Restorative Pain Management New Patient Questionnaire

Name: _____Date: _____ Age: _____

Date of Birth: _____Social Security_____

Address: _____

City:_____ State:_____Zip: _____

Phone:_____Email: _____Gender: M F

Please provide an emergency contact name and phone number where we may leave a message:
Name: _____Relationship:_____ Phone: _____

Primary Care Provider: _____ Referring Provider: _____

Please list your current insurance provider(s)

Primary Insurance: _____ID #: _____Group #: _____

Secondary Insurance: _____ID#: _____Group #: _____

Is there pending litigation associated with the pain? Workers Comp Personal Injury

Car Accident

PAIN HISTORY

Approximate Date that pain began: _____ Chief Complaint:_____

How did your pain start? _____

Have you been treated by another pain doctor in the past? Yes No

Doctor's Name: _____

Have you received any previous pain injections? Yes No

Please choose the word(s) that best describes your pain:

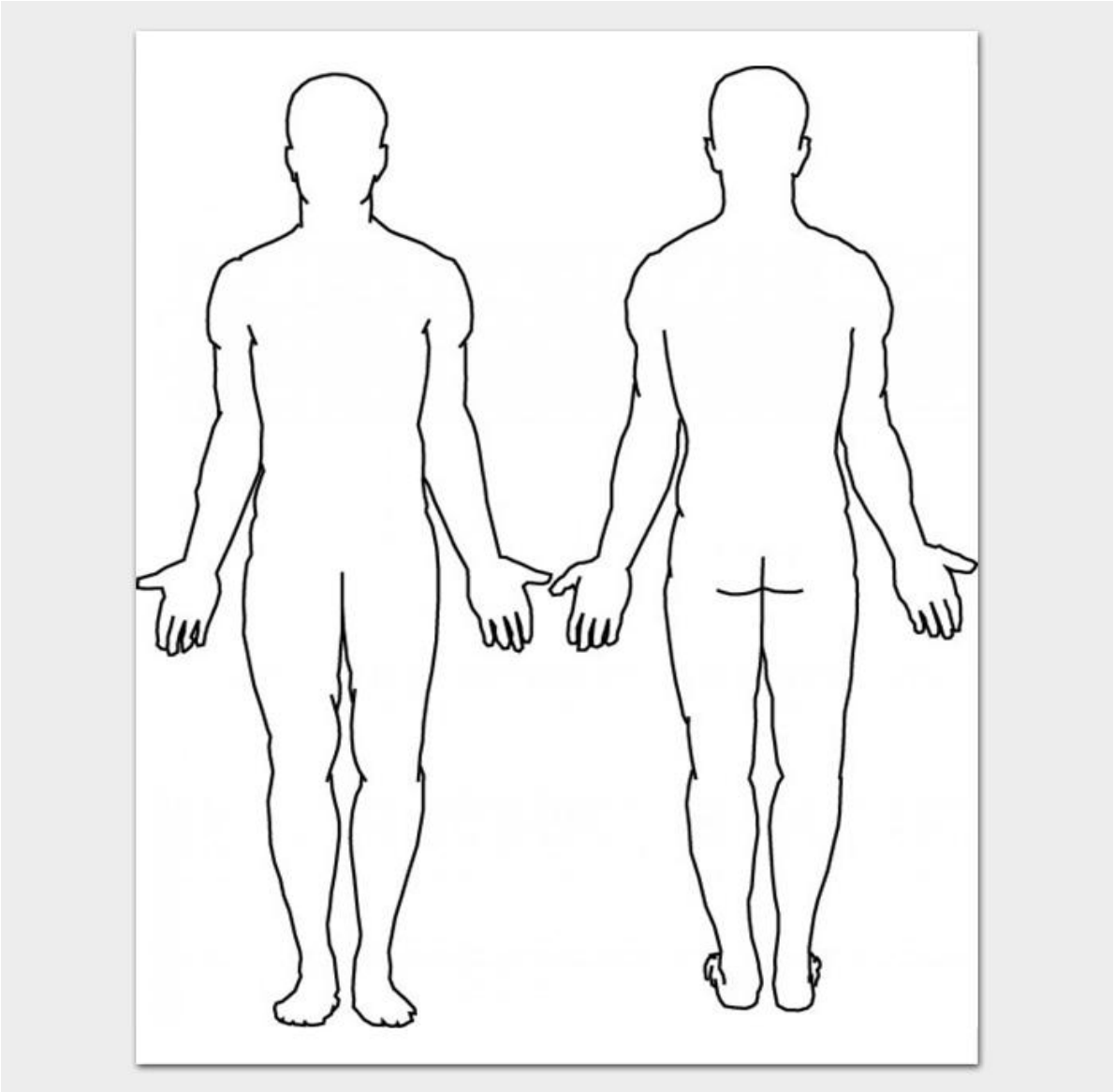
SHARP SHOOTING STABBING BURNING TINGLING/NUMB OTHER

What activity brings on the pain or makes it worse? _____

What eases or eliminates the pain? _____

Is your pain getting better, worse, or staying the same? _____

Where is your pain? Please mark “x” on the drawings in the areas where you feel your pain



Rate your overall pain: No Pain 0—1—2—3—4—5—6—7—8—9—10 Worst Pain Ever

Prior Treatment for Pain: Mark any imaging or treatments performed below.

- MRI of the _____Date: _____ Facility: _____
- X-Ray of the _____ Date: _____Facility:_____
- CT of the _____ Date:_____Facility:
- DEXA/ Bone Scan _____ Date:_____Facility: _____

Treatment	Helpful	Comments	Facility/Dates performed
☐ Surgery	☐ YES or ☐ NO		
☐ TENS/MENS	☐ YES or ☐ NO		
☐ Physical therapy	☐ YES or ☐ NO		
☐ Occupational Therapy	☐ YES or ☐ NO		
☐ Biofeedback/Relaxation therapy	☐ YES or ☐ NO		
☐ Acupuncture	☐ YES or ☐ NO		
☐ Chiropractor	☐ YES or ☐ NO		
☐ Other Pain Center (s)	☐ YES or ☐ NO		
☐ Professional Psychological Support	☐ YES or ☐ NO		
☐ Other:	☐ YES or ☐ NO		

MEDICATIONS

List medications with dosage (include any prescribed, over the counter, and/or vitamins):

_____

_____

_____

_____

Allergies to Medication

Medication Name:	Reaction:

Preferred Pharmacy (Name and Location): _____

Blood Thinner Questionnaire

Do you take any of the following medications, frequently referred to as "blood thinners"?
If YES, please circle the medication(s) you are taking.

☐ Aggrenox (Aspirin/Dipyridamole)	☐ Eliquis (Apixaban)	☐ Cilostazol
☐ Brilinta (Ticagrelor)	☐ Coumadin (Warfarin/Jan)	☐ Pradaxa (Dabigatran)
☐ Ticlid (Ticlopidine)	☐ Persantine (Dipyridamole)	☐ Effient (Prasugrel)
☐ Pradaxa (Dabigatran)	☐ Pletal (Cilostazol)	☐ Xarelto (Rivaroxaban)
☐ Lovenox (Enoxaparin Sodium) Injection	☐ Aspirin	☐ Fish Oil/Omega 3
☐ Plavix (Clopidogrel)	☐ NSAIDS: Motrin, Advil, Ibuprofen, Aleve, Naproxen, Meloxicam, Relafen, Nabumetone, Voltaren, Diclofenac, Celebrex	Other:

PAST MEDICAL HISTORY

Surgical History: List all surgical procedures related to your pain, year and surgeon that performed them

_____

_____

_____

Medical History: (Check as many that apply)

Allergies	YES	NO		Depression	YES	NO		Myocardial Infarction	YES	NO
Anemia	YES	NO		Diabetes Mellitus	YES	NO		Nerve/Muscle Disease	YES	NO
Anxiety	YES	NO		Dexa/Bone Density	YES	NO		Osteoporosis	YES	NO
Arthritis	YES	NO		Emphysema	YES	NO		Seizures	YES	NO
Asthma	YES	NO		GERD	YES	NO		Shortness of Breath	YES	NO
Blood Transfusion	YES	NO		Glaucoma	YES	NO		Sickle Cell Anemia	YES	NO
Cancer	YES	NO		Heart Murmur	YES	NO		Stroke	YES	NO
Cataracts	YES	NO		High Cholesterol	YES	NO		Substance Abuse	YES	NO
Chest Pain	YES	NO		HIV/ AIDS	YES	NO		Thyroid Disease	YES	NO
CHF	YES	NO		Hypertension	YES	NO		Tuberculosis	YES	NO
Clotting Disorder	YES	NO		Kidney Disease	YES	NO		Ulcers	YES	NO
COPD	YES	NO		Meningitis	YES	NO		Migraines	YES	NO
Fatigue	YES	NO		Sleep Apnea	YES	NO				

Weight:_____Height:_____ Last menstrual period: _____ Could you be pregnant? Yes No

SOCIAL HISTORY

Occupation/Occupation prior to Retirement: _____Retired: Yes No

Are you legally disabled? Yes No Are you currently working? Yes No

Marital Status? Single Married Widowed Divorced/Separated Domestic Partnership

# of Children: _____ Do you have a support system at home? Yes No

Race: Caucasian African American Hispanic Asian Other: _____

Alcohol Use? Yes No If yes, how many drinks do you have in an average week? _____
Do you have a history of alcohol, or drug abuse? Yes No If yes, how long sober? _____
If yes, what substance was abused? _____
Do you manage your pain with illicit drugs? Yes No What type? _____

Tobacco Use? Yes No If so, Ready to Quit? Yes No
Smoker: Packs/day _____
Former Smoker: Quit Date _____ Packs/day_____
Smokeless Tobacco: How Often? _____
Former Smokeless Tobacco User: Quit Date _____

Code of Conduct for Patients and Visitors

To provide a safe and healthy environment for staff, visitors, patients and their families, Restorative Pain Management expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive and/or pose a threat to the rights or safety of other patients and staff.

- ✓ If you have any questions about the care received OR are unhappy with the service received in our office, please contact our practice manager before leaving our office.
- ✓ Please be sure to communicate all issues that you wish to discuss with the doctor at the time of your appointment. After a visit has ended, another appointment will be necessary to address additional concerns or questions as the doctor works diligently to give all patients the time allocated for their appointment.
- ✓ Questions about your billing can be addressed by calling Gateway Medical Solutions at 573-307-0500.
- ✓ Please be courteous with the use of cell phones and other electronic devices. Please minimize volumes or put the device on silent/vibrate when in our office.
- ✓ Adults are expected to supervise their children.
- ✓ Our practice follows a zero-tolerance policy for aggressive behavior by patients toward our staff.

The following behaviors are PROHIBITED:

- Possessing firearms or a weapon of any kind
- Intimidating or harassing staff or other patients and visitors, including but not limited to using verbally abusive or offensive language
- Making threats of violence through phone calls, letters, voicemail, e-mail or other forms of written, verbal or electronic communication
- Physically assaulting or threatening to inflict bodily harm
- Making verbal threats to harm another individual or destroy property
- Damaging business equipment or property

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

I have read, understand and agree to the Code of Conduct for Patients and Visitors.

Patient/Patient's representative Name

Patient/Patient's representative Signature Date

Patient Financial Agreement

I understand that as a recipient of medical care, I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. Full payment is due at the time of delivery of service. I understand that a fee is charged for all visits, examinations, or medical reports. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate him/her for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third-party payer (for example: insurance company, employer, etc).

The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents; and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Pain Management Medical Center, LLC, d.b.a. Restorative Pain Management, all benefits. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility. Full payment is due at the time of service except if otherwise arranged or mandated by law.

Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances.

Unpaid charges over 60 days will incur a monthly service fee of $25. Accounts with no activity for 60 days may be forwarded for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency (25% of total balance) and attorney fees. Any and all advance collection fees incurred by the practice will be included in my final bill. I understand and agree that some additional charges may come through from my treatments that are not included in the initial estimated bill. There is a $35.00 service charge for a returned check.

I UNDERSTAND THAT IT IS MY RESPONBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Providing Pain Management Medical Center, LLC, d.b.a. Restorative Pain Management with complete an accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/or referrals for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.
2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit.

I give my consent to Pain Management Medical Center, LLC, d.b.a. Restorative Pain Management to provide medical care and treatment to the below-named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I HAVE READ AND AGREE TO THE TERMS OUTLINE ABOVE

SIGNED (patient or guarantor):_____

DATE: _____ **FOR (print patient name):** _____

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I hereby authorize Dr. Gregory Stynowick/Restorative Pain Management/Restorative Surgery Center to:

- ❑ **Release** my records to (designate below) **OR**
- ❑ **Obtain** my records from (designate below)

Patient's full name: _____

Date of Birth: _____ Social Security Number: _____

I request only the following information to be released/obtained:

- o Clinician office notes
- o Laboratory reports
- o Diagnostic imaging reports
- o Urgent Care records
- o All hospital records (including Emergency room and/or operative reports, progress notes, etc)

Date(s) of Treatment: _____

Records to/from (circle one): Physician/Institution/Self Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

For the purpose of: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the Organization authorized to receive the information is not a health plan/provider covered by Federal Privacy Regulations, the released information may no longer be protected by Federal Privacy Regulations.

I permit the release of all information indicated above including, if any, concerning drugs/alcohol treatment, abuse and/or use. Psychiatric treatment or AIDS/HIV and other communicable diagnosis and treatment thereof, and to include any Hepatitis Testing/results.

I understand that this authorization will expire one year from the date listed below.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, except to the extent the organization has taken action in reliance on the consent. I understand that I may be required to pay the cost of preparing and mailing the copies, except for uses and disclosure for treatment.

_____ _____

Signature of patient or patient's Representative Date

_____

Printed Name of patient or patient's Representative Basis of Representative's Authority