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McDowell Ambulatory Surgery Center

Referred by _____

How did you find out about our practice? _____

PATIENT INFORMATION

Patient name _____ Birth date _____ Age _____

Street address _____ Apt # _____

City _____ State _____ Zip code _____

Home # (____) _____ Cell # (____) _____ Alt/work # (____) _____ Email _____

Driver's lic _____ SS # _____ Male/Female _____

Marital status: () Single () Divorced () Widowed () Married. Name of spouse _____ Student: () PT () FT

EMPLOYMENT INFORMATION

Employer _____ Occupation _____

Emergency contact _____ Phone # (____) _____

Who is your primary care physician? _____

Address _____ City / State / Zip _____ Phone # (____) _____

Are your symptoms related to an accident? Yes () No () Don't know () Date of accident _____

If yes, what type? Auto () On the job () Other () _____ Date reported _____

Is there an open claim related to this injury? No _____ Yes _____ State in which accident occurred _____

APPOINTMENTS

We ask that our patients come to their appointments 15 minutes before their scheduled time in order to fill out needed paperwork. If you are late, we will need to reschedule your appointment for a later time and date at our discretion.

PERMISSION FOR TREATMENT

I authorize the staff at Arizona Pain Treatment Centers to examine me and render treatment they deem necessary.

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Arizona Pain Treatment Centers and its member physician to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate treatment and payment by third parties, collection of data for purpose of utilization review, quality assurance, or medical outcome evaluation purposes. Such information may be released to insurance companies, HMOs, PPOs, Managed Care organizations, IPAs or third party payers or any organizations contracting with any of the entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary or specialist physician that is directly or indirectly responsible for my medical care or the payment thereof.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed and agree to the Notice of Privacy Practices of Arizona Pain Treatment Centers/McDowell Ambulatory Surgery Center, which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practices. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information.

Name _____ Signature _____ Date _____

Patient Billing Information

HEALTH INSURANCE PRIMARY:

Insurance Co _____ Telephone # to verify benefits: _____
Name of Insured: _____
Insured's Soc. Sec. # _____ DOB _____
Group/Policy # _____
Mail claims to: _____

HEALTH INSURANCE SECONDARY:

Insurance Co _____ Telephone # to verify benefits: _____
Name of Insured: _____
Insured's Soc. Sec. # _____ DOB _____
Group _____ Policy # _____
Mail claims to: _____

Med-pay Insurance: (Insurance for vehicle you were in)

Insurance Co: _____ Name of Insured: _____
Claims office Address: _____ Phone: _____ Date of Injury: _____
Med Pay Limits: \$ _____ Is claim open? _____
Policy #/Claim # _____ Adjustor's name: _____ Phone: _____

Attorney's name:

Attorney's Name: _____ Law Firm: _____
Phone: _____ Date of Injury: _____ Contact Person _____
Address: _____ Liens to file: _____ County _____ Attorney _____

Third Party/Liability Insurance Company: (Insurance info for at fault vehicle)

Insurance Co _____ Address: _____
Phone: _____ Date of Injury: _____ Claim Adjuster: _____
Insured's name: _____ SS#: _____ DOB _____
Policy/Claim #: _____ Is claim still open? _____

Workers' Compensation Insurance Company:

Insurance Company _____ Insured's Name: _____
Address: _____ Employer: _____
Phone: _____ Employer Phone: _____
Case Manager: _____ Address: _____
Claim #: _____ Date of Injury _____
Is Claim still open? _____ Policy #: _____

Arizona Pain Treatment Centers

1301 East McDowell Road, Suite 100, Phoenix, AZ 85006
5656 South Power Road, Suite 139, Gilbert, AZ 85295
(602) 265-8800 Phone (602) 265-8151 Fax

Consent to Release Information

I, **(Patient Name)** _____ authorize:

Name of Doctor or Institution _____

Street Address _____

City, State, Zip Code _____

Phone: _____ **Fax:** _____

To release medical information to:

Name of Person or Institution Arizona Pain Treatment Centers

Street Address 1301 East McDowell Road, Suite 100

City, State, Zip Code Phoenix, AZ 85006

Phone: (602) 265-8800 Fax: (602) 265-8151

Information to be disclosed for continuing medical care:

**X 3 most recent progress notes, medication list,
diagnostic testing (MRI, x-ray, EMG) procedure
notes (injection/surgical note). Urine drug screen**

This consent may be revoked at any time by sending written notice to the above-named provider of information. Any release of information made prior to the revocation of this compliant authorization is not a breach of confidentiality. Disclosed information may be reviewed by contacting the provider of information.

Please note this authorization will automatically expire one year from the date of signature, unless otherwise specified below:

Date of Expiration: _____

Signature of patient or legal guardian: _____ **Date:** _____

Social Security Number: (last 4 digits) _____

Relationship, if not the patient: _____ **Patients DOB:** _____

To the recipient of this information: this information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making further disclosure without additional consent.

Date information is sent: _____ Sent by (name) _____

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is not sufficient for this purpose.

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Date: _____

Name: (last, first) _____, _____ DOB _____ AGE _____

How did you hear about our practice? _____

Who is your Primary Care Physician (PCP)? _____

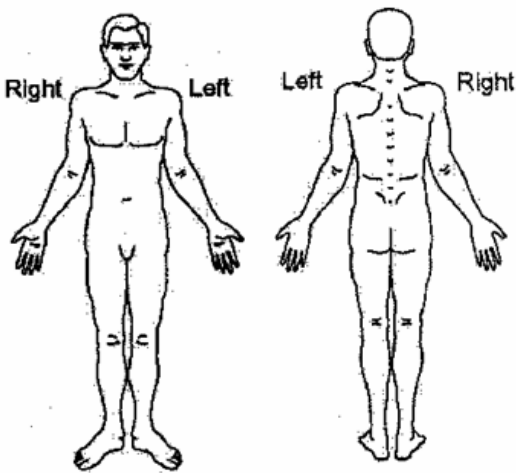
Please provide the name, specialty, approximate date of last visit and phone number (if you have it) of any other physician you have consulted regarding your condition (specifically include any Rheumatologists, Neurologists, Orthopedic Surgeons, or Spine Surgeons) _____

Please provide your pharmacy contact information: _____
(include cross streets and phone #)

What are your primary pain complaint(s) / problem(s)? 1. _____
2. _____

Please draw where you have your pain: **Current Medications** (if you need more space, continue on the next page):

on the next page):



Do you have allergies to latex, adhesive tape, contrast dye, iodine/shellfish or medications? Please list the allergy and the reaction you had

Vital signs (office use only) BP: _____ HR: _____ HT: _____ WT: _____

Medication:	Strength:	Dose/Schedule:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What spinal injections have you received for your condition?

Type	Date	Response
Epidural	_____	_____
Facet Joint	_____	_____
Radiofrequency ablation	_____	_____
Trigger Point Injection	_____	_____
Other	_____	_____

How would you describe your pain?

- Aching Burning Cramping Pins and Needles Throbbing Dull Pressure
- Tightness Sharp Stabbing

If you have shooting or electrical pain, what area?

- Right arm Left arm Both arms Right leg Left leg Both legs I do not have shooting or electrical pain

How would you currently rate your pain?

- Least 0 1 2 3 4 5 6 7 8 9 10 Worst

What was your lowest pain level?

- Least 0 1 2 3 4 5 6 7 8 9 10 Worst

What was your highest pain level?

- Least 0 1 2 3 4 5 6 7 8 9 10 Worst

When did your pain begin? _____ How many.....

- Very recently Days ago Weeks ago Months ago Years ago

What caused your pain to start?

- No specific event or trauma there a long but recently got worse Gradual onset Motor vehicle accident Has been
- A fall Trying to lift or carry something Bending

My pain is made worse with:

- Sitting Twisting Activity Driving Standing Lifting Cold
- Sneezing Lying down Position changes while lying down Rising from a seated position
- Coughing Walking Looking up Looking down Looking left Looking right
- Everything Bending Work Vacuuming

My pain is improved by:

- Ice Sitting Walking Narcotics Heat Standing OTC Medications
- Nothing Activity Lying down Prescription medications Rest Frequent position changes

My pain is associated with:

- Poor appetite Difficulty in performing household chores Poor sleep Unable to perform household chores
- fatigue Difficulty in performing physical activity Weakness A significant decrease in ability to work / job
- Anxiety Unable to work / remain employed increased anger
- Impaired sexual function / activity Inability to control emotions Impaired personal relationships
- Other _____ None of the above

My goal is to:

- Return to work Enjoy family again Reduce my pain Enjoy work again Get control of my life
- Restore functionality

Please indicate the treatments received and the level of relief:

Chiropractic treatment: temporary relief was not beneficial have not tried

Physical therapy: provided relief did not provide relief have not tried

Massage therapy: provided relief did not provide relief have not tried

TENS: provided relief did not provide relief have not tried

Acupuncture: provided relief did not provide relief have not tried

Biofeedback: provided relief did not provide relief have not tried

Have you received psychological counseling for your pain?

Yes No

List any diagnostic tests you have had for this condition (MRIs, X-Rays, EMGs, CT Scans, Etc.)

Test	Date	Response
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any surgeries and hospitalizations you have had

Surgery/Hospitalization	Date	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate if you have a history of the following:

- Anticoagulant use Heart problems/high blood pressure/chest pain Bleeding problems
- Lung problems/shortness of breath Cancer Problems with surgery or anesthesia
- Diabetes Psychiatric disorders Bipolar disorder Major depression Schizophrenia
- Stroke/TIAs Other _____ None of the above

Are you married?

- Yes No

With whom do you live?

- I live alone Roommate Spouse/Significant Other Parents

Is there substance abuse in the home?

- Yes No

Are you able to care for yourself?

- Yes No

Are you currently employed?

- Yes No

Did you leave your job because of your pain?

- Yes No

Are you involved in a lawsuit over your pain?

- Yes No

Do you have a family history of? (Please [bX]WHY all that apply)

- Cancer Strokes/TIAs Headaches
- Cardiac disease Neurological diseases Adopted/Unknown
- Cardiac disease below age 40
- Anesthetic Other _____ None of the above
- Compilcations

Print Patient's Initials: _____ **Reviewed By:** _____ **Date:** _____

Are you currently using any illegal drugs? Yes No

Do you consume alcohol?
 No I have 2-4 drinks per week I have 6-8 drinks per week I have more than 8 drinks per week

Do you use tobacco?
 No I used to smoke, but quit I smoke 1 pack per day I smoke 2 packs per day

Have you had any of the following pulmonary (lung-related) issues?
 Asthma/ Difficulty breathing COPD Emphysema Other _____
 None of the above

Have you had any of the following cardiovascular (heart-related) issues or procedures?
 Heart surgeries Congestive heart failure Murmurs or valvular disease Heart attacks or MIs
 Heart disease / problems Hypertension Pacemaker Angina / chest pain
 Irregular heartbeat Advised to use antibiotics before a dental procedure Other _____
 None of the above

Have you had any of the following neurological (nerve-related) related issues?
 Visual changes/Loss of vision One-sided weakness of face or body History of seizures
 One-sided decreased feeling in the face or body Headaches Memory loss
 Tremors Vertigo Loss of sense of smell Strokes/TIAs Other _____
 None of the above

Have you had any of the following endocrine (glandular / hormonal) related issues or procedures?
 Thyroid disease Hormone replacement therapy Injectable steroid replacements
 Diabetes Other _____ None of the above

Have you had any of the following renal (kidney-related) issues or procedures?
 Renal calculi/stones Hematuria (Blood in the urine) Incontinence (can't control)
 Bladder infections Difficulty urinating Kidney disease Dialysis Other _____
 None of the above

Have you had any of the following gastroenterological (stomach-related) issues?

- Nausea Difficulty swallowing Ulcerative disease Frequent abdominal pain
- Hiatal hernia Constipation Pancreatic disease Irritable bowel/colitis
- Hepatitis or liver disease Bloody or black tarry stools Vomiting blood
- Bowel incontinence Gastroesophageal reflux/heartburn Other _____
- None of the above

Have you had any of the following hematological (blood-related) issues?

- Anemia Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) HIV positive
- Abnormal bleeding/bruising Sickle-cell anemia Enlarged lymph nodes Hemophilia
- Hypercoagulation or deep venous thrombosis/history of blood clots Anticoagulant therapy
- Regular aspirin use Other _____ None of the above

Have you had any of the following dermatological (skin-related) issues?

- Significant burns Significant rashes Skin grafts Psoriatic disorders Other _____
- None of the above

Have you had any of the following musculoskeletal (bone-related) issues?

- Rheumatoid arthritis Gout Osteoarthritis Broken bones Spinal fracture
- Spinal surgery Joint surgery Arthritis (Unknown type) Scoliosis Metal implants
- Other _____ None of the above

Have you had any of the following psychological issues?

- Psychiatric diagnosis Depression Suicidal ideations Bipolar disorder Homicidal ideations
- Schizophrenia Psychiatric hospitalizations Other _____ None of the above

Is there anything else in your past medical history that you feel is important to your care here?
