# Comprehensive Spine and Pain Management, LLC

**New patient personal and insurance in-take form**

**Personal information:**

Name_____Date_____
Address_____
City_____State_____Zip_____
Tel # (Home)_____(Cell)_____
E-mail_____
BirthDate_____Age_____Soc.Sec.#_____Gender_____
Ethnicity: please circle one

| | | |
|---|---|---|
| American Indian/Alaska Native | Asian | Black or African American |
| Native Hawaiian/other Pacific Islander | White | Decline to specify |

Referred by_____ Primary Care Physician's name_____
Primary Care Physician's Tel#_____
Primary Care Physician's Fax#_____

EmergencyContact_____Relationship_____
EmergencyContactPhone (Home)_____(Cell)_____

Employment □Full-time -□Part-time -□Self-employed - □Student -□Unemployed -□Retired
Occupation: _____ Employer's Name: _____

**Billing and Insurance Account paid by:**

Primary Insurance Company: _____Tel#:_____
PolicyHolder'sName_____Relationship_____
Policy#/MemberID#_____Group#_____
Secondary Insurance Company: _____Tel#_____
Policy#/MemberID_____Group#_____

**If Auto or Worker Compensation fill**:

□Auto □Workmen's Comp
Insurance company name_____ Claim #_____
Adjuster's name_____ Phone #_____Fax #_____
Date of injury_____
Is this involving a law-suit?_____ Lawyer's name_____ Tel #_____

# INITIAL PATIENT HISTORY

Name:_____ Today's Date:_____

1. Why are you coming to us?_____
2. Who referred you or how did you hear about us?_____
3. Describe your PAIN: (write it out or circle the words)
   Where is it?_____
   How long have you had it?_____
   What caused it? Work related, car accident, unknown or_____
   Is it constant or occasional?
   Is it sharp, dull, stabbing, cramping?
   Does it shoot or radiate anywhere—such as into an arm or leg, right, left or both?
   How severe is the pain on a scale of 0 to 10? 0 is no pain and 10 is the most severe imaginable.
   What aggravates your pain?
   What helps relieve your pain?
   What treatments have you had?—physical therapy, injections or surgery?
   What diagnostic studies have you had in the past 2 years? MRI, Xrays, EMG
4. List your MEDICATIONS:_____
   _____
5. List your Medication ALLERGIES:_____
6. List your MEDICAL HISTORY: High blood pressure, Diabetes, heart disease, Breathing or any other
   _____
7. List all your SURGERIES:_____
   _____
8. List FAMILY ILLNESSES:_____
9. SOCIAL HISTORY: Are you a smoker/non-smoker; single/married/divorced; live alone/with family/with friend; education completed—grade school/high school/college/other_____
   unemployed/disabled/retired/employed—type of work_____
10. REVIEW OF SYSTEMS: (Please circle those that you are currently experiencing)
    General: Loss of appetite or Weight?
    Hematologic: Are you on a blood thinner or suffer your excessive bleeding?
    ENT: Difficulty swallowing or painful swallowing?
    Respiratory: Breathing problems or Cough?
    Breast: Breast pain or Nipple discharge?
    Cardiovascular: Chest pain, shortness of breath with lying flat, calf tightness with walking?
    Gastrointestinal: Abdominal pain, black or bloody stools?
    Genitourinary: Difficulty urinating or painful urination?
    Peripheral Vascular: Pain/tightness in calf with walking or ulceration of feet.
    Neurologic: Headache or Paralysis.
    Psychiatric: Denies Auditory/visual hallucinations.
    Endocrine: numbness in feet or excessive thirst?

## SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

| | |
|---|---|
| 1. How often do you have mood swings? | 0 1 2 3 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up? | 0 1 2 3 4 |
| 3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 1 2 3 4 |
| 4. How often have any of your close friends had a problem with alcohol or drugs? | 0 1 2 3 4 |
| 5. How often have others suggested that you have a drug or alcohol problem? | 0 1 2 3 4 |
| 6. How often have you attended an AA or NA meeting? | 0 1 2 3 4 |
| 7. How often have you taken medication other than the way that it was prescribed? | 0 1 2 3 4 |
| 8. How often have you been treated for an alcohol or drug problem? | 0 1 2 3 4 |
| 9. How often have your medications been lost or stolen? | 0 1 2 3 4 |
| 10. How often have others expressed concern over your use of medication? | 0 1 2 3 4 |
| 11. How often have you felt a craving for medication? | 0 1 2 3 4 |
| 12. How often have you been asked to give a urine screen for substance abuse? | 0 1 2 3 4 |
| 13. How often have you used illegal drugs (for example, Cocaine, etc.) in the past five years? | 0 1 2 3 4 |
| 14. How often, in your lifetime, have you had legal problems or been arrested? | 0 1 2 3 4 |

**Consent for Chronic Opiate Therapy**

Medications prescribed by our office may reduce your pain, improve your function and sleep but they could make you feel drowsy, dizzy and constipated. While tolerance and dependence may develop to these medications for many patients with prolonged treatment, addiction may develop in susceptible individuals. For males it may decrease sex drive due to decrease in testosterone levels. For females, if pregnant or intending to get pregnant, taking these medications may affect the growth and development of a fetus and may lead to withdrawal syndrome in the new born.

When we prescribe medications, you agree to:
1. Use only one pharmacy.
2. Bring medication bottles with remaining medications at the time of next refill or medication change.
3. Provide your urine sample for drug testing whenever requested.
4. Not drive or do any activities deemed dangerous to yourself or to others if you are feeling drowsy, dizzy or otherwise not well due to the medication.
5. If you are a female and intend to get pregnant or are pregnant---immediately let your obstetrician and us know so we can monitor/change/discontinue medications and other treatments.
6. Not obtain narcotics from other sources such as emergency rooms or other medical providers unless approved by our office.
7. Take medications as prescribed only and not take additional medications from family or friends.
8. You will not use illicit drugs such as cocaine, ecstasy, bath salts and like.

If this agreement is broken, once or multiple times, it could lead to termination of further medication management by Comprehensive Spine and Pain Management, LLC.

Patient Name: Signature: Date:

_____ _____ _____

**Comprehensive Spine and Pain Management, LLC office policies for ongoing treatment:**

1. For any medication refill or schedule changes--please call office during office hours (8 am-4:30 pm) only. If you are experiencing a life threatening event, please call 911 or go to the hospital.
2. For injections and interventional treatments: We request that you not drive, operate heavy machineries for at least 4 hours after the procedure because you may experience numbness or weakness of one or multiple limbs. You are to bring a driver for such injections. If you are not able to bring a driver, please let us know and we can alter or reschedule the treatment.
3. Payment policy: You agree to pay the following:
   A. $70 charge for missed appointments, no-show, or cancellations less than 24 hours prior to appointment (please do not call during weekends, holidays or after hours for these).
   B. $25 charge for any forms that you require us to fill/medication prior authorizations /copies of your records.
   C. Any cancelled procedures must be rescheduled immediately. All planned treatments must be completed prior to medication refills. No exceptions.
   D. If you do not have a valid insurance or we are not in network for your insurance, then you are responsible and agree to pay the account balance.
   E. If your insurance has a deductible, you are responsible to pay for the office visit payment at the time of the appointment. The bill for the treatments will be separate.
   F. For patients with Medicare insurance and no secondary insurance, please note that Medicare will cover only 80% of the bill. The remaining 20% will be your responsibility.
   G. All co-pays and late fees are to be paid prior to the next appointment.
   H. $35 charge for all bounced checks.
   I. Account balances not paid within 90 days, will be charged an additional 35% fee and the account will be sent to a collection agency.
4. I authorize contact from this office to confirm my appointments, treatment & billing information as well as convey information about my health via home phone, cell phone, text message to my cell phone, or email.
5. My signature also serves as PHI (Protected Health Information) documents release should I request documents be sent to other attending doctor/treatment facility in the future.

Patient Name: Signature: Date:

_____ _____ _____