NEW PATIENTS' INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

(First) (MI) (Last)

Name ______________________________

Date of Birth: ______________ Sex: Male / Female Marital Status: S M W D

(Street) (City) (State) (ZIP)

Address: ______________________________

Home Phone #: ______________ Cell Phone#: ______________ Social Security #: ______________

E-mail: ______________________________

Employer: ______________ Work #: ______________

Employer's Address: ______________________________

If Student, School Name: ______________ Full / Part Time

Emergency Contact: ______________ Phone #: ______________ Relationship: ______________

Do you have an Advance Directive or Living Will? ☐Yes (please provide copy) ☐No

WORKER'S COMP/ACCIDENT INFORMATION

Insurance Name: ______________________________

Address: ______________ Phone #: (   )   -

Adjuster Name: ______________ Adjuster Phone #: (   )   -

Date of Injury or Accident: ______________ Claim #: ______________

Type of Injury: ☐Back ☐Leg ☐Hip ☐Neck ☐Shoulder ☐Arm ☐Head ☐Other: ______________

Place of work during time of accident: ______________ Phone #: (   )   -

In Litigation: ☐Yes ☐NO Amount of Medical Benefits: ______________ Notice of Compensation Payable: ☐Yes ☐NO

INSURANCE INFORMATION

Insurance Co.: ______________________ Phone #: ______________________

Insurance Address: ______________________

Identification #: ______________________ Group #: ______________________

Insured's Name: ______________________ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: ______________________ Phone #: ______________________

Employer's Address: ______________________

Insured's Social Security #: ______________________ Date of Birth: ______________________ Sex: Male / Female

If the patient is *covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!*

INSURANCE INFORMATION

Insurance Co.: ______________________ Phone #: ______________________

Insurance Address: ______________________

Identification #: ______________________ Group #: ______________________

Insured's Name: ______________________ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: ______________________ Phone #: ______________________

Employer's Address: ______________________

Insured's Social Security #: ______________________ Date of Birth: ______________________ Sex: Male / Female

I hereby assign, transfer, and set over to Center for Pain Control all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.
I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature ______________________ Date ______________________

CENTER FOR PAIN CONTROL

1235 Penn Ave, Suite 302, Wyomissing, PA 19610
Phone: 610-374-2927 - Fax: 610-374-2909

Jason T. Bundy, MD | Karen A. Kerns, PA-C | Nicole L. Harper, PA-C | April E. Palmer, NP-C | Martha Decembrino, RN, MAc

DATE: ______________________ REFERRING PHYSICIAN: ______________________

NAME: ______________________ FAMILY DOCTOR: ______________________

DOB: ______________________

PLEASE COMPLETE THESE FORMS PRIOR TO YOUR APPOINTMENT AND BRING THEM WITH YOU THE DAY OF YOUR SCHEDULED APPOINTMENT. If you are unable to fill them out yourself, please have your family doctor give you a list of your medical history and current medication. You will need to arrive at our clinic 30 min prior to your appointment so we can assist you with this form.

- ***What is your chief complaint?*** (example: 30% low back pain and 70% right leg pain)

____

____

- ***When did it start?*** (example: 2months ago, or "7-26-03")

____

____

- ***Did you sustain any trauma immediately prior to the onset?*** YES NO
- ***Is this work related or motor vehicle accident related?*** YES NO
- ***Do you have an attorney?*** (Please provide their contact information) YES NO

____

____

- ***Please describe the trauma.***

____

____

____

- ***Is the pain there constantly, intermittently, or both?*** (example: constant back pain with intermittent left leg pain)

____

____

- ***Please describe the characteristics of your pain.*** (sharp vs. dull, burning, squeezing, throbbing, tingling, etc.)

____

____

- ***What makes the pain worse?*** (Please circle)

Sitting Standing Walking Lying flat Bending over Lifting Others______________________

____

____

- ***What makes the pain better?*** (Please circle)

Sitting Standing Walking Lying flat Lifting Change Positions Other__________________

Taking medications (please list______________________)

- ***What have you tried?***

	Dosage?	How long?	Helpful?	Reason stopped
Ibuprofen (Advil, Motrin)				
Acetominophen (Tylenol)				
Naproxen (Aleve, Naprosyn)				
Diclofenac (Voltaren)				
Nabumetone (Relafen)				
Meloxicam (Mobic)				
Celecoxib (celebrex)				
Other NSAID				
Carisoprodol (Soma)				
Cyclobenzaprine (Flexeril, Amrix)				
Metaxalone (Skelaxin)				
Tizanidine (Zanaflex)				
Other Muscle Relaxant				
Gabapentin (Neurontin)				
Pregabalin (Lyrica)				
Topiramate (Topamax)				
Amitriptyline (Elavil)				
Duloxetine (Cymbalta)				
Venlafaxine (Effexor)				
Nortriptyline (Pamelor)				
Hydrocodone/APAP (Vicodin, Lortab, Norco)				
Oxycodone/APAP (Percocet, Endocet, Tylox, Roxicet)				
Methadone				
Morphine				
Fentanyl patch				
Oxycontin				
Lidoderm Patches				
Flector Patches				
Voltaren Gel				
Medrol Dosepak				
Other medications				

	How long?	Helpful?	Reason stopped
Chiropractors			
Massage therapy			
Physical therapy / Aquatic therapy			
Tens Unit			
Heat Compress			
Cold compress			
Acupuncture therapy			
Psychotherapy / Biofeedback			
Behavior modification therapy			

- ***Images*** (X-Ray, CT Scan, Bone Scan, etc.)

Study	Date	Where

- ***Spine Injections***

	Doctor	Date	Helpful?	How long did it last?
Epidural steroid inj				
Facet injections				
Radiofrequency ablations				
SI joint injections				

- ***Spine surgery***

	Doctor	Date	Helpful?	How long did it last?

- ***Current Medication*** (Please list **ALL** medications including vitamins and OTC meds)

Medication	Why prescribed	Dosage

- **Are you allergic to any medications?** (Please list and describe reaction)

Medication	Reaction

IV contrast allergy? YES NO

Shellfish allergy? YES NO

- ***Past Medical History*** (Please circle all)

AIDS / HIV Alcoholism Asthma Cancer Diabetes Emphysema Epilepsy Heart Disease
Hepatitis Herpes High Blood Pressure Multiple Sclerosis Pacemaker Seizures Stroke
Thyroid Disorders Tuberculosis Fibromyalgia Depression Bipolar Disorder Schizophrenia
Anxiety Disorder Other Psychiatric Issues Irritable Bowel Syndrome Chronic Pelvic Pain Migraine
Other:_______________________________

- ***Past Surgical History***

Surgery	Year

- ***Family History*** (Please list all significant family medical history such as bleeding problems (hemophilia), psychiatric disorders, chronic pain, or any substance abuse)

____
____
____
____
____

- ***Social history***

Who do you live with now?____

Do you have any children? ___ How many? ___ How is their health? ______________________

Are you currently working? ___ If not, why not?___________________ When did you stop?___________________________

What do/did you do for a living?____

Do you smoke? ____ If yes, how much? ____________ (per day on average)

Do you drink? ____ If yes, how much? ____________ (per day on average)

Do/did you use any illicit drugs? ___ What kind and how much?______________________________

Have you ever gone through rehab for drug or alcohol abuse? ____.

Are you currently pregnant or plan to become pregnant? YES NO

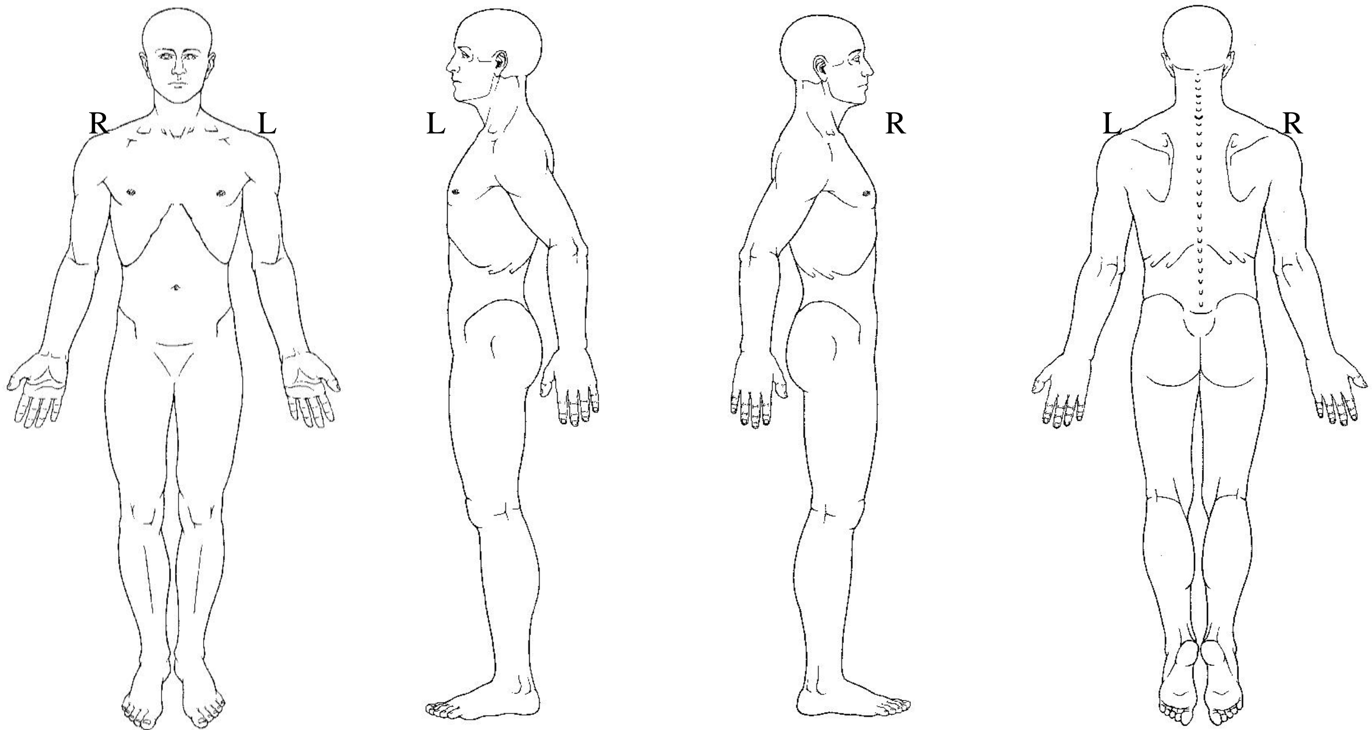
Have you ever been discharged from a doctor’s office because of noncompliance not following their directions?

- ***Review of system***

In the past month, have you experience any significant (Please circle all)

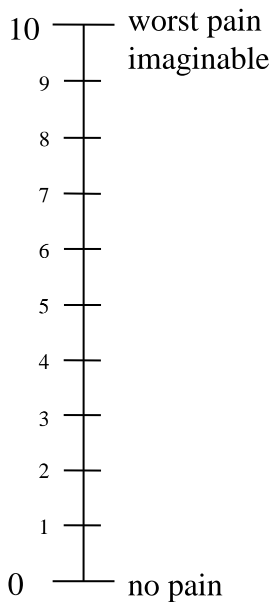
Weight loss/gain Fever/chills Changes in hearing/vision Dizziness Pass out Shortness of breath
Productive cough Chest pain Abdominal pain Diarrhea/constipation Weakness in the extremities
Lost control of bowel/urinary functions Bleeding problems Rashes Depression Suicidal thoughts
Homicidal thoughts Others ________________________

- ***Please shade in on the drawings the areas where you feel pain.***

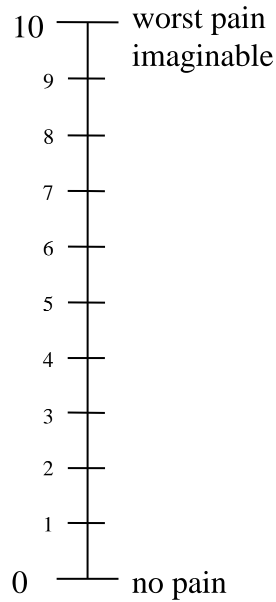


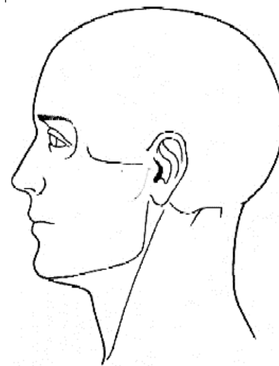
Please rate the severity of your pain (mark "baseline" and "with exacerbation")

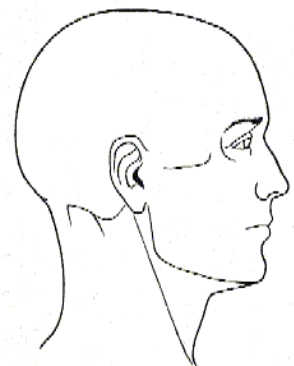
BASELINE



WITH ACTIVITY







- ***Who has treated you since the onset of the chief complaint?***

____

____

Patient's Signature ____ Date ____________________