

PAIN MANAGEMENT CENTERS
215-771-1179
TRICOUNTYPMC.COM

New Patient Intake

Name: _____ Age: _____ Date of birth: _____ Date: _____
 LAST FIRST MIDDLE

Address: _____ Social Security #: _____ Male Female

City, State, Zip: _____ Marital Status: M S W D # of Children _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email address: _____

Employer: _____ Occupation: _____

In case of emergency, notify _____ Relationship: _____ Phone (_____) _____

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

Current Symptoms: 1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; Constant >76% Frequent 51-75% Occasional 26-50% Intermittent <25% of your waking hours

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Patient's Name: _____ Date: _____

Please list all medications and dosage:

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

List any allergies to medications, foods or other: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis <input type="checkbox"/> Yes	Lung Disease <input type="checkbox"/> Yes	Gout <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> Yes
Kidney Disease <input type="checkbox"/> Yes	Stomach/Ulcer <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> Yes
Sciatica <input type="checkbox"/> Yes	High Blood Pressure <input type="checkbox"/> Yes	Transfusion <input type="checkbox"/> Yes	Polio / MS <input type="checkbox"/> Yes
Colon Disease <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> Yes	Bleeding <input type="checkbox"/> Yes
Paralysis <input type="checkbox"/> Yes	Seizures <input type="checkbox"/> Yes	Arthritis <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> Yes
Anemia <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> Yes	Drug Dependence <input type="checkbox"/> Yes	AIDS <input type="checkbox"/> Yes
COPD <input type="checkbox"/> Yes	Migraine Headaches <input type="checkbox"/> Yes	Neck Pain <input type="checkbox"/> Yes	Back Pain <input type="checkbox"/> Yes

Past Surgical History: Date: _____ Procedure: _____
 Date: _____ Procedure: _____
 Date: _____ Procedure: _____
 Date: _____ Procedure: _____

Family History

Please list any conditions your parents or siblings may have: _____

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED RECENTLY:

<input type="checkbox"/> Headache	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Ears Ring
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lower Back Stiffness	<input type="checkbox"/> Buzzing in Ears
<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Bruised Chest	<input type="checkbox"/> Radiating Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Sleep Disruption	<input type="checkbox"/> Bruising Anywhere	<input type="checkbox"/> Tingling in Legs	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Depression	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Tingling in Arms	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sensitivity to Light	<input type="checkbox"/> Jaw Pain (TMJ)	<input type="checkbox"/> Increased Thirst
<input type="checkbox"/> Fainting	<input type="checkbox"/> Upper Arm Pain	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/> Difficulty Walking
<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Lower Arm Pain	<input type="checkbox"/> Lower Leg Pain	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Bowel/Bladder Changes	<input type="checkbox"/> Weight Change

Current Work Status: Retired Working Disability Other: _____

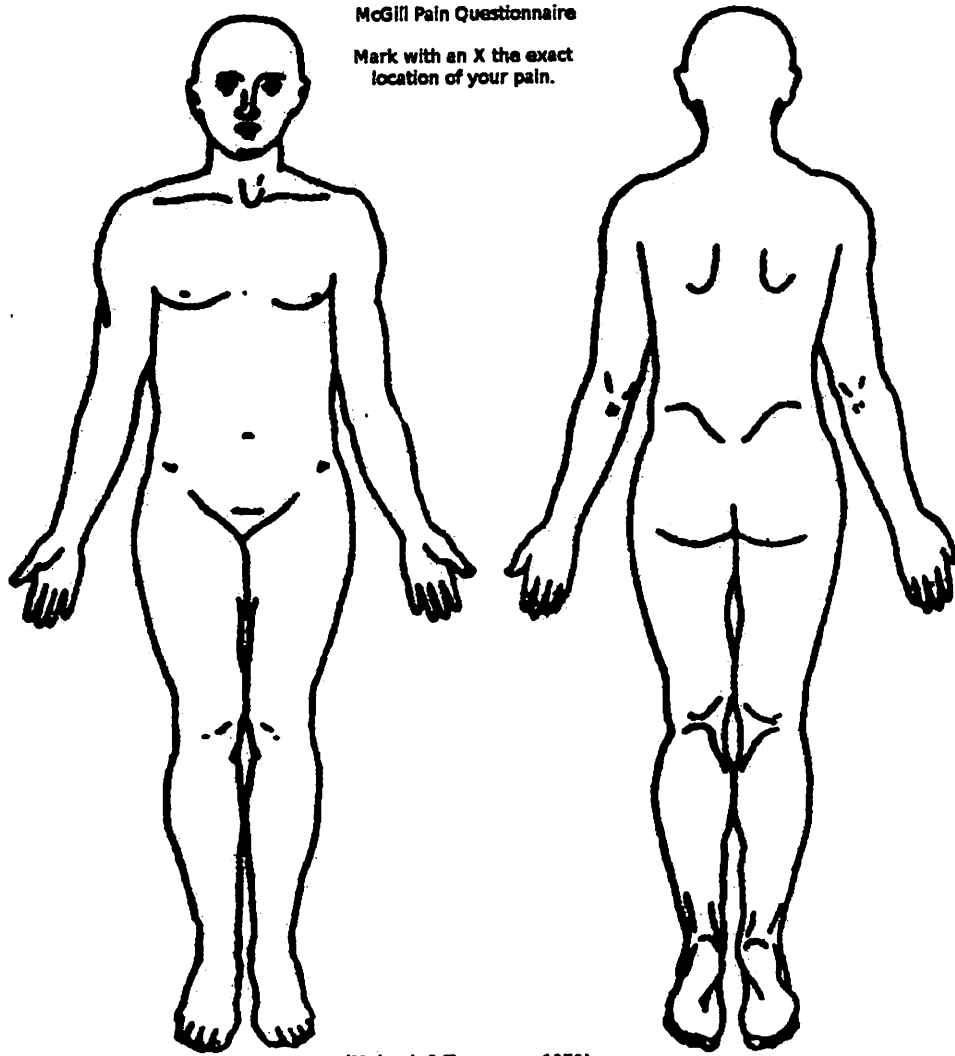
Do you smoke? Yes No; _____ pack(s) per day

Do you drink alcohol? Yes No; _____ drink(s) per day

Do you live in a: House _____ Apartment _____; List other household members: _____

PAIN MANAGEMENT CENTERS PAIN CHART

Mark the diagram with an X over any area of pain.



(Melzack & Torgerson, 1971)

Patient Signature: _____ Date: ____/____/____

CONSENT TO TREAT and ADMINISTRATIVE AUTHORIZATION

1. Authorization for Treatment and Diagnostic Procedures: I voluntarily authorize, request and consent to outpatient care services, including procedures, examinations, and medical treatment as ordered by my physicians, his/her assistants, or other health care provides. I understand that, except in emergency situations, this consent does not include surgical procedures or other procedures or treatment that may require separate consent. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of any procedures, treatments or examinations.

2. Assignment of Insurance Benefits to Tri County Pain Management Center: I authorize payment of health care benefits directly to Tri County Pain Management Center. In making this assignment, I understand and agree that I may be financially responsible to Pain Management Center for charges not paid under my insurance policy(ies). I permit a copy of this authorization to be used in place of the original. I authorize payment of authorized Medicare or other payor benefits to be made to me or on my behalf, to the physician or supplier for any services provided to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby certify that I have read and fully understand the above consent. I have sufficient opportunity to ask whatever questions I might have, and they have been answered to my satisfaction. I voluntarily and freely consent to the above and accept its term.

Signature: _____ Date: _____

Printed Name: _____

CONSENT TO TREAT A MINOR:

I hereby authorize the doctors of the Pain Management Centers, and/or whomever they may designate as assistants to administer treatment as deemed necessary to

Signature of Parent or Legal Guardian: _____

Printed name: _____ Date: _____ Relationship: _____

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: _____ Date: _____

Please answer the following questions:

Yes / No Leave a message regarding your appointment on your voicemail, email or with your spouse, apparent, or other member of your household (or at work, if this is the number you provide us with).

Yes / No Leave a message regarding test results on your voicemail, email, or with your spouse, a parent, or other member of your household (or at work, id this is the number you provide us with).

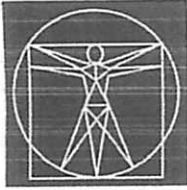
Yes / No Give test results to your spouse, a parent or to other designated family member or friend. If yes, please specify: _____.

___ I request the above restrictions to the use or disclosure of my Protected Health Information (PHI).

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices and use of PHI, but acknowledgement could not be obtained because:

- ___ Individual refused to sign
- ___ Communication barriers prohibited obtaining the acknowledgement
- ___ An emergency situation prevented us from obtaining acknowledgement
- ___ Other (Specify: _____)



Pain Management Centers

TriCountyPMC.com
Phone: 215-771-1179 Fax: 877-884-6224

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.