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Medical History Form

NAME _____

Height _____ **Weight** _____

MEDICATIONS: List all medications you are currently prescribed.

Name	Dosage	Frequency

List all non-prescription drugs and frequency of usage:

_____

Are you on a blood thinner? (Coumadin, Warfarin, Lovanox, Plavix) **If yes, what medication**? _____

Have you been treated for any of the following medical conditions? Check all that apply.

___ Anemia	___ Diabetes	___ Gastroesophageal Reflux
___ Angina, Heart Blockage	___Epilepsy or Seizure	___ GI Bleed
___ Anxiety	___ High Blood Pressure	___ Heart Attack/MI
___ Asthma	___ High Cholesterol	___ Heart Rhythm problems
___ Mental Illness (bipolar, schizophrenia)	___Kidney Disease or stones	___ Hepatitis
___Cancer Type_____	___ Lupus	___Sleep Apnea
___ Cirrhosis of Liver	___Migraine Headaches	___ Stomach Ulcer
___Congestive Heart Failure	___ Multiple Sclerosis	___ Stroke/CVA
___ COPD or Emphysema	___ Pancreatitis	___ Thyroid Dysfunction
___ Depression	___Shingles	___ HIV

Do you have any allergies to medications, immunizations, foods? List all that apply:

_____

_____

_____

Are you allergic to contrast dye? YES NO **Are you allergic to Latex?** YES NO

Are you allergic to Betadine? YES NO **Do you have ANY known allergies?** YES NO

List any/all surgeries you have had and the year they were performed: _____

_____

_____

_____

_____

List any overnight hospitalizations you have had for reasons other than surgery, with year they were performed:

_____

_____

_____

_____

Have any family members had the following medical problems? Check all that apply:

___ Heart Disease ___ Substance Abuse or Alcoholism

___ Stroke ___ Arthritis

___ Cancer Other: _____

Are you experiencing any of these symptoms? Check all that apply.

___ Weight change	___ Cough	___ Tremors
___ Fatigue	___ Shortness of breath	___ Joint pain or stiffness
___ Fever	___ Blood in stool	___ Muscle cramps
___ Loss of appetite	___ Constipation	___ Abnormal bleeding or bruising
___ Loss of vision	___ Nausea or vomiting	___ Enlarged lymph nodes
___ Depression	___ Loss of bowel/bladder control	___ Painful skin sensitivity
___ Chest Pain	___ Headache	___ Excessive sweating
___ Swelling of legs	___ Seizures	___ Rash
___ Stress/Anxiety	___ Insomnia	

Are you currently employed? YES NO **Retired?** YES NO **Disabled?** YES NO

Most recent occupation? _____

Do you smoke? _____ **Number of years**? _____ **How many per day**? _____ **Year you quit?**_____

Do you chew tobacco? _____ **No. of years** _____ **Do you drink alcohol**? _____ **Drinks per week** _____

Do you use drugs recreationally? _____ **Which drug**? _____

Do you have a dependency on any prescription drugs? _____

Have you ever been treated for drug addiction? _____ **If yes, what was your addiction, and when were you treated?**

Describe the pain that brings you in today: _____

When did your pain begin? _____

Was there a specific cause for your pain? YES NO **If so, please describe:** _____

_____

Did you have a work related injury? YES NO **Have you pursued legal action for an injury?** YES NO

If part of a legal case, is the case pending or resolved? _____

Please circle the word (s) that best describes your pain: ACHING BURNING GNAWING SHARP SHOOTING

SPASM OTHER_____

Does your pain radiate to another area? YES NO **If yes, where does it radiate?** _____

On a scale of 1 to 10, with 10 being the worst pain, what is the present severity of your pain? _____

What is the maximum severity, when your pain is at its worst? _____

Does your pain interfere with your daily activities? NO MILDLY MODERATELY SEVERELY

Does your pain affect your sleep? YES NO

Is your pain: CONSTANT/STEADY

INTERMITTENT (COMES & GOES)

CONSTANT WITH TIMES WHEN ITS WORSE

Is there a time of day when your pain is better or worse? If so, please describe:

What makes your pain worse?_____

What relieves your pain? _____

Do you have any of the following with your pain?

weakness numbness tingling skin sensitivity bowel or bladder problems skin color change

If yes, please describe what area of your body is affected:

_____

Have you been treated by another pain management doctor in the past? YES NO

If so, who? _____

Have you had an MRI of your back? YES NO **Location of MRI:** low back neck thorax

Approximate date of MRI: _____ **Where was it done?**_____

Please check the following that apply to your current pain condition:

Physical Therapy Did it help? _____ When was it last done? _____

TENS Unit Did it help? _____

Epidural injection Did it help? _____ How long did your relief last? _____

Radiofrequency Did it help? _____ How long did your relief last? _____

Other _____

What medications have been used to treat your pain, and were they beneficial?

_____

_____

_____

What do you expect from your visit today?

_____

_____

_____

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Insurance Information

ALL PATIENTS MUST COMPLETE THIS FORM AND PROVIDE A PICTURE ID AND INSURANCE CARD BEFORE SEEING A PHYSICIAN.

LAST NAME _____ FIRST NAME _____MIDDLE INITIAL _____

ADDRESS _____

CITY _____STATE_____ ZIP _____

PHONE (H) _____PHONE (C) _____PHONE (W) _____

BIRTHDATE _____ **SEX** M F MARITAL STATUS _____

SSN _____ EMAIL ADDRESS _____

PRIMARY CARE PHYSICIAN _____WHO REFERRED YOU TO US? _____

EMERGENCY CONTACT _____PHONE NUMBER _____

PRIMARY INSURANCE COMPANY: _____

ID/SUBSCRIBER NUMBER: _____

Policy Holder: _____Policy Holder's Date of Birth: _____

SECONDARY INSURANCE COMPANY: _____

ID/SUBSCRIBER NUMBER: _____

Policy Holder: _____Policy Holder's Date of Birth: _____

I acknowledge and agree that payment for services rendered is due at the time of service. Any applicable co-payments or deductible amounts are due at the time of service. I authorize payment of benefits to Physician Pain Management, for services rendered under the terms of my insurance policy. I authorize Physician Pain Management to release any medical information necessary to process insurance claims. I understand that I am responsible for any balances that are unpaid or denied by my insurance carrier. I also understand that by giving you the above phone numbers, I am giving you authority to leave messages for me or about my care at these numbers unless otherwise indicated by me on this form.

_____ _____

Signature Printed name

_____

Date

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Financial Policy

Physician Pain Care is committed to meeting your health care needs. The following statements explain our Financial Policy. Please read, sign and return to us prior to your treatment.

1. You are ultimately responsible for payment of charges for services you receive from our office. You are responsible for providing accurate and complete personal and insurance information prior to receiving services. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service.
2. **You are responsible for obtaining your referral** (if necessary) to our office, and if you are seen without a valid referral you will be responsible for payment of the visit.
3. We participate with most insurance plans. However, your insurance policy is a contract between you and your carrier. It is your responsibility to ensure that treating physicians are in your insurance network.
4. Payment is due at the time of rendered services. Unpaid personal balances must be paid in full prior to receiving additional treatment.
5. If we are denied payment after billing your insurance, you will be responsible for payment of these services.
6. **All copayments and deductibles are due at the time of visit.** If you are unable to pay your copayment at the time of your visit, you will need to reschedule your appointment.
7. The fee for returned checks is $30 and must be paid prior to any additional services.
8. We accept Master Card, Visa, and Discover cards.
9. **Cancellations for appointments or procedures must be received at least 24 hours prior to the scheduled appointment.** We reserve the right to charge $25.00 for any “no show” appointments and $50 for any “no show” procedures.
10. Past Due Accounts may be referred to a collection agency. Any legal fees that we pay to secure past due balances will be added to your account. If your balance exceeds $200—please see our financial counselor for assistance.
11. If you are not compliant with this agreement, this will be grounds for immediate dismissal from the practice.

By signing this document, you understand that you will be bound by this agreement and that you have read, understood, and accepted these terms.

Signature: _____ Date: _____

Printed Name: _____

Payment Authorization/Consent for Treatment/ Privacy Policy (HIPAA)

AUTHORIZATION

I, the undersigned certify that I (or my dependent) have insurance coverage and assign payments directly to Physician Pain Management. I understand that I am financially responsible for all charges not covered by my insurance plan, including co-pays, deductibles, non-covered services, and any other outstanding charges. I hereby authorize Physician Pain Management to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

X Signature_____Date_____

Are you the policy holder? Yes__ No __ If not please see receptionist.

CONSENT FOR TREATMENT

Having voluntarily presented myself (or my dependent) to Physician Pain Management, I acknowledge recognition of the fact that the evaluation and treatment received, advised, or deemed necessary, to be the judgment of Dr. Rubin.

X Signature_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA)

☐ I have read a copy of the Physician Pain Management Privacy Notice

☐ Physician Pain Management has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

X Signature_____Date_____

ADDITIONAL PERSON(S) AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF MY PHYSICIAN

Physician Pain Management values your privacy. Your medical information will not be given to anyone without your written consent. If you want anyone other than your referring physician to have access to your medical information, please list their name, address, relation, and phone number below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

X Signature_____Date_____

☐ **This will never expire**

The staff of PPM should complete this section if Acknowledgement Form is not signed by the Patient:

1. Does the patient have a copy of the Privacy Notice? **Yes__ No __**
2. Please explain why the patient was unable to sign an acknowledgement form and our efforts in trying to obtain the patient signature: _____

Employee Signature: _____ Date _____

Authorization to Release Medical Records

I, _____ authorize the following person or organization, _____, to mail or fax my medical records to:

PHYSICIAN PAIN CARE
240 Heritage Walk
Woodstock, GA 30188
Phone: (770) 516-7880
Fax: (770) 516-7870

I understand that this information will include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care and evaluations, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should not be released: _____

I understand that I may revoke authorization of consent at any time except to the extent that action has previously been taken in reliance thereof.

Patient Signature _____ Date of Birth_____

Printed Name _____ Date _____

Witness_____

This form is valid for one year from patient signature date

Medication Agreement and Refill Policy

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement.

1. I agree to follow the dosing schedule prescribed to me by my doctor.
2. I will never share, sell or exchange my medications with anyone for any reason.
3. I understand that I am *solely* responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that Physician Pain Management does not replace LOST OR STOLEN prescriptions or controlled medications.
4. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
5. I agree to notify Physician Pain Management if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to the office for disposal.
6. I agree that if I receive a controlled substance prescription from Physician Pain Management, I am not allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
7. I agree to use only one pharmacy for my pain-related medications. In the event, that circumstances require the use of another pharmacy, I will notify Physician Pain Management of this immediately and provide them with all pertinent contact information. I authorize Physician Pain Management to access my full prescription history at pharmacies or by electronic means at any time.
8. I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled appointment with Dr. Rubin. **Narcotic pain medication refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.**
9. **I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments.** I understand that if I am more than **15** minutes late to my scheduled appointment time, I may have to reschedule for another time.
10. I know that I can not be seen at the office without a scheduled appointment *for ANY reason.*
11. I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).
12. I understand that Physician Pain Management will write and dispense narcotic medication prescriptions on a 30 day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
13. I understand that abusive behavior or harassment toward any staff will not be tolerated. If Dr. Rubin determines at his sole discretion that this has occurred on a case-by-case basis, I can be dismissed from the practice.
14. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from Physician Pain Management.
15. I understand that I may suffer withdrawal effects possibly even requiring hospital detox if I violate this contract and am dismissed from the practice.
16. I understand that URINE DRUG SCREENS MAY BE PERFORMED AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If I refuse a drug test, or if tested, the results do not reflect the medicine prescribed by my doctor,or test positive for illegal or non prescribed drugs, I understand that I can be dismissed immediately from the practice.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. Non-compliance with this agreement will be grounds for immediate dismissal from the practice.

_____ _____

PHARMACY NAME **PHARMACY PHONE NUMBER**

_____ _____

PATIENT NAME ***Please Print** **DATE**

_____

SIGNATURE