

# *Center for Pain Management*

## **GENERAL INFORMATION TO NEW PATIENTS**

Welcome to our clinic. The basic initial visit at Center for Pain Management includes a complete history and examination. Laboratory tests may be required if not previously completed by another physician. X-ray, CT scans and MRI's may also be required for a review by our physicians.

You should plan to spend approximately 90 minutes at the clinic for the initial visit. In some cases hospitalization may be indicated. Because of our philosophy regarding a multidisciplinary approach to controlling your pain, you may be asked to see a pain psychiatrist and/or psychologist.

If you should be scheduled for a procedure such as a nerve block, please make sure you are aware of the following items. You may need to be without food or water for six (6) hours prior to your procedure and you may be required to have someone to drive you home after the procedure. If you are currently on any type of blood thinner medication including aspirin or coumadin, please contact our office for instructions prior to the procedure.

**IMPORTANT:** Patients who require narcotics for their condition will be required to sign a narcotic contract which delineates the responsibilities of the physician and patient regarding the prescribing of these medications. Note that it is the patient's responsibility to make sure that they contact the clinic if they change pharmacies or if their medication will run out before their next appointment. We ask that you give us at least three (3) days to solve the problem. Calling the clinic after 12:00 noon, calling in the evening, or on weekends may make it impossible to obtain refills. The majority of patients will be required to present themselves for evaluation by a physician before they obtain refills.

**IMPORTANT:** It is very important that you bring your insurance card with you. Please familiarize yourself with your insurance as far as what facilities you will receive the maximum benefits. If you are currently on a Health Maintenance Organization (HMO) plan, you will be required to have your with referral with you. It is your responsibility to get the referral from your primary care physician. Failure to present your referral may result in your appointment being cancelled or you will be responsible for the entire bill at the time of service. Any and all co-pays are due on the date of service. Please note that insurance does not guarantee benefits and all balances due are the responsibility of the patient.

We can understand and sympathize as to the discomfort you are experiencing, and hope we can offer help to you.

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Date

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Patient Signature

# Center for Pain Management Patient Information Sheet

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS# \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK# \_\_\_\_\_

\*\*\*\*\*

## Medical Insurance Information

PRIMARY INSURANCE: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

\*\*\*\*\*

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

PLEASE LIST THE NAME AND PHONE NUMBERS OF ALL PHYSICIANS WHO CARE FOR YOU.

\_\_\_\_\_ PHONE# \_\_\_\_\_

\_\_\_\_\_ PHONE# \_\_\_\_\_

\_\_\_\_\_ PHONE# \_\_\_\_\_

Please present your insurance card(s), co-pay and a photo ID to the front desk. Thank You.

## Center for Pain Management Health History

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Referring Physician Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

Allergies: (Please list allergies to any medications, foods, x-ray, dye, etc and give type of reaction).

**Medication**

**Reaction**


**MEDICATION LIST**

1.	
2.	
3.	
4.	
5.	

6.	
7.	
8.	
9.	
10.	

**ILLNESSES**

Please note if you have, or had any of the following:

- |  |       |  |      |   |      |
|--|-------|--|------|---|------|
| <input type="checkbox"/> Sugar diabetes      | 19__  | <input type="checkbox"/> Asthma              | 19__ | <input type="checkbox"/> Degenerative joint disease | 19__ |
| <input type="checkbox"/> Kidney stones       | 19__  | <input type="checkbox"/> Hepatitis           | 19__ | <input type="checkbox"/> Heart disease              | 19__ |
| <input type="checkbox"/> Osteoporosis        | 19__  | <input type="checkbox"/> High blood pressure | 19__ | <input type="checkbox"/> Prostate problems          | 19__ |
| <input type="checkbox"/> Emphysema           | 19__  | <input type="checkbox"/> Thyroid disease     | 19__ | <input type="checkbox"/> Bladder problems           | 19__ |
| <input type="checkbox"/> Other major illness | _____ |  | 19__ |   |      |

**SURGERIES:**

1.	
2.	
3.	
4.	
5.	

6.	
7.	
8.	
9.	
10.	

**FAMILY HISTORY Living/Deceased**

<p><b>Health</b> (please enter correct letter to correspond with their health along and list any health problems they had/have)  <b>G</b>–Good, <b>F</b>-Fair, <b>P</b>-Poor <b>U</b>-Unknown, <b>D</b>-Deceased (list cause of death)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%; text-align: center;">Age</th> <th style="width: 70%; text-align: center;">Condition/Health Problems</th> </tr> </thead> <tbody> <tr><td>Father</td><td></td><td></td></tr> <tr><td>Mother</td><td></td><td></td></tr> <tr><td>Brother/Sister</td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td>Spouse</td><td></td><td></td></tr> <tr><td>Children</td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> <tr><td> </td><td></td><td></td></tr> </tbody> </table> <p>Family History Unknown Patient Adopted <input type="checkbox"/></p>		Age	Condition/Health Problems	Father			Mother			Brother/Sister												Spouse			Children									<p><b>Has any blood relative had any of the Following and list who.</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>Cancer</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Tuberculosis</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Diabetes</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Stroke</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Thyroid disease</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Bowel disease</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Ulcers</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Kidney disease</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Heart disease</td><td>Yes/No</td><td>_____</td></tr> <tr><td>Heart attack</td><td>Yes/No</td><td>_____</td></tr> </table>	Cancer	Yes/No	_____	Tuberculosis	Yes/No	_____	Diabetes	Yes/No	_____	Stroke	Yes/No	_____	Thyroid disease	Yes/No	_____	Bowel disease	Yes/No	_____	Ulcers	Yes/No	_____	Kidney disease	Yes/No	_____	Heart disease	Yes/No	_____	Heart attack	Yes/No	_____
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**Review of Symptoms**

	Yes	No
1. Having pain now	_____	_____
2. Pain within past 24 hours	_____	_____
3. Type of pain:		
Burning	_____	_____
Sharp	_____	_____
Aching	_____	_____
Throbbing	_____	_____
Shooting	_____	_____
Numbness/Tingling	_____	_____
4. Rate your pain on a scale from 0 to 10		
0 being no pain and 10 being worst pain _____		
5. When did your pain start? _____		
6. At what time in a 24 hour day is the pain the worst? _____		
7. What makes the pain better? _____		
8. What makes the pain worse? _____		
9. Estimate your ability to cope with pain on scale of 0 to 10		
0 unable to cope and 10 able to cope _____		
10. Are you able to perform daily activities?	_____	_____
11. Fever, chill, nightsweats	_____	_____
12. Weight gain or loss	_____	_____
13. Difficulty falling or staying asleep	_____	_____
14. Fatigue, lack of energy	_____	_____
15. Double vision, dry eyes	_____	_____
16. Glaucoma, cataracts	_____	_____
17. Headaches	_____	_____
18. Deafness, ringing in ears	_____	_____
19. Sinus troubles, nosebleeds	_____	_____
20. Chest pain or discomfort	_____	_____
21. Palpitations irregular heart beat	_____	_____
22. Swelling ankles, hands	_____	_____
23. Shortness of breath – rest, activity	_____	_____
24. Wheezing or cough	_____	_____
25. Difficulty swallowing, heart burn	_____	_____
26. Pain stomach	_____	_____
27. Nausea, vomiting	_____	_____
28. Poor appetite	_____	_____
29. Diarrhea or constipation	_____	_____
30. Difficulties or pain with urination (burning)	_____	_____
31. Joint pain, swelling or stiffness	_____	_____
32. Skin rash or itching	_____	_____
33. Hands change color when cold	_____	_____
34. Tremor, seizures, or black outs	_____	_____
35. Depression or anxiety	_____	_____
36. Heat or cold intolerance	_____	_____
37. Unusual bleeding or bruising	_____	_____
38. Other _____	_____	_____
39. Is there any chance you might be pregnant?	_____	_____
40. Last menstrual period _____		
41. Sexual dysfunctions	_____	_____

**SOCIAL HISTORY**

SUBSTANCE USE:	Quantity	
Coffee		Cups per day
Tea		Cups per day
Beer		Per day/ per week
Alcoholic Beverages		Per day/ per week
Tobacco Use		Per Day

**MID-MISSOURI ANESTHESIA CONSULTANTS, P.C.**  
**CENTER FOR PAIN MANAGEMENT**

**CONSENT TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS, CONSENT FOR  
TREATMENT AND FINANCIAL OBLIGATION**

Patient Name: \_\_\_\_\_  
(Please print) First Middle Initial Last

Date of Birth: \_\_\_\_\_ Effective Date/First Visit with MMAC: \_\_\_\_\_

1. **Consent for Treatment:** I, the undersigned, a patient of Mid-Missouri Anesthesia Consultants, P.C. (“MMAC”), request and authorize my attending physician, his or her nurse anesthetist and/or physician assistant, and any other MMAC physician or MMAC healthcare provider, who he or she may designate as his or her associates or assistants or who he or she may refer me to, to administer such treatment as is medically necessary (hereinafter referred to singularly and collectively as “MMAC Healthcare Provider(s)”). I understand that I may see more than one MMAC Healthcare Provider(s) for my medical care. Therefore, I voluntarily consent to said evaluation, medical care, and treatment by the MMAC Healthcare Provider(s). This consent further applies to any and all such medical services, care, diagnostic procedures and/or medical treatment as my MMAC Healthcare Provider(s) deem reasonable and necessary, including, but not limited to testing, laboratory, pathology and radiology. All of the foregoing referenced health care and services shall be referred to generally throughout the rest of this document as (“My Health Care”). In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained by the appropriate MMAC Healthcare Provider(s).
  
2. **Release of Information:** I hereby authorize any MMAC Healthcare Provider(s) and/or MMAC, to release, transfer, provide access to, divulge, and furnish my private healthcare information and medical records, including, but not limited to, diagnosis, medical history, treatment history and/or plan, test and diagnostic results, prescriptions, and all billing, payment and collection information and records as follows:
  - a. to MMAC employees, MMAC Healthcare Provider(s) and non-MMAC healthcare providers to provide, coordinate, and/or managed My Health Care and related services; and
  - b. to my health insurance company, health maintenance organization, health care network, health care plan, Medicare, Medicaid, Medigap, Health Care Financing Administration/Center for Medicare/Medicaid, third party administrator of any such health care plans or companies, or other authorized agent of any such health care plans or companies which provide insurance coverage in whole or in part for My Health Care (hereinafter separately or collectively referred to as “Plan(s)”) in order to obtain insurance payments, determine eligibility or coverage, coordinate benefits, adjudicate or subrogate health benefit claims, provide risk adjustment of amounts due, provide billing and collection services, manage claims, obtain payment under contract for reinsurance, process date for related healthcare, review medical necessity or coverage, and provide utilization review; and
  - c. to MMAC’s employees, agent or subcontractors to engage in billing and account collection activities in an effort to obtain payment from me and/or from any applicable Plan(s) for My Health Care.

3. **Payment:** I hereby authorize and direct any of the Plan(s) listed above to make payment directly to MMAC on my behalf whenever possible.
4. **Discrimination:** If you feel you have been denied services because of your race, color, national origin, age, sex, disability, religious or political beliefs; you may file a complaint of discrimination with the clinic administrator of MMAC or Administration Department of Social Services or the Department of Health and Human Services. If you need assistance please ask for Administration.
5. **Contracted Plan(s):** If my Plan(s) is a contracted plan, i.e. HMO, PPO or Open Access product, I understand and agree that I am financially responsible for non-covered medical services, co-payments, co-insurance, and deductibles as set forth in the provisions of my Plan(s).
6. **Assignment of Benefits:** In consideration for services provided, I hereby assign to MMAC, the benefits due me covering My Health care costs and expenses otherwise payable to me, for the Plan(s), policy or policies I have in effect for Plan(s) coverage, insurance coverage and policy(s) named, whichever applicable.
7. **Financial Obligation for MMAC:** I understand and agree that I am financially responsible for the payment of all charges, that are my responsibility, for My Health Care, unless waived by contractual agreements between MMAC and my Plan(s) or insurer or if prohibited by state, federal laws or regulations. MMAC cannot accept responsibility for collecting your insurance or Plan(s) claim if there is no contractual agreement between MMAC and the Plan(s) or insurer.
8. **Collection Fees, Costs, and Venue:** In the event that it becomes necessary for MMAC to employ the services of a collection agency or an attorney to pursue collection of my account, I agree to be responsible for the payment of such collection fees and costs, including but not limited to, reasonable attorney's fees, court costs, and service fees. Interest on my outstanding account shall accrue at the rate of 1.5% per month. Should MMAC file a legal action to collect on my account, I hereby waive venue and agree that venue shall be appropriate in Cole County, Missouri.
9. **Force and Effect:** I have read and understand the above provisions and agree to all terms and conditions as stated. A copy of this consent shall be as effective and valid as original. This consent and all provisions contained herein shall be in force without expiration or time limitation no matter whether I change my insurance coverage or Plan(s). I understand and agree that none of the provisions of this Consent in anyway seek to limit applicable Federal, State, and Local law, including, but not limited to the Health Insurance Portability and Accounting Act of 1996 ("HIPAA").

Patient Name: \_\_\_\_\_

Patient/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_