DESERT PAIN SPECIALISTS
Interventional Spine Care

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: _____ Sex: ☑ Male ☐ Female

Mailing Address: _____ Date of Birth: _____ /_____ /_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Social Sec. # _____

Email: _____ Marital Status (Select one): Single Married Divorced Separated Widowed

Race: ☐ American Indian ☐ African American ☐ White ☐ Other: _____

Ethnicity: ☐ Non Hispanic or Latino ☐ Hispanic or Latino ☐ Decline

Preferred Communications: ☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email

***Referring and/or Primary Care Physician (REQUIRED): _____

EMERGENCY CONTACT *REQUIRED*

Name: _____ Phone #: _____ Relationship: _____

RESPONSIBLE PARTY INFORMATION * Minors or Power of Attorney only

Name: _____ Relationship to Patient: _____

Date of Birth: _____ /_____ /_____ Primary Phone: _____ Social Sec. # _____

INSURANCE INFORMATION *Insurance cards must be provided at time of visit*

Primary Insurance: _____ Policy Holder: _____ Date of birth: _____

Secondary Insurance: _____ Policy Holder: _____ Date of birth: _____

Is your pain related to: ☐ Worker's Comp ☐ Auto Accident **Date of injury:** _____

Authorization to release health information to: (Example: Spouse/Partner, Parent, Child)

Name(s): _____ **Relation to patient:** _____

Release the following information: ☐ All Records ☐ Chart notes ☐ Financial Information

Dates of service: ☐ All or ☐ From: _____ To: _____ Authorization expires: ☐ Never or ☐ Date: _____

_____ _____

Signature of patient or legal representative Date

DESERT PAIN SPECIALISTS
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Policy, Authorizations and Financial Agreement

Patient Name:_____

AUTHORIZATION AND CONSENT:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH) and Omnibus Rule. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out any and all of the following:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
2. Obtaining payment from third party payers (e.g., my insurance company);
3. The day-to-day healthcare operations of Desert Pain Specialists.
4. Any other non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits for me and/or my dependent(s).

I have also been informed of and given the right to review and secure a copy of your Notice or Privacy Practices, which contains a more complete description of uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I certify that I understand the privacy risks of mail, email and phone calls. I hereby authorize a Desert Pain Specialists representative or my physician to mail, email or call me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to this requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I have the right to revoke this consent at any time by notifying Desert Pain Specialists to that effect in writing. However, if you do agree, you are then bound to comply with this restriction.

I hereby consent to evaluation, testing and treatment (including but not limited to, medication history, use of x-ray and other non-invasive procedures such as diagnostic testing) to be performed as directed by my Desert Pain Specialists physician or his or her designee. I realize that if a medical procedure is required, I will be given additional information.

FINANCIAL AGREEMENT:

I hereby authorize direct payment of my insurance benefits to Desert Pain Specialists, or the physician individually, for services rendered to me or my dependents by the physician or under his/her supervision and agree to pay any balance that is due. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit.

I understand that I may receive a separate bill if my medical care includes lab, x-ray and/or other diagnostic services. I understand and agree that I will be financially responsible for any co-pay or balance due that Desert Pain Specialists is unable to collect from my insurance carrier for whatever reason. I understand that I will be responsible for any additional fees incurred from the following:

• Returned Checks • Missed Appointments • Copies of Medical Records • Non-payment of co-pays/deductibles at time of service

In the event any balance is not paid as agreed upon and/or my account is referred to a collection agency, I agree to pay all collection fees. I further agree to pay court costs and reasonable attorney's fees in addition to the collection fee. I hereby authorize the facility, Desert Pain Specialists, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, mobile/cellular, wireless or similar devices for any lawful purpose. I agree to pay any fee(s) and/or charge(s) that I may incur for incoming calls from collectors, and/or outgoing calls to collectors, to or from any such number and understand I will not be reimbursed.

APPOINTMENT POLICY:

Because your appointment has been reserved for you and/or your family member(s), you are required to provide at least 24 hours advanced notice if you are unable to keep your scheduled appointment. This allows us to offer another patient that time spot and prevents a cancellation fee from being applied to your account. The No Show fee for all appointments is $50.00. It is important to note that our No Show fees are not payable by your insurance carrier(s) and will be your responsibility. Repeated missed appointments may result in termination of your physician's care. There may be a time when your physician may need to cancel your appointment for an emergency; we will make every effort to reschedule you in an appropriate time frame.

PRESCRIPTION REFILL REQUESTS:

With any long-term medications, we require regular office visits. We request a 48 hour notice if you are requesting a refill to be called into your pharmacy.

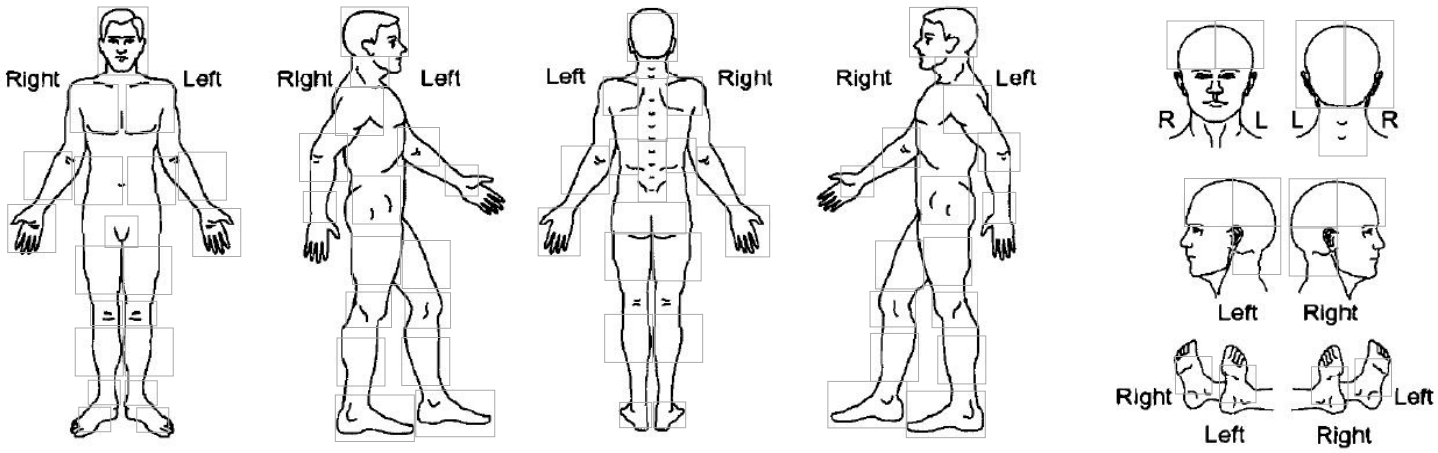
By signing the line below you are stating that you have read and agree to all portions of this contract.

_____ _____

Signature of patient or patient's representative Date

PAIN DIAGRAM

Please use the diagram below to indicate the area of your pain. Put an "X" on the area that hurts the most.



PAIN HISTORY

Chief Complaint (Reason for your visit): _____ Height: _____ Weight: _____

Briefly describe under what circumstances your pain first began: _____

_____

PAIN DESCRIPTION

How long has your current pain problem existed? _____Years _____Months _____Weeks _____Days

How did your current pain problem begin? ☐ Gradually ☐ Suddenly

Does your pain radiate? ☐ Yes ☐ No If yes, where? _____

Since your pain began, how has it changed ☐ Improved ☐ Worsened ☐ Stayed the same

How often does your pain occur? ☐ Constantly (100 % of the time) ☐ Frequently (75 % of the time)
☐ Intermittently (50 % of the time) ☐ Occasionally (25 % of the time)

What time of day is your pain at its **WORST**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

What time of day is your pain at its **BEST**? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

If "0" is no pain and "10" is the most severe pain imaginable, how would you rate your pain?
Right now: _____ At its worst: _____ At its best: _____

How would you describe your pain (choose as many adjectives as apply)?

☐ Aching	☐ Deep	☐ Shooting	☐ Tightness
☐ Burning	☐ Dull	☐ Stabbing	☐ Tingling
☐ Cramping	☐ Sharp	☐ Throbbing	☐ Other: _____

Has your pain been associated with any of the following factors?

☐ Bladder/Bowel dysfunction	☐ Instability	☐ Rash
☐ Chills	☐ Muscle weakness	☐ Redness
☐ Fever	☐ Numbness	☐ Stiffness

Which of the following factors seem to aggravate your pain?

☐ Bending	☐ Lifting	☐ Sneezing	☐ Twisting
☐ Coughing	☐ Pulling	☐ Standing	☐ Walking
☐ Driving	☐ Pushing	☐ Stress	☐ Weather
☐ Exercise	☐ Sitting	☐ Touch	☐ Other: _____

Which of the following factors help alleviate your pain?

- ☐ Exercise
- ☐ Heat
- ☐ Ice
- ☐ Lying down
- ☐ Meditation
- ☐ Position change
- ☐ Relaxation
- ☐ Sitting
- ☐ Standing
- ☐ Stretching
- ☐ Walking
- ☐ Other: _____

What areas of your life have been affected by your pain?

- ☐ Appetite
- ☐ Finances
- ☐ Intimacy
- ☐ Mood
- ☐ Personal care
- ☐ Physical activity
- ☐ Relationships
- ☐ Sleep
- ☐ Travel
- ☐ Work
- ☐ Other: _____

Which of the following treatments have you tried for your current pain?

	Approximate Date	Excellent Relief	Moderate Relief	No Relief
☐ Anti-Inflammatory/NSAIDS				
☐ Back Brace				
☐ Chiropractic care				
☐ Heat/Ice				
☐ Epidural / Radiofrequency Injections				
☐ Pain Medication				
☐ Physical Therapy				
☐ Surgery				
☐ Other				

DIAGNOSTIC TESTS AND IMAGING

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

- ☐ **MRI** of the: _____
- ☐ **CT** scan of the: _____
- ☐ **X-ray** of the: _____
- ☐ **EMG/NCV:**_____

MEDICAL HISTORY

Do you have a history of <u>any</u> of the following?

- ☐ Alcohol abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding problems
- ☐ CAD coronary artery disease
- ☐ Cancer
- ☐ Chest pain
- ☐ CHF congestive heart failure
- ☐ Depression
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hypertenstion
- ☐ HIV or AIDS
- ☐ Infection problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Shortness of breath
- ☐ NONE of the problems listed
- ☐ Other: _____

ALLERGIES

Have you ever had an allergic reaction to any of the following?

☐ Adhesive tape ☐ Anesthesia ☐ Aspirin ☐ Latex ☐ Contrast Dye ☐ Other: _____

Do you have any history of medication allergies?

☐ No known allergies ☐ Yes, please specify: _____

SURGICAL HISTORY *Specific to your current pain

Type of Surgery	Approximate Year/Date

FAMILY HISTORY

Is there a history of any of the following in your **immediate family**?

- ☐ Anesthesia problems
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Headache/Migraines
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Substance abuse
- ☐ Other:

SOCIAL HISTORY

Occupation/previous occupation: _____ ☐ Retired ☐ Disabled

Do you use tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never

Have you ever had a history of substance abuse? ☐ Yes ☐ No

PRESENT MEDICATIONS

Are you currently taking any blood thinners or anti-coagulants? ☐ Yes ☐ No

If YES, which ones? ☐ Aspirin ☐ Coumadin ☐ Eliquis ☐ Lovenox ☐ Plavix ☐ Pradaxa ☐ Other: _____

Please list all prescription, OTC, herbal and/or vitamin (nutritional) supplements you are currently taking.

Name of Medication, OTC, herbal and/or vitamin	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

REVIEW OF SYMPTOMS *Please mark any signs or symptoms that you are currently experiencing.

Constitutional
- ☐ Body aches
- ☐ Difficulty sleeping
- ☐ Fatigue
- ☐ Weight loss

Eyes
- ☐ Blurred vision
- ☐ Sensitivity to light
- ☐ Use of glasses/contacts

Head/Ears/Nose
- ☐ Difficulty hearing
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Vertigo

Cardiovascular
- ☐ Blood clots
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Swelling in feet or legs

Respiratory
- ☐ Asthma

Integumentary
- ☐ Rash

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bowel incontinence
- ☐ Constipation
- ☐ Nausea

Genitourinary
- ☐ Groin pain
- ☐ Painful urination
- ☐ Urinary incontinence

Neurological
- ☐ Dizziness
- ☐ Headaches/Migraines
- ☐ Numbness and tingling
- ☐ Seizures

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Neck pain

Endocrine
- ☐ Diabetes
- ☐ Increased fatigue

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts

Hematologic/Lymphatic
- ☐ Bleeding disorder
- ☐ Easy bruising
- ☐ Excessive bleeding