NEW PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US? _____

PATIENT INFORMATION

NAME _____ DATE OF BIRTH _____ AGE _____ M / F
HOME PHONE # _____ CELL PHONE # _____ SS # _____
ADDRESS _____

EMPLOYER/OCCUPATION _____ WORK # _____
EMPLOYER ADDRESS _____

REFERRING/PRIMARY DOCTOR _____ PHONE # _____
DOCTOR ADDRESS _____

IN CASE OF EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____
ADDRESS _____
HOME PHONE # _____ CELL PHONE # _____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____
NAME OF POLICY HOLDER _____ RELATIONSHIP _____
POLICY NUMBER _____ POLICY HOLDER SS # _____

SECONDARY INSURANCE COMPAY _____
NAME OF POLICY HOLDER _____ RELATIONSHIP _____
POLICY NUMBER _____ POLICY HOLDER SS # _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN SELF)

NAME _____ RELATIONSHIP _____
ADDRESS _____
HOME PHONE # _____ CELL PHONE # _____ SS # _____

EMPLOYER _____ WORK # _____
EMPLOYER ADDRESS _____

ACCIDENT INFORMATION

DATE OF ACCIDENT _____
WAS AN AUTO INVOLVED? YES NO
CLAIM # _____
ATTORNEY _____
PHONE # _____
INSURANCE CO _____
PHONE # _____

WORKERS COMP INFORMATION

DATE OF ACCIDENT _____
EMPLOYER NAME _____
CLAIM # _____
CONTACT NAME _____
ATTORNEY _____
PHONE # _____

I affirm that the information given within this document is true and correct to the best of my knowledge and that I am the financially responsible party.

Patient/Responsible Party Signature _____ Date _____

MEDICATION HISTORY

Do you have any allergies to medication(s)? YES NO

Please decribe _____

_____

Do you have any allergies or sensitivities to dusts, chemicals, latex or other substances? YES NO

Please decribe _____

_____

Do you take blood thinners? YES NO

List all current pain medication(s) with doses and frequency taken:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

List all other medication(s) including prescription, over the counter, weight loss, vitamins or supplements:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____
11. _____ 12. _____

Please identify which of the following medication(s) have been tried in the past by checking the appropriate box. Please do not check any medications that you have not taken.

	Helpful?			Helpful?			Helpful?			Helpful?	
NSAID	Y	N	**Muscle Relaxant**	Y	N	**Others**	Y	N	**Antidepressant**	Y	N
Motrin			Skelaxin			Stadol			Elavil		
Lodine			Norflex			Talwin			Pamelor		
Naprosyn			Soma			Fioricet			Doxepin		
Relafen			Robaxin			Ultram			Tofranil		
Indocin			Flexeril			Zostrix			Desyrel		
Celebrex			Zanaflex			Ketamine Gel			Wellbutrin		
Mobic			Valium			Lidoderm			Anafranil		
						Imitrex			Luvox		
Opiod	Y	N	**Anticonvulsant**	Y	N	Amerge			Zoloft		
Darvocet			Neurotin			DHEA			Remeron		
Percocet			Lamictal			Guanifenesin			Paxil		
Lortab/Vicodin			Topamax			Dextromethorphan			Prosac		
Norco/Zydone			Depakote			Steroids			Serzone		
Duragesic			Tegretol			Suboxone			Effexor		
Oxycontin			Dilantin						Respiradol		
MS Contin			Lyrica						Zyprexa		
Kadian									Cymbalta		
Levorphanol											
Methadone											
Actiq											

Physician Signature After Review _____ Date_____

MEDICAL HISTORY

Patient Name_____ Date of Birth_____

Today's Date _____ Height _____ Weight _____ Age _____

The information you provide on this form will be useful to the consultant(s) you will be seeing today and will help your exam go smoothly and quickly as possible. Please complete it to the best of your ability.

1. Describe the location(s) of your pain _____

_____

2. Describe the events that caused your pain and when it began _____

_____

3. What do you hope to accomplish with this visit? _____

_____

4. What hand do you use most often? (please circle one) RIGHT LEFT

5. Have you ever had a tetanus (lockjaw) immunization/boosters? YES NO NOT SURE

Last year of booster _____ Less than 5 years _____ Between 5-10 years _____ More than 10 years_____

6. Family History: Does anyone in your family have or had any of the following

Heart disease/ high blood pressure/ strokes? YES NO Who _____

Diabetes/ sugar problems? YES NO Who _____

Cancer? (what type) YES NO Who _____

Tuberculosis? YES NO Who _____

7. Have you ever experienced heart-related problems including fainting, exhaustion, dehydration? YES NO

Please describe _____

8. Have you ever had to change your type of work or job site due to health conditions or injuries? YES NO

Please describe _____

9. Do you work any other jobs or participate in any sports/ recreational activities? YES NO

Please describe _____

10. Do you have a permanent disability? YES NO

Please describe _____

11. Do you currently smoke? YES NO # of packs per day _____ How many years? _____

If you used to smoke when did you quit?_____

Do you currently or have you ever chewed tobacco? YES NO How many years? _____

12. Do you drink alcohol? YES NO # of drinks per week _____ □ beer □ hard liquor □ wine

Have you ever felt a need or been told you should cut down on your drinking? YES NO

13. Do you currently or have you ever had a substance (drug) dependency problem? YES NO

Have you ever gone through a rehabilitation program? YES NO

Please describe _____

14. WOMAN: Have you ever been pregnant? YES NO How many times? _____

How many children do you have? _____ Are you or could you be pregnant now? YES NO

15. Have you seen any physicians or had any tests, procedures, surgeries, injections or physical therapy? YES NO

** If YES please place this information on the MEDICAL RECORDS TO OBTAIN page of this packet **

Do you currently or have you had any of the following?

	YES	NO		YES	NO
Frequent headaches			Diabetes or thyroid problems		
Head injury e.g. concussion			Cancer		
Seizures/ convulsions			Broken bones or sprains		
Faint/ blackout spells			Arthritis e.g. swollen, painful joints		
Eye injuries/ problems			Shoulder problems		
Hearing Problems e.g. ringing			Tendinitis of hand/ wrist/ forearm		
Sinus problems			Carpal tunnel syndrome		
Asthma/ difficulty breathing			Knee problems		
High blood pressure			Ankle/ foot problems		
Heart trouble/ stroke			Serious infections/ STDs		
Ulcers or heartburn problems			Hernias		
HIV/ Hepatitis (A,B,C or other)			Depression/ anxiety/ high stress		
Abdominal pain			Big swings in weight		
Genitourinary tract problems			Anything no included in this form		

Briefly describe any YES answers _____

_____

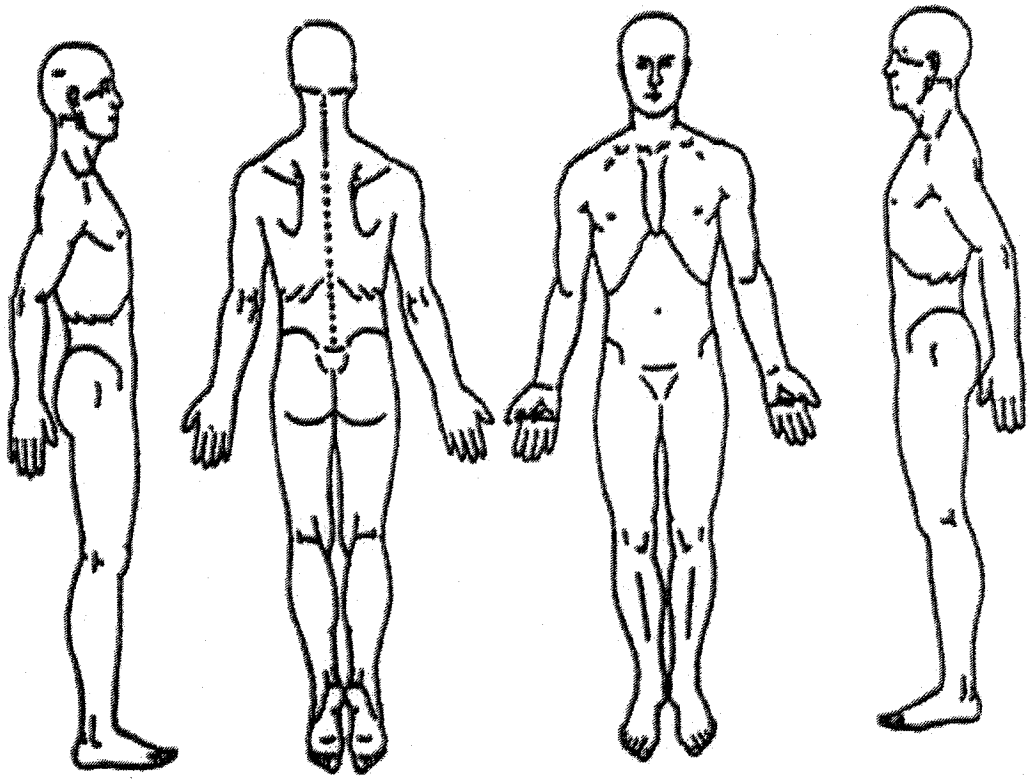
_____

_____

PAIN DIAGRAM

If you are being evaluated for a painful condition, mark the diagram below according to how you feel today.

Types of Pain: **B** = Burning **N** = Numbness **S** = Stabbing **A** = Aching **P** = Pins & Needles



RIGHT SIDE BACK FRONT LEFT SIDE

MEDICAL RECORDS TO OBTAIN

List all doctors involved in your care in the past 5 years:

Facility/Physician	Specialty	Location	Phone Number

Tests have you had to evaluate your pain:

X-RAY MRI CT EMG/NCS LABS BONE SCAN SLEEP STUDY EKG/ECG PET ULTRASOUND

Facility/Physician	Type of Test	Date	Phone Number

Procedures, surgeries or injections you have had in the past 5 years:

Facility/Physician	Type of Procedure	Date	Phone Number

If any of these procedures were work-related, please place a √ in front of it

Physical therapy you have had in the past 5 years:

Facility	Body Part	Start/Finish Date	Phone Number

UNITED
INTERVENTIONAL PAIN CENTER

1169 N Main St, Suite 9 Bluffton, IN
Phone (260) 353-1444
Fax (260) 353-1447

HIPAA Privacy Practices Receipt Acknowledgment

Effective December 9, 2014

Patient Name_____ **Date of Birth**_____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information (PHI). I understand that United Interventional Pain Center can use my PHI for treatment, payment and operations **without** my written consent including the following:

- Conduct, plan and direct my treatment and follow-up care among health care providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physicians certifications.

By signing this form I acknowledge that:

- I have been given the opportunity to □ **Accept** or □ **Decline** United Interventional Pain Center Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my PHI and I have been provided an opportunity to review it.
- I understand that Kara Health, Inc has the right to change its Notice of Privacy Practices and that I may request a revised copy at any time by contacting the office.

I authorize the following person(s) **complete access** to my protected health information **unless otherwise indicated**

1. First and Last Name	**Date of Birth**	**Relationship**	**Phone number**
limit access to: □ verbal health info only	□ verbal billing only	□ copies of health info only	□ copies of billing only
2. First and Last Name	**Date of Birth**	**Relationship**	**Phone number**
limit access to: □ verbal health info only	□ verbal billing only	□ copies of health info only	□ copies of billing only
3. First and Last Name	**Date of Birth**	**Relationship**	**Phone number**
limit access to: □ verbal health info only	□ verbal billing only	□ copies of health info only	□ copies of billing only
4. First and Last Name	**Date of Birth**	**Relationship**	**Phone number**
limit access to: □ verbal health info only	□ verbal billing only	□ copies of health info only	□ copies of billing only

Patient/Representative Name_____ **Relationship**_____

Patient/Representative Signature_____ **Date**_____