listed individual. **At any time the above individual with written authorization may revoke such authorization.**

Signature _____

Date _____

Release of Medical Information

Please release and forward the following information to Pain Care Physicians

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Patient Name:_____ DOB: _____

(Custodian of Medical Records)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

I hereby authorize the above mentioned party to provide and obtain a copy, summary, or narrative of my medical records and release the following confidential information including HIV, psychiatric, and drug rehabilitation if applicable:

☐ Complete Record
☐ Information on the following dates:
_____ to _____
☐ Other: _____
☐ Records concerning the following condition:
_____

Reason for this request:

☐ Continuing Medical Care
☐ Changing Doctor Care
☐ Other:_____

I, as the undersigned patient, understand that the requested medical facility will provide this information within 15 business days from the receipt of this request and that a fee for preparing and furnishing this information may be charged to the patient according to rulings set forth by the Texas State Board of Medical Examiners.

This release will stay in effect until it has been revoked in writing.

Patient Signature:_____ Date: _____