PREMIER PAIN CARE PA

Carlos J Garcia MD
2435 W. Oak Street # 103 Denton, TX 76201
Phone 940-323-9404 Fax 940-323-9422

PATIENT REGISTRATION

Last Name _____First Name _____MI_____
Mailing Address _____City _____Zip code_____
Home Phone # _____Cell Phone #_____
Date of Birth _____Social Security Number_____ M F
Single Married Widowed Separated Divorced Referring Physician_____
Employer _____Work #_____

Primary Insurance_____ (Please bring insurance card to be copied)
Name of Insured _____Social Security Number _____
Date of Birth _____Relationship to Insured_____
Employer _____Work#_____

Secondary Insurance_____ (Please bring insurance card to be copied)
Name of Insured_____ Social Security Number_____
Date of Birth _____Relationship to Insured_____
Employer _____Work#_____

EMERGENCY CONTACT_____ Phone # _____

THIS IS A WORK RELATED INJURY___
It will be filed as workman's compensation.

THIS IS NOT A WORK RELATED INJURY___
It will not be filed as workman's compensation.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to **Premier Pain Care PA, Carlos J Garcia MD.** I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

_____ _____
Signature of Patient or Guardian Date

Premier Pain Care, PA

PATIENT AUTHORIZATION & CONSENT

Premier Pain Care is committed to fulfilling all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Section A: ***AUTHORIZATION***

Must be completed for all authorizations. The patient or the patient's representative must read and initial the following statements:

1. I authorize Premier Pain Care to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care. **Initials: _____**
2. I understand that I may revoke this authorization any time by notifying Premier Pain Care in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions Premier Pain Care took before they received my revocation**.** **Initials: _____**

   You may revoke this authorization by signing a Revocation Authorization form and returning it to Premier Pain Care. To request a Revocation Authorization form, you may ask the reception desk or contact our office at: Privacy Contact, Premier Pain Care, 2435 W. Oak, Suite 103 Denton, TX 76201, (940) 323-9404.
3. Premier Pain Care will not base condition for treatment or payment for health care services on your completing and signing this authorization. **Initials: _____**

For additional information regarding disclosures of uses of my health information, I acknowledge I may obtain a copy of Premier Pain Care **"Notice of Privacy Practices"** at any time from the reception desk or by contacting the above business office.

Initials: _____

Section B: ***CONSENT***

In the event a family member or care giver attends my office visit and is in the exam room at the time of evaluation and/or treatment, I give Premier Pain Care and it's physicians or employees my permission to discuss freely my condition, treatment, diagnosis or insurance/payments issues with that person. **Initials: _____**

May we leave a message on your HOME Phone: (provide #) _____☐YES☐ NO
May we leave a message on your WORK Phone: (provide #) _____☐YES☐NO
May we leave a message on your CELL Phone: (provide #) _____ ☐YES☐NO
May we leave a message on your PAGER (if applicable) _____ ☐YES ☐NO

May we leave a message at one of the numbers listed above about appointments with this office? ☐YES ☐NO

We address our patients by name in our office and reception area. If you do not wish us to do please note here. _____
With whom may we discuss or release information about your care, treatment, or diagnosis?
_____Relationship_____
_____Relationship_____

Print Name _____Signature _____Date _____

Premier Pain Care, P.A.
Pain Management History

Name_____ Age _____
Marital Status _____ Place of Residence _____
Occupation _____ Phone Number _____
Referring Doctor_____ Primary Care Doctor_____
Date_____

Current Pain Problem

1. Date of onset of pain: _____
   Date of diagnosis: _____
2. Under what circumstances did the pain begin: Work accident _____
   Home accident_____ Auto accident_____ After surgery_____
   Describe briefly _____
3. In what part of the body is the pain localized? Describe_____
   _____
4. Describe your pain. The following words may help you. Aching [ ] Throbbing [ ]
   Stabbing [ ] Shooting [ ] Burning [ ] Penetrating [ ] Sharp [ ] Numb [ ]
   Tingling [ ] Constant [ ] Intermittent [ ]
5. Intensity of the pain: Mild ____ Moderate _____ Severe ____ Excruciating ___
6. What makes the pain worse? _____
   Sitting____ Standing____ Walking____ Coughing___ Bending over_____
   Exercise____ Lying on your back____ Lifting____ Deep breathing_____
7. What eases the pain? (Massage, rest, medication, etc.) _____
   _____
8. If you take any pain medication, describe the effect:
   I do not take pain medications_____ It does not help_____
   How long does the pain relief last? (Hours)_____
   How many times a day do you take it? _____
   In the last two weeks, are you taking: more_____ same_____ less _____ pain medications?
9. Has the pain caused depression or other emotional problems? _____
   If so, have you sought medical care?
10. Has the pain affected your ability to work? _____ For how long?_____
11. Does the pain interfere with your sleep?_____
12. Has the pain affected your ability to enjoy life, personal relationships, other? ____
    _____
13. In the last 24 hours, how much relief has treatments and medications provided?
    0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100

In the last 24 hours how would you rate your average pain?
Pain Level – 0 1 2 3 4 5 6 7 8 9 10

In the last 24 hours how would you rate your worst pain?
Pain Level – 0 1 2 3 4 5 6 7 8 9 10

In the last 24 hours how would you rate your least pain?
Pain Level – 0 1 2 3 4 5 6 7 8 9 10

14. Describe any previous treatment for your pain:

Treatment	**Location**	**Date**	**Response**
Physical Therapy			
Work Hardening			
Pain Program			
Injections/ Nerve blocks			
Others (Surgery, TENS, Acupuncture, Chiropractor, Biofeedback)			

15. What is your current occupation or last job? _____
16. If not working currently, when did you work last?_____
17. What prevents you from returning to work?_____
18. Do you receive compensation or disability payments? _____
    Do you have an application for compensation or disability payments?_____
19. Are you in active litigation because of pain or injury?_____
20. Do you enjoy your work?_____
21. Last grade completed? (High school, College, Masters, Professional)
    _____
22. Are you R or L handed?

PAST MEDICAL HISTORY

1. Please **circle** any of the following illness, which you have or had in the past:

High Blood Pressure	Stomach Ulcer	Asthma
Angina	Gallbladder Disease	Tuberculosis
Heart Attack	Colon Disorder	Gout
Heart Murmur	Heart Surgery	Cancer
Hepatitis	Rheumatoid Arthritis	Diabetes Mellitus
Osteoarthritis	Vascular Disease	Thyroid Disease
Kidney Disease	Anemia	Glaucoma
Bleeding Disorder	Seizures	Drug abuse
Recent weight loss	Change in bladder or bowel habits	
Depression	Other_____	
Chronic Pain Syndrome		

2. Please list all recent hospitalizations and all surgeries:

_____
_____
_____
_____
_____
_____
_____

4. List Medications you are taking now:

Medication	Dose	Frequency (Times a day)	**Medication**	Dose	Frequency (Times a day)

5. List medications to which you are **allergic**:

Medication **Type of reaction** (rash, itching, swelling, etc)

_____
_____
_____
_____

FAMILY HISTORY

Circle condition and describe as follow (**F**-father, **M**-mother, **S**-sibling **GF**-grandfather, **GM**-grandmother, **O**-other)

High blood pressure _____ Heart attack_____
Diabetes _____ Cancer _____
Bleeding disorder _____ Seizures _____
Neurological Disorders _____ Chronic Pain _____
Problems with anesthesia _____ Depression _____
Other _____

SOCIAL HISTORY

1. Do you drink **alcoholic beverages**: Yes____ No ____
   If yes, what type and on the average, how much per week:
   _____
2. **Smoking habits**: No____ Yes____ Past_____
   If yes, who much do you smoke and for how long:_____
3. History of substance abuse? Yes_____No____
. History of Drug Detoxification Program? Yes_____No____
   Explain _____

Name_____ **Date**_____

MEDICATION EVALUATION :(Complete only if taking medication at this time for pain)

Is your medication effective in decreasing your pain**?** ☐ yes ☐ no

If yes, to what degree? ☐ significant ☐ moderate ☐ minimal

If no, why do you think is not effective? ☐ not strong enough ☐ short relief ☐ no relief

Are you experiencing side effects? ☐ yes ☐ no (circle below)

Nausea, headaches, dizziness, nightmares, loss of balance, unable to think properly,

Fluid retention, constipation, depression, sexual dysfunction, itching, morning-

hangover, other_____

Are you currently obtaining any pain medications from a different provider? ☐ yes ☐ no

Are you currently taking any herbal supplements/vitamins/other natural products? ☐ yes ☐ no

If yes, describe_____

Have you been informed of the benefits, alternatives, risks and side effects of narcotic pain relievers? ☐ yes ☐ no

Have you been to the Emergency Room for pain control? ☐ yes ☐ no

If yes, explain_____

Have you been informed that taking an illicit drugs or alcohol along with pain medications can be potentially lethal and harmful? ☐ yes ☐ no

PSYCHOLOGICAL EVALUATION :

1. Are you sad more days than not? ☐ Yes ☐ No

- In past weeks, have you had difficulty concentrating, thinking, or making decisions? ☐ Yes ☐ No
- Are you experiencing a lack of interests in activities that you used to enjoy? ☐ Yes ☐ No
- Do you feel as if you're progressively losing energy, or becoming more restless in performing your daily activities? ☐ Yes ☐ No

If yes to any question, proceed to question 2.

2. **Would you describe yourself as depressed?** ☐ Yes ☐ No

- Do you have feelings of worthlessness or hopelessness on a regular basis? ☐ Yes ☐ No
- Do you often experience unprecedented feelings of guilt? ☐ Yes ☐ No
- Have you recently had an unplanned weight gain or loss? ☐ Yes ☐ No
- Have you recently had trouble sleeping, or sleeping too much? ☐ Yes ☐ No
- Do you feel that you can't shake the blues, even with the help of family and friends? ☐ Yes ☐ No

If yes to any questions, proceed to question 3.

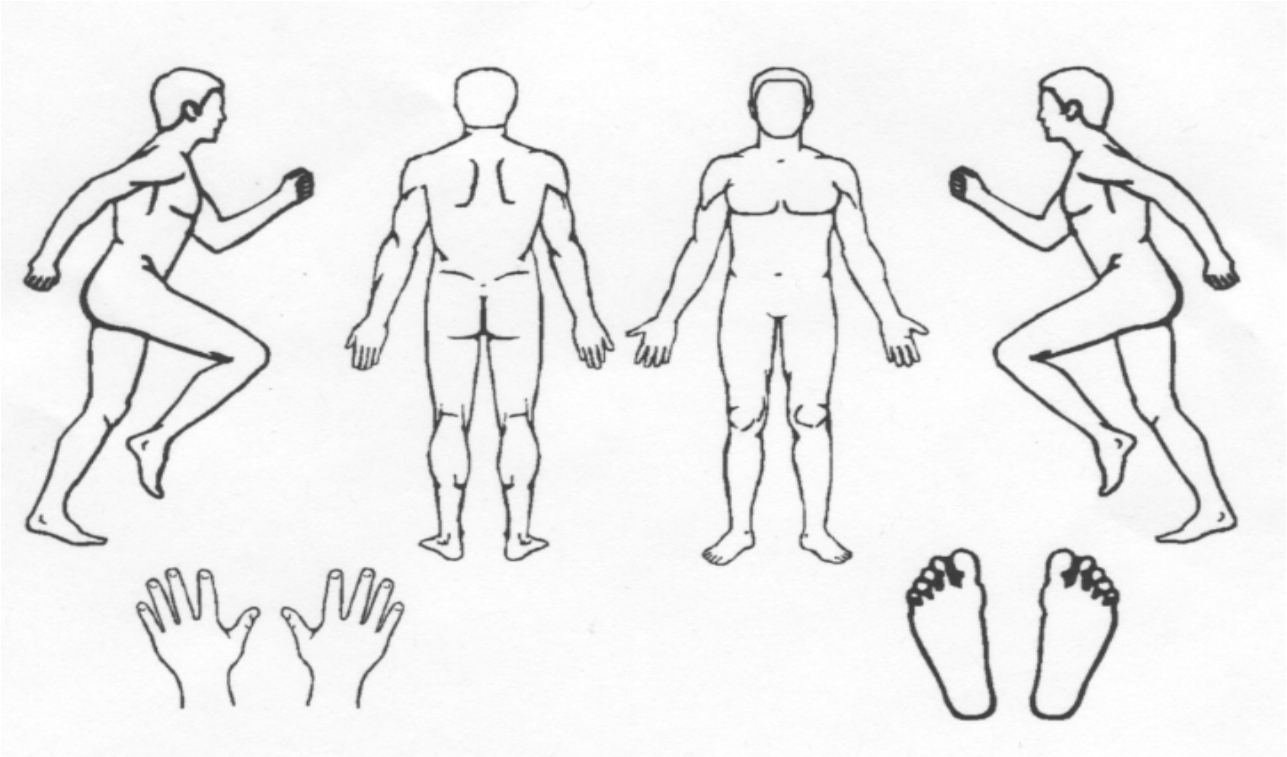
3. **Have you thought about suicide?** ☐ Yes ☐ No

- Do you sometimes feel that life isn't worth living? or people will be better off without you? ☐ Yes ☐ No
- Have you engaged purposely in reckless behavior, or thought about hurting yourself? ☐ Yes ☐ No
- Have you ever attempted suicide? ☐ Yes ☐ No

If yes to any questions, do you have a plan? ☐ Yes ☐ No

Name: _____ Date: _____

Please mark painful areas with an X.



<u>REVIEW OF SYSTEMS</u> (Please answer the following below with N- for No and Y- for Yes. If yes circle all that apply)

General - Recent weight loss, fever, too drowsy?

ENT - Ringing in ears, frequent nose bleeds, eye or ear infection?

GU - Blood in urine, urine infection, painful urination, flank pain?

GI -Nausea, vomiting, loss of appetite, constipation, bowel control, black stools, blood in stools, stomach pain or burning?

Heart- Chest pain, shortness of breath, fluttering of heart?

Neurological - dizziness, fainting spells, black out spell?

Psyche - depressed, angry, can't sleep, worry, unhappy? Thought of harming yourself?

Blood - bleeding problems, are you on a blood thinners , aspirin, plavix, others?

Lungs- Wheezing, cough, asthma?

Recent Emergency Room visits for pain management?