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.

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:	
Mailing Address:		Apt:
City:	State:	Zip:
Referring Physician Name:		Phone Number:

DEMOGRAPHIC INFORMATION

Ethnicity: Hispanic or Latino/Spanish – Not Hispanic or Latino

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:

CONTACT INFORMATION

When necessary for us to contact you regarding health information, please indicate (in order of preference) the phone numbers we may use. Please place a checkmark next to your preferred number for our automated appointment reminder calls.

☐ (1) ( ) home/work/cell/other

☐ (2) ( ) home/work/cell/other

☐ (3) ( ) home/work/cell/other

☐ Check here to authorize the PCP staff to leave detailed voicemails regarding plan of care and test results.

PROTECTED HEALTH INFORMATION

We are only allowed to discuss your protected health information (which includes billing information) with persons in whom you give us permission. May we discuss your protected health information with any person other than yourself? **Please place a checkmark next to your emergency contact**

☐ Yes ☐ No If yes, please provide his/her information below

☐ Contact:	Relationship:	Phone Number:
☐ Contact:	Relationship:	Phone Number:
☐ Contact:	Relationship:	Phone Number:

PREFERRED PHARMACY INFORMATION

More information regarding pharmacy preference can be located in the Opioid Agreement (presented at consultation visit)

Name:	Phone:	Fax:
Address:		

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MEDICAL INSURANCE INFORMATION	
Primary Insurance:	Effective Date:
ID Number:	Group Number:
Secondary Insurance:	Effective Date:
Insured's ID Number:	Group Number:

Are you covered under the policy of a spouse, partner, parent, or legal guardian?

☐ Yes ☐ No (if no, please skip this section)

Name: (Last)	(First)	(Middle Initial)
SSN:	DOB:	
Phone: (home)	(work)	(cell)
Address:		Apt:
City:	State:	Zip:

Workers' Compensation

Is your visit related to a condition that you claim is a result from a Work Related Injury?

☐ Yes (If yes, please complete the following) ☐ No (if no, please skip this section)

DOI (date of injury):	Claim Number:
Workers' Compensation Carrier Name:	
Address:	

City:	State:	Zip:
Adjuster Name:	Phone:	Fax:
Employer:		
Contact:	Phone :	Zip:
Address:		
City:	State:	Zip:

Is your visit related to a condition that you claim is a result from a Motor Vehicle Accident?

☐ Yes ☐ No (if no, please skip this section)

Date of Accident:

Do you have attorney representation for your Workers' Compensation or Motor Vehicle Accident claim?

☐ Yes ☐ No (if no, please skip this section)

Attorney Name:	Phone:	Fax:

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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, Avinash Ramchandani, MD, 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:	
List all previous PAIN MANAGEMENT doctors you have seen in the last 5 years (name and phone number):	
Please list all specialists you have seen (name and phone number, if known)	
Name:	Phone (if known)
Name:	Phone (if known)
Name:	Phone (if known)
Name:	Phone (if known)
What is your main reason causing you to be referred for treatment?	
Describe your symptoms in detail:	
When did your symptoms begin?	
How did your symptoms occur? ☐ Gradually ☐ Suddenly	
Is your condition related to:	
Illness? ☐ Yes ☐ No	Employment? ☐ Yes ☐ No
Auto Accident? ☐ Yes ☐ No	Other Accident? ☐ Yes ☐ No
Do you have an idea of what DIRECTLY CAUSED these symptoms to occur?	

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HEALTH SUMMARY	
Allergies:	☐ No Known Allergies
Please list all known allergies (medications, foods, environmental, etc.):	
Are you allergic to iodine, shellfish, or contrast dye? ☐ Yes ☐ No	

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

Also list vitamins and supplements

Name:	Dose:	Duration:	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 all spine surgeries and dates that you have had surgery.

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

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.

Condition	Relation

SOCIAL HISTORY

Marital Status

Please check all that apply to you.

- ☐ Single
- ☐ Married
- ☐ Married (Common Law)
- ☐ Separated
- ☐ Divorced
- ☐ Divorced & Remarried
- ☐ Widowed
- ☐ Widowed & Remarried
- ☐ Other:

Alcohol: ☐ Never

Current or past history of:

Type of alcohol:

Quantity:

Frequency:

Tobacco: ☐ Nonsmoker

Current or past use of:

Type of tobacco:

Number of Children: Please list how many children including step-children.

Quantity:

Frequency:

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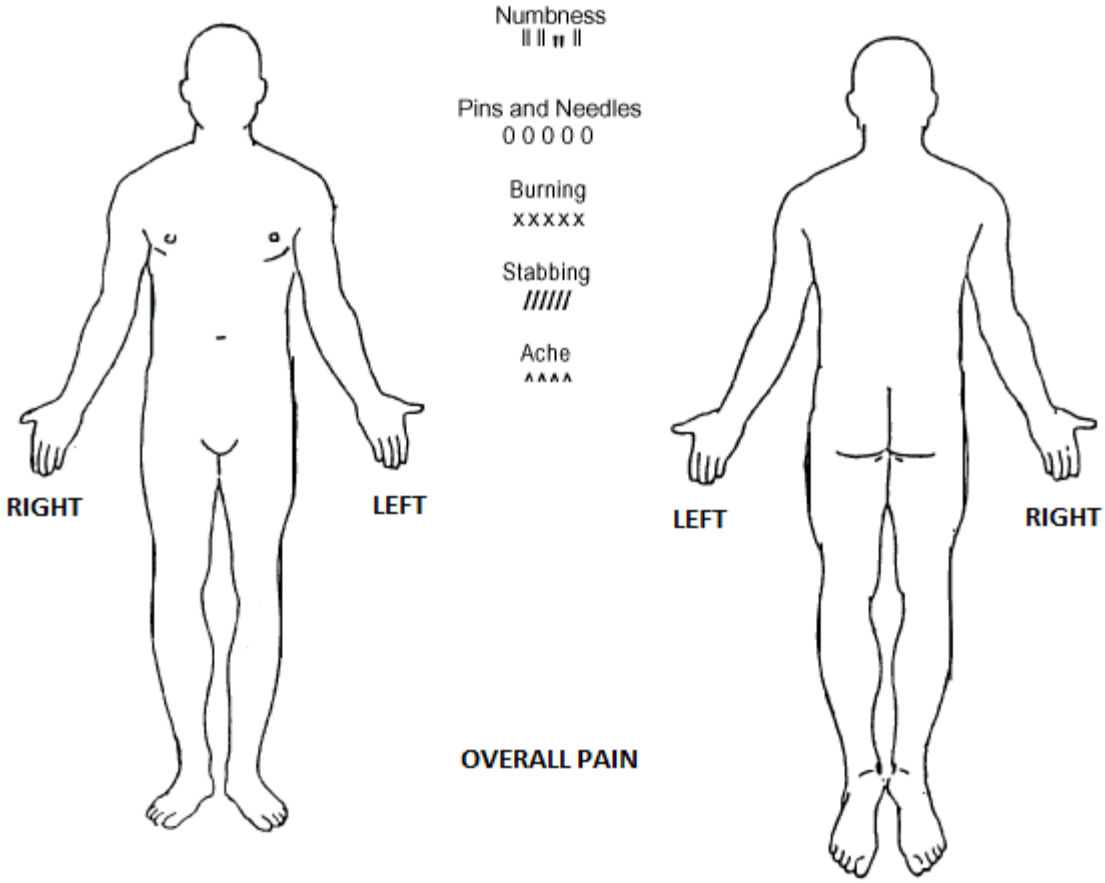
Pain Diagram Instructions: Mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc.). If you feel any of the following sensations, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected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