Patient Registration Form

12332 Bear Plaza Suite 100
Burleson, TX 76028

Phone: 817-615-8840 Fax: 682-285-2468

Patient Information (confidential):

Name: _____ Date: _____
(First) (Middle) (Last)

Address: _____ City _____ State ____ Zip _____

Phone: Home (___) _____ Work (__ _) _____ Cell (____) _____

Birth Date: _____ SS# ___ - ___ - _____ E-Mail : _____

Employer (if Minor, Parent's Employer) _____

Employer Address: _____ City _____ State ____ Zip _____

Spouse Name (if Minor, Parent's Name) _____ Phone: (___) _____

Primary Care Physician : _____ Phone: (___) _____

Emergency Contact**:** _____ Phone: (___) _____

Relationship to patient: _____

How did you hear about our practice? _____ Phone: (___) _____

Responsible person if different from above.

Do you have medical insurance coverage: □ Yes □ No

Name of Person on account : _____ Phone : _____

Relationship to Patient: _____ SSN - ____- Birth Date: _____

Insurance Company: _____ _____ Policy No: _____ _ Group Number:_____

Phone Number of insurance company:_____ _____

Do you have addition al insurance? □ Yes □ No If yes, please complete the following:

Name of Insured: _____ Relationship to patient: _____

SSN:_____ DOB:_____ ____

Insurance Company: _____ _____ Policy No: _____ _ Group N mber:_____

If you are covered und er worker's compensation or motor vehicle insurance, enter info below:

Name of Worker's Co p or Motor Vehicle Accident Insurance Carrier: _____

Employer:_____ Claim No .:_____

Date of Injury: _____ Adjuster/Case Manager: _____

Adjuster/Case Manager Phone No.:_____

Carrier Address: _____

Patient Initial: ___

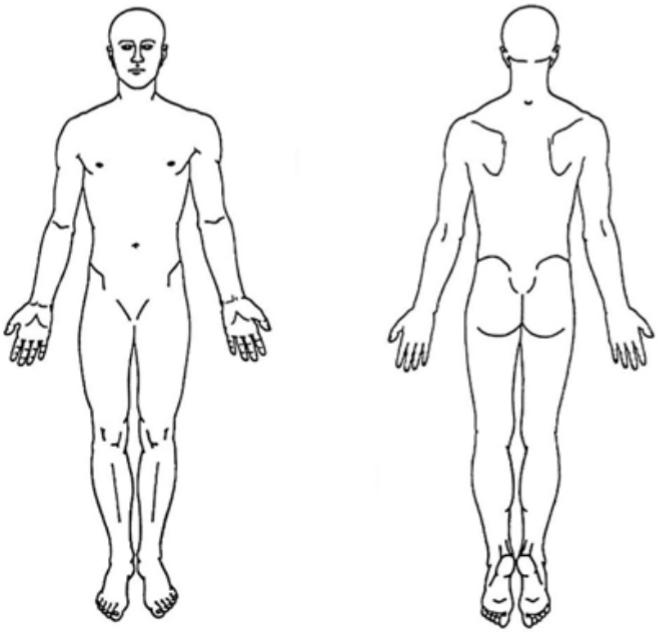
INTERVENTIONAL PAIN & SPINE

NEW PATIENT FORM

Patient Name :		**DOB:**	**Age :**		☐ **M** ☐ **F**
Name of Referring Physician :			**Name of PCP :**		
Reason for Visit:					
How long have you had this pain?		**Average Pain Level** (1 (no pain) to 10 (worst)) **:**		-	

Height:_____ Weight:_____

On the diagram below, mark the area where you have pain.



Describe the pain

☐ **Aching**	☐ **Mild**	☐ **Moderate**
☐ **Burning**	☐ **Throbbing**	☐ **Severe**
☐ **Pins/needles**	☐ **Constant**	☐ **Sharp/stabbing**
☐ **Numbness**	☐ **Intermittent**	

What makes your pain Worse:

What makes your pain Better:

Do you have WEAKNESS in your : ☐ **Arms** ☐ **R** ☐ **L**
☐ **Legs** ☐ **R** ☐ **L**

Do you have NUMBNESS in your : ☐ **Arms** ☐ **R** ☐ **L**
☐ **Legs** ☐ **R** ☐ **L**

TREATMENT HISTORY

For your current symptoms, please mark the boxes for the following imaging/studies that have been performed

☐ X-Ray ☐ MRI ☐ CT scan ☐ Discogram ☐ EMG/NCV (nerve test) ☐ CT myelogram

Where was this imaging/study done?

Please mark the type of treatment(s) that you have had in the past and how well they worked, OTHERWISE LEAVE BLANK:

Injections: ☐ Better ☐ Worse ☐ No Change
Type:

Spine Surgery: ☐ Better ☐ Worse ☐ No Change
Type of surgery and year?

TENS unit: ☐ Better ☐ Worse ☐ No Change

Chiropractor: ☐ Better ☐ Worse ☐ No Change

Massage: ☐ Better ☐ Worse ☐ No Change

Physical Therapy: ☐ Better ☐ Worse ☐ No Change
How recently?

Bracing: ☐ Better ☐ Worse ☐ No Change
Type:

Heat / Ice: ☐ Better ☐ Worse ☐ No Change

Acupuncture: ☐ Better ☐ Worse ☐ No Change

Psychology: ☐ Better ☐ Worse ☐ No Change

INTERVENTIONAL PAIN & SPINE

PAST MEDICATIONS

Please indicate which medications you have used in the past for your current pain condition (OTHERWISE DO NOT CHECK):

ANTI-INFLAMMATORY	Helped? Yes	No
Naproxen (aleve)	☐	☐
Ibuprofen (advil, motrin)	☐	☐
Diclofenac (voltaren)	☐	☐
Tylenol (acetaminophen)	☐	☐
Flector patch	☐	☐

MUSCLE RELAXANTS	Helped? Yes	No
Carisoprodol (soma)	☐	☐
Cyclobenzaprine (flexeril)	☐	☐
Skelaxin (Metaxolone)	☐	☐
Methocarbamol (robaxin)	☐	☐
Tizanidine (zanaflex)	☐	☐

NARCOTICS / OPIOIDS	Helped? Yes	No
Tramadol	☐	☐
Tylenol with codeine	☐	☐
Hydrocodone (Vicodin)	☐	☐
Oxycodone (Percocet)	☐	☐
Morphine, MS Contin	☐	☐
Hydromorphone	☐	☐
Nucynta (tapentadol)	☐	☐
Fentanyl patch	☐	☐
Methadone	☐	☐
Opana	☐	☐
Suboxone	☐	☐

NERVE MEDICATIONS	Helped? Yes	No
Gabapentin (Neurontin)	☐	☐
Lyrica	☐	☐
Amitriptyline (Elavil)	☐	☐
Nortriptyline	☐	☐
Cymbalta	☐	☐
Effexor	☐	☐
Savella	☐	☐
Lidoderm patch	☐	☐

PAST MEDICAL HISTORY

Please document all medical history below , including any of the following medical conditions :

☐ **Anxiety Disorder**	☐ **Depression**	☐ **High Blood Pressure**	☐ **Obsessive Compulsive d/o**
☐ **Bipolar Disorder**	☐ **Diabetes**	☐ **Heart attack/disease**	☐ **Abuse during childhood**
☐ **Schizophrenia**	☐ **Cancer**	☐ **Attention deficit d/o**	☐ **Kidney/Liver disease**
☐ **Osteoporosis**	☐ **Gout**	☐ **Attention deficit d/o**	☐ **Rheumatoid arthritis**
☐ **HIV or AIDs**	☐ **Stroke**	☐ **Hepatitis (A , B, C)**	☐ **Peptic Ulcer Disease**

Other past medical history:

ALLERGIES TO MEDICATIONS

Iodine Allergy	☐ **Yes** ☐ **No**
Shellfish Allergy	☐ **Yes** ☐ **No**

INTERVENTIONAL PAIN & SPINE

PAST SURGERIES

FAMILY HISTORY

PRESENT MEDICATIONS

Are you currently taking any of the following medications? If so, indicate by marking the check box next to the medication.

☐ **Coumadin/Warfarin** ☐ **Plavix** ☐ **Xarelto** ☐ **Pradaxa** ☐ **Eliquis** ☐ **Brilinta**

Other Blood Thinners

NAME OF MEDICATION	DOSE and # of pills/day

SOCIAL HISTORY

Occupation :

Are you currently working? ☐ **Yes** ☐ **No** ☐ **Part-time** ☐ **Full-time**

Education : ☐ **Elementary** ☐ **High School** ☐ **College** ☐ **Graduate school**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Significant Other**

Children : ☐ **Yes** ☐ **No** **If Yes, how many?** _____

Do you have any lawsuits pending? ☐ **Yes** ☐ **No**

Are you on disability? ☐ **Yes** ☐ **No** **Worker's Comp?** ☐ **Yes** ☐ **No**

Do you use tobacco? ☐ **Yes** ☐ **No** **# of packs / day** _____ **How many years?** _____

Do you use alcohol? ☐ **Yes** ☐ **No** **# of drinks / day** _____ **How many years?** _____

Do you use illicit substances? ☐ **Yes** ☐ **No**

If Yes, describe _____

INTERVENTIONAL
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REVIEW OF SYSTEMS:

Are you CURRENTLY experiencing any of the following symptoms? If so, check mark Yes. Otherwise, check no (blank also implies no)

GENERAL:	Yes	No	ENDOCRINE:	Yes	No	EARS/NOSE/THROAT:	Yes	No
Loss of appetite ……	☐	☐	Thyroid disease……	☐	☐	Hoarseness……	☐	☐
Recent weight loss	☐	☐	Heat/Cold intolerance	☐	☐	Trouble swallowing……	☐	☐
Fever or chills ……	☐	☐				Hearing loss……	☐	☐
RESPIRATORY:	**Yes**	**No**	**CARDIOVASCULAR:**	**Yes**	**No**	**PSYCHIATRIC:**	**Yes**	**No**
Shortness of breath	☐	☐	Chest pain……	☐	☐	Depression……	☐	☐
Chronic cough ……	☐	☐	Palpitations……	☐	☐	Drug/Alcohol addiction	☐	☐
						Suicidal Thoughts……	☐	☐
KIDNEY/BLADDER:	**Yes**	**No**	**EYES:**	**Yes**	**No**	**NEUROLOGICAL**	**Yes**	**No**
Painful urination……	☐	☐	Blurred vision……	☐	☐	Headaches……	☐	☐
Blood in urine……	☐	☐	Double vision……	☐	☐	Seizures……	☐	☐
Kidney problems ……	☐	☐	Loss of vision……	☐	☐	Dizziness……..	☐	☐
GASTROINTEST	**Yes**	**No**	**HEMATOLOGIC:**	**Yes**	**No**	**SKIN:**	**Yes**	**No**
Nausea/vomiting	☐	☐	Easy bruising……	☐	☐	Frequent Rashes	☐	☐
Blood in stool……	☐	☐	Easy bleeding……	☐	☐	Skin ulcers……	☐	☐
Heartburn……	☐	☐				Lumps……	☐	☐
Constipation……	☐	☐						

Patient/Representative Name (print) _____

Signature_____

Date _____

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NAME: _____ **DATE**: _____

AGREEMENT FOR CHRONIC PAIN MEDICATION

PLEASE INITIAL ALL SECTIONS BELOW:

_____ I UNDERSTAND THE PURPOSE OF THIS AGREEMENT IS TO PREVENT MISUNDERSTANDINGS ABOUT CERTAIN MEDICATIONS YOU WILL BE TAKING FOR PAIN MANAGEMENT. THIS IS TO HELP YOU AND YOUR DOCTOR TO COMPLY WITH THE LAW REGARDING CONT ROLLED MEDICATIONS.

_____ I UNDERSTAND THAT IF I BREAK THE AGREEMENT, WE WILL STOP PERSCRIBING PAIN MEDICATIONS TO YOU.

_____ I WILL NOT USE ANY ILLEGAL CONT ROLLED SUBSTANCES. I WILL NOT INCREASE OR DECREASE THE DOSAGE W ITHOUT INFOR MING MY DOCTOR. IF I FEEL THAT ADJUSTMENTS IN THE MEDICATION DOSAGE IS REQUIRED, I AGREE TO CONTACT THE PRESCRIBING DOCTOR.

_____ I WILL NOT SHARE MY MEDICATIONS WITH ANYONE NOR WILL I TAKE ANOTHER PERSON'S MEDICATION.

_____ I WILL NOT RECEIVE ANY PAIN ME DICATIONS FROM ANY OTHER DOCTORS, INCLUDING ER DOCTORS. ALL PATIENT'S WILL BE MONITORED FOR THIS VIA THE STATE OF TEXAS PHARMACY MONITORING PROGRAM AT EACH VISIT AND ANY VIOLATIONS OF THIS RULE MAY LED TO DISCHARGE FROM THE PRACTICE.

_____ I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SAFEGUARD MY MEDICATION. THEY WILL **UNDER NO CIRCUMSTANCE** BE FILLED EARLY IF THEY ARE LOST, STOLEN, DESTROYED OR USED UP EARLY.

_____ I UNDERSTAND THAT THERE MAY BE RISKS THAT ASSOCIATE WITH THE USE OF PAIN MEDICATION, INCLUDING RISK OF DEATH, RESPIRATORY DEPRESSION, BOWEL AND BLADDER DYSFUNCTION, SEXUAL DYSFUNCTION, CHANGE OF A PPETITE WITH POSSIBLE WEIGHT GAIN OR LOSS, CHANGE OF COORDINATION (WHICH MAY INTERFERE WITH DRIVING, OPERATING MACHINERY AND FINE MOTOR MOVEMENT) AND OTHERS.

_____ ADDITIONALLY, THE CONTINUOUS USE OF PAIN MEDICATION MAY RESULT IN DEPENDENCE, ADDICTION, CHANGE IN PERSONALITY AND SLEEP CHANGES. I ALSO UNDERSTAND THAT I WILL NOT MIX ACOHOL WITH PAIN MEDICAITON AND I WILL REPORT ANY CHANGES IN MY MENTAL STATE AS WELL AS POSSIBLE SIDE EFFECTS.

_____ I AGREE TO SUBMIT TO FREQUENT URINE TESTING ON AN AS NEEDED BASIS TO MONITOR FOR MEDICATION COMPLICATIONS AND COMPLIANCE WITH RECOMENDED TREATMENT.

_____ I UNDERSTAND THE RISKS AND BENEFITS OF TAKING PAIN MEDICATIONS. I UNDERSTAND THAT OPIOIDS CAN IMPAIR MY JUDGEMENT AND MOTOR SKILLS AND FOR THIS REASON I WILL NOT TAKE PART IN ACTIVITIES THAT WILL ENDANGE R MYSELF AND/OR OTHERS WHILE USING THESE MEDICATIONS.

_____ I UNDERSTAND THAT SUDDEN STOPPING OF PAIN MEDICATION CAN LEAD TO REBOUND PAIN, WITHDRAWAL SYMPTOMS, SEIZURES AND OTHER SYMPTOMS. I HAVE BEEN IN FORMED NOT T O STOP ANY PAIN MEDICATION SUDDENLY UNLESS DECIDED JOINTLY BY MYSELF AND MY PAIN DOCTOR.

_____ I AGREE TO ALLOW MY PAIN PHYSICIAN TO REVIEW ANY OF MY PAST MEDICAL OR PSYCHOLOGICAL RECORDS.

_____ I AGREE THAT WHEN I HAVE ANY CONTACT WITH THE DOCTORS, NURSES OR ANY OTHER STAFF MEMBER IE: MEDICAL ASSISTANTS, DOCTORS, ASSISTANTS, PHONE ANSWERS, ETC. I WILL NOT BE RUDE, AGGRESSIVE, SWEAR AND OR BE DISRUPTIVE, WITH ANY MEMBER OF THE OFFICE.

_____ **I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I AGREE AND UNDERSTAND THAT NON-COMPLIANCE WITH THE ABOVE WILL RESULT IN FORMAL DISCHARGE WITH NOTIFICATION TO MY PRIMARY CARE PHYSICIAN AND OTHER TREATING PHYSICIANS.**

PATIENT SIGNATURE _____ **DATE** _____

PHYSICIAN /WITNESS SIGNATURE _____ **DATE** _____

INTERVENTIONAL PAIN & SPINE

Financial Policy and Consent to Proceed

BY PROVIDING US WITH ACCURATE INFORMATION, WE CAN SERVE YOU BETTER AND MORE EFFICIENTLY.

1. We need copies of your insurance card or card s for our files. Proper group numbers and Social Security numbers of all insurances are required with the name of the person who carries the insurance. If retired, please list under employer "Retired From" (List name of company). Without the information completed you will be considered a personal pay account. RESPONSIBLE PARTY IS THE PERSON SIGNING THIS FORM.
2. We expect you to know and understand your insurance policy. Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay that portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer). FOR UN-INSURED PATIENTS, WE REQUEST PAYMENT ARRANGEMENTS BE MADE BEFORE YOUR VISIT. Special arrangements can be made for large accounts.
3. As a courtesy we will file your insurance. (If you do file your own insurance, you need to pay for your services today. We do not accept what your insurance pays as payment in full. It is your responsibility to ensure that the services provided are covered and authorized by your insurance plan. If authorization is required, Integrated Pain Consultants will attempt to get authorization on your behalf. As a courtesy we will file your insurance. (If you do file your own insurance, you need to pay for your services today. We do not accept what your insurance pays as payment in full. It is your responsibility to ensure that the service provided are covered and authorized by your insurance plan. If authorization is required, Interventional Pain and Spine will attempt to get authorization on your behalf.
4. If your insurance company does not pay Interventional Pain and Spine the balance may become your responsibility. Balances are due within 30 of receiving a statement.
5. It is your responsibility to inform us of any insurance changes and/or cancellation of your policy.
6. If your insurance requires a special claim form, we must have it within two working days, or the insurance billing will be processed and sent without it.
7. If your visit is related to an injury at work, you must report it to the receptionist. A special form needs to be completed. If the patient does not file on his work-related injury; it must be done by this office. Patients will continue to receive statements pf their record until we are satisfied by the insurance.
8. In accordance with the FEDERAL TRUTH-IN-LE NDING ACT, all doctors are required to give to their patient's complete information in connection with the extension of credit. BASIC POLICY: The patient is responsible for all medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you, without charge. It is the patient's responsibility to know your contract benefits assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims.
9. WORKMAN'S COMPENSATION: In the event it is determined by the Workman's Compensation board that the illness or injury is not a result of a compensated Workman's Compensation case, I hereby agree to pay usual and customary fees for services rendered.
10. REJECTED CLAIMS: If your insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full, contact our Business Office.
11. DELINQUENT ACCOUNTS: Delinquent accounts over 90 days are turned over to our Collection Manager. If the bill remains unpaid and satisfactory arrangements for payment are not made, the Collection Manager will review the account with the doctor to decide appropriate legal action. We reserve the right to add late charges for delinquent accounts requiring collection action and to add attorney's fees and court costs. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
12. RETURNED CHECKS: A $25.00 handling charge is applied to all returned checks.
13. YOU MAY BE CHARGED A FEE OF $50.00 IF A CLINIC APPOINTMENT IS MISSED (AND $10 0 FOR PROCEDURE VISIT) OR NOT CANCELLED 24 HOURS PRIOR TO SCHEDULE D APPOINTMENT OR BEING 15 MINUTES LATE AND THE APPOINTMENT MAY BE RESCHDULED. A PATIENT MAY BE DISMISSED FROM OUR PRACTICE FOR TWO MISSED APPOINTMENTS IN A YEAR.
14. Co-Payments and outstanding balances must be made before your appointment. Otherwise, your appointment may rescheduled. We may not be authorized to see you until referral authorization and insurance benefits have been obtained.
15. MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to be aware of the status of payments on your account and have a record of services. Once your insurance has paid, you are responsible for the unpaid balance. Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50¢ per month.

I have read and agree with the Financial Policy of this office.

Patient. _____ Date _____

Insured _____ Witness._ ___ _ _____