NEW PATIENT INTAKE FORM

DATE: _____

NAME: _____DATE OF BIRTH: _____

SOCIAL SECURITY #:_____

ADDRESS: _____

CITY: _____STATE:_____ZIP CODE: _____

HOME PHONE #: _____ WORK PHONE #:_____ CELL#:_____

EMAIL: _____

WEIGHT: _____ HEIGHT: _____

REFERRING PHYSICAN: _____

PAST MEDICAL HISTORY:

KIDNEY STONES AIDS OR HIV LIVER DISEASE ANEMIA STROKE GOUT

EMPHYSEMA CANCER SHINGLES ARTHRITIS (RHEUMATOID OR OSTEOARTHRITIS)

DEPRESSION INSOMNIA DIABETES HEADACHES/MIGRAINES ASTHMA

HEART DISEASE/ ATTACK HEPATITIS (A, B, C, D) HIGH BLOOD PRESSURE LUPUS

PROSTATE ENLARGEMENT TUBERCULOSIS PANIC ATTACKS KIDNEY DISEASE

PERIPHERAL VASCULAR DISEASE HYPOTHYROIDISM SEIZURES FIBROMYALGIA

SCHIZOPHRENIA OR BIPOLAR BLEEDING DISORDER OTHER: _____

PAST SURGICAL HISTORY:

- _____
- _____
- _____
- _____
- _____
- _____

SOCIAL HISTORY:

OCCUPATION: _____

DO YOU SMOKE? YES □ NO □ HOW MANY PACK/DAY? _____YEARS? _____

DRINK ALCOHOL? YES □ NO □ IF YES, HOW MUCH? _____

DO YOU USE ANY OTHER DRUGS (MARIJUANA, COCAINE, ETC.?) YES □ NO □

IF YES PLEASE NAME: _____

MARITAL STATUS? □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED

DO YOU LIVE ALONE? YES □ NO □ IF NO, WHO DO YOU LIVE WITH? _____

FAMILY HISTORY:

Please list any diseases, illness, or aliments in you IMMEDIATE family. (I.e. mother- breast cancer, father –diabetic, grandfather –heart disease)

- _____
- _____
- _____
- _____
- _____
- _____

CURRENT MEDICATIONS:

- _____
- _____
- _____
- _____
- _____
- _____
- _____

ALLERGIES:

- _____
- _____

REVIEW OF SYSTEMS:

ARE YOU CURRENTLY EXPERIENCING *ANY* OF THE FOLLOWING SYMPTOMS?

GENERAL:

LOSS OF APPETITE ……YES ☐ NO ☐
FEVER OR CHILLS ……YES NO
RECENT WEIGHT LOSS…….YES ☐ NO ☐
LOW ENERGY/FATIGUE……YES ☐ NO ☐

ENDOCRINE:

THYROID DISEASE ……..YES ☐ NO☐
HEAT/COLD INTOLERANCE ……YES ☐ NO ☐

CARDIOVASCULAR:

CHEST PAIN ……..YES ☐ NO☐
LEG SWELLING ……..YES ☐ NO☐
PALPITATIONS……YES ☐ NO ☐
ORTHOPNEA……YES ☐ NO ☐

RESPIRATORY:

SHORTNESS OF BREATH …….YES ☐ NO☐
WHEEZING ……YES ☐ NO☐
CHRONIC COUGH……YES ☐ NO ☐

EYES:

BLURRED VISION……YES ☐ NO☐
LOSS OF VISION……..YES ☐ NO☐
DOUBLE VISION……YES ☐ NO ☐
EYE PAIN……..YES ☐ NO ☐

KIDNEY/BLADDER/URINE:

PAINFUL URINATION……YES ☐ NO☐
FREQUENT URINATION ……YES ☐ NO☐
BLOOD IN URINE……YES ☐ NO ☐

SKIN:

RASH……YES ☐ NO☐
FREQUENT RASH ……YES ☐ NO☐
ITCHING……YES ☐ NO ☐

GASTROINTESTINAL:

NAUSEA OR VOMITING ……YES ☐ NO☐
BLOOD IN STOOL ……..YES ☐ NO☐
HEARTBURN…… YES ☐ NO ☐
CONSTIPATION…… YES ☐ NO ☐

HEAD/EARS/NOSE/THROAT:

HOARSENESS……YES ☐ NO☐
TROUBLE SWALLOWING…….YES ☐ NO☐
HEARING LOSS……YES ☐ NO ☐
EAR PAIN……YES ☐ NO ☐

NEUROLOGICAL:

TREMORS……YES ☐ NO☐
TINGLING……YES ☐ NO ☐
DIZZINESS……..YES ☐ NO ☐
SEIZURES……YES ☐ NO ☐

PSYCHIATRIC:

DEPRESSION……YES □ NO □ SUICIDAL THOUGHTS……..YES □ NO □

DRUG/ALCOHOL ADDICTION…….YES □ NO □ TROUBLE SLEEPING (INSOMNIA)……YES □ NO □

HEMATOLOGICAL/LYMPHATIC:

EASY BRUISING……..YES □ NO □ EASY BLEEDING……..YES □ NO □

IS THERE AN ONGOING LAWSUIT RELATED TO YOUR VISIT TODAY? YES □ NO □

ARE YOU CURRENTLY UNDER WORKERS' COMPENSATION? YES □ NO □

ARE YOU APPLYING TO BE ON DISABILITY? YES □ NO □

ARE YOU CURRENTLY ON DISABILITY? YES □ NO □

LOCATION OF YOUR PAIN: _____

WHEN DID IT START? : _____

WHAT HAPPENED AND WHEN? (CAR ACCIDENT, FALL, NOTHING, ETC.):

_____

_____

IS YOUR PAIN CONSTANT, OR COMES AND GOES? :_____

FROM A SCALE OF 0 TO 10 (0=NO PAIN AND 10=SEVERE PAIN), HOW BAD IS YOUR PAIN TODAY?

_____

OVER THE PAST 30 DAYS WHAT WAS YOUR AVERAGE PAIN SCORE?_____

WHERE DOES YOUR PAIN START? _____

WHERE DOES IT TRAVEL TO? _____

QUALITY OF YOUR PAIN (CHECK ALL THAT APPLY)

NUMBNESS □ PINS & NEEDLES □ BURNING □ ACHING □ STABBING □ SHOOTING □

WHAT **AGGRAVATES** YOUR PAIN? (CHECK ALL THAT APPLY)

SITTING □ BENDING □ WALKING □ LYING DOWN □ LEANING FORWARD/BACK □

COUGHING/SNEEZING CLIMBING UPSTAIRS □ GOING DOWNSTAIRS □

WHAT **RELIEVES** YOUR PAIN? (CHECK ALL THAT APPLY)

SITTING □ BENDING □ WALKING □ LYING DOWN □ LEANING FORWARD/BACK □

STRETCHING □ REST □ HEAT □ COLD □ MEDICATION □

IF MEDICATION, WHICH ONES? _____

WHAT **TREATMENTS** HAVE YOU TRIED? (CHECK ALL THAT APPLY):

PHYSICAL THERAPY □ CHIROPRACTOR □ TENS UNIT □ INJECTIONS □

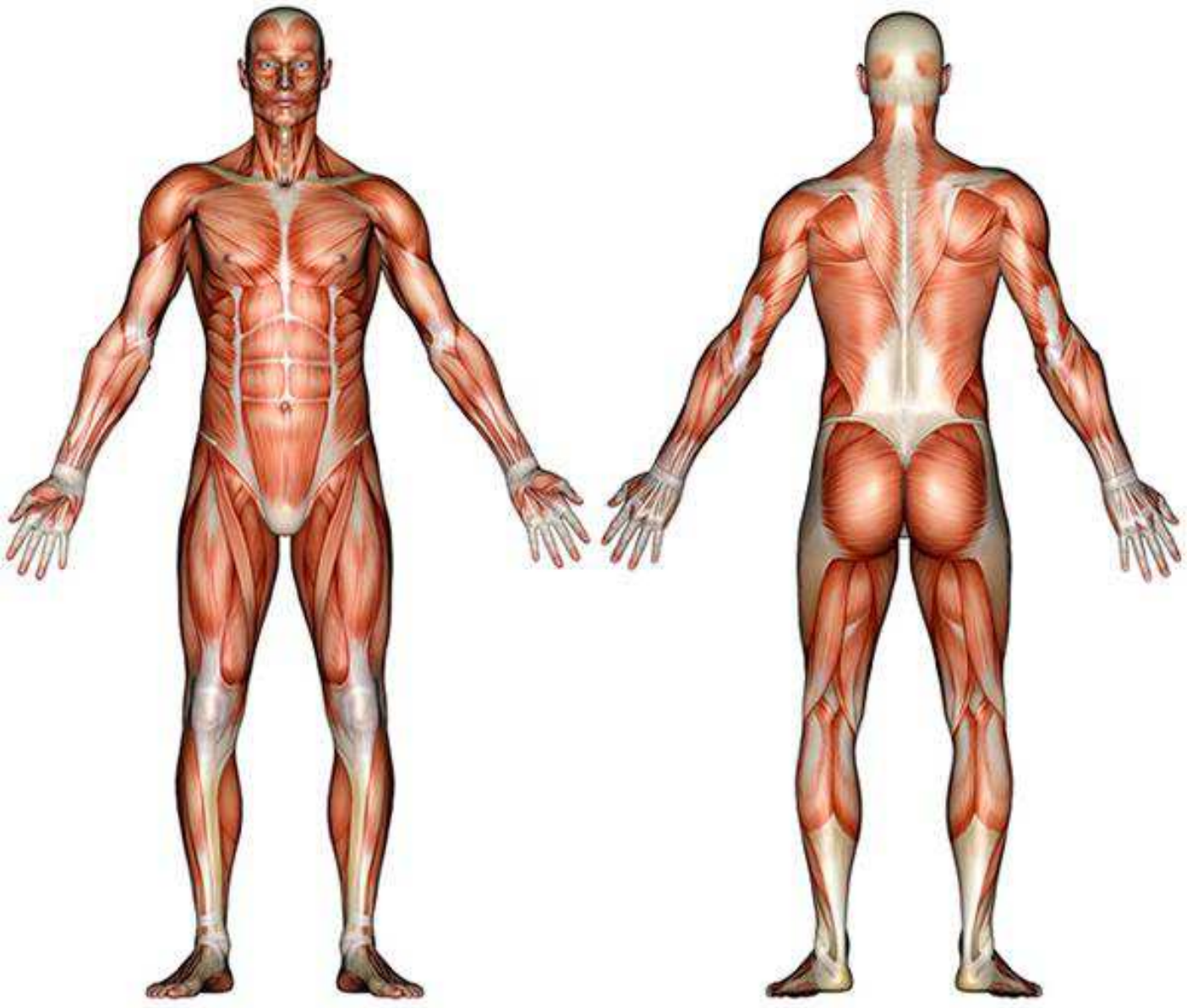
MASSAGE THERAPY □ IBUPROFEN/ALEVE/MOTRIN □

OVER THE COUNTER OINTMENTS (BEN GAY, ICY-HOT, MYOFLEX) □

DID ANY OF THE ABOVE TREATMENTS HELP? IF SO, WHICH ONES?

_____

_____



FRONT **BACK**

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
----------	oooooooooo	^^^^^^^	XXXXXXXXX	ϕϕϕϕϕϕϕϕϕ

USING THE APPROPRIATE SYMBOL, MARK THE AREA(S) ON YOUR BODY WHERE YOU FEEL EACH OF THE SENSATIONS ABOVE.

ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to: Interventional Pain Management, for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment, except in instances where No-Fault or Workers' Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from obligation to pay professional fees.

A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____

Patient Signature Date

APPOINTMENT POLICY

In effort to provide efficient treatment to all of our patients, it is the policy of this company that if you are unable to make your scheduled appointment , you must call to cancel the appointment no later than 24 hours before the scheduled time. If you fail to cancel your appointment or fail to show up to your appointment, you will be charged a "NO SHOW" fee of $30.00 per occurrence. For most insurance plans and Workers' Compensation carriers "NO SHOW" charges are a non-covered service. You will be solely responsible for payment of this charge. Repeated "NO SHOWS" and cancellations of your scheduled appointments may result in you being DISCHARGED from care at Interventional Pain Management.

If you arrive **15 minutes late** after your scheduled appointment, your appointment will be rescheduled for the next available appointment. If you have any questions regarding this form, please speak to our staff before signing.

_____ _____

Patient Signature Date

TRI-CITY PAIN ASSOCIATES

Assignment of Benefits/ Medicare Lifetime Signature:

I hereby authorize payment directly to the physician of the surgical or medical benefits, if any, for his services, I realize I am responsible for non-covered services, co-payments and deductibles. I also understand that this assignment does not relieve my liability on these services, I request payment of authorized Medicare Benefits be made on my behalf to Interventional Pain Management, P.A. for any service furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

_____ _____

Patient Signature Date

Release of information:

I hereby authorize the physician to release information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company/companies.

_____ _____

Patient Signature Date

Consent for Treatment:

_____, the patient and/or legal guardian of said patient do hereby give my consent for medical examination and treatment under the care of the practice and deemed necessary.

_____ _____

Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practice:

I have received a copy of this offices' Notice of Privacy Practice.

_____ _____

Patient Signature Date

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

In accordance with the HIPPA law it is required that you provide our office with the name of any person you want your personal office records released to in paper, over the phone, by fax or via email. This does not include other healthcare providers you see. I hereby give permission for the following mentioned persons to obtain information in regards to my medical records at Tri-City Pain Associates.

Name and Birthdate: _____

Relationship to Patient: _____

Telephone Number: _____

Name and Birthdate: _____

Relationship to Patient: _____

Telephone Number: _____

Name and Birthdate: _____

Relationship to Patient: _____

Telephone Number: _____

Name and Birthdate: _____

Relationship to Patient: _____

Telephone Number: _____

Name and Birthdate: _____

Relationship to Patient: _____

Telephone Number: _____

TRI-CITY PAIN ASSOCIATES MEDICATION AGREEMENT

I _____ am entering into contract with Interventional Pain Management /Tri-City Pain Associates and their doctors – **Dr. Urfan Dar M.D., Dr. Sridhar Vasireddy M.D., Dr. Kanishka Monis M.D., Dr. Raheel Bengali M.D. ,Dr. Isaac Tong M.D., Dr. David J. Kim M.D., Dr. Joysrees Subramanian M.D., Dr. Joshua Shroll M.D., Dr. Jeremy Epstein M.D., Dr. Gary Kao M.D., Christopher Watson P.A-C, Howard Kagan P.A-C**, **Mustafa Monis P.A-C, Luis Trevino P.A-C**. regarding the prescription of chronic narcotics for my pain. I understand that if I break this agreement all narcotic therapy may be discontinued.

I agree to the following:

1. All controlled substances must come from the physician who is assigned to your care, or during his or her absence, by covering provider, unless specific authorization is obtained for an exception. You are **not** to receive **any** prescriptions for narcotics or sedative drugs from any other provider.

2. The prescribing provider has permission to discuss all diagnostic and treatment detail with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

3. All controlled substances must be obtained at the same pharmacy, where possible. Should the need to arise to change pharmacies, our office must be informed. The pharmacy you have selected is :

   Pharmacy Name: _____ Pharmacy #: _____

4. Unannounced urine or serum toxicology screens will be requested, and your cooperation is REQUIRED. Presence of unauthorized substances may prompt termination of your opioid treatment and referral for assessment for addictive behavior.

5. Refills will occur on a monthly basis and **ONLY** after a visit and physical examination. **NO REFILLS WILL BE MADE OVER THE TELEPHONE. NO REFILLS WILL BE GIVEN AFTER HOURS, ON WEEKENDS, OR HOLIDAYS.** Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

6. If refill requests are made after hours, you will be instructed by the answering service to go to an emergency room of your choice.

7. You are expected to inform our office of any new medications, or medical conditions, and of any adverse effects you experienced from any medications that you take.

8. Prescriptions may be issued early if the physician or patient will be out of town when refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date. There will be NO early refills or pre-dated prescriptions.

9. Any evidence of prescription, forged prescriptions, substance abuse, or aberrant behavior (including verbal abuse to our office staff) will result in termination of patient –physician relationship.

10. Medications will not be replaced if they are lost, stolen, destroyed, left on airplane, etc. It is YOUR responsibility to protect your medications.

11. Prescriptions are to be used **ONLY** as written. Use of increased amount of medication without consultation with a physician will not be allowed.

12. You may **NOT** share, sell, or otherwise permit others to have access to these medications.

13. Originals containers of medication should be brought to each office visit.

14. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

15. Termination terms will include a written letter to you and fulfillment of your medical needs, one month after the date of termination.

16. PLEASE ALLOW 48 HOURS FOR MEDICATION REFILLS.

17. Due to overwhelming phone calls for prescription refills, if you call Interventional Pain Management/Tri-City Pain Associates for medication refills you are allowed one phone call per day, if you call multiple times a day, you will be charged a $5 fee per call.

Your pain is **YOUR** responsibility. Making appointments for medication refills is **YOUR** responsibility. Tri-City Pain Associates will provide medical support in your quest to minimize your pain. You must make new efforts to improve sleep habits, nutrition, body weight, conditioning and psychological state. Narcotics are **not** the answer to chronic pain, but can be used to effectively to improve your pain.

I _____ have read and accept the conditions of this contract.

_____ _____

Patient Signature **Date**