Patient Information

Patient Name: ____
Last First M.

(Please circle) Male / Female Race: *(Please circle)* White / Black / Hispanic / Asian / Other __________

Address (incl. city & zip): ____

Daytime Phone: ______________________ Ext.___ Evening Phone: ______________________

Date of Birth: ______________ SSN: ______________________ Marital Status: _______

Email: ______________________________

Please provide your e-mail address for appointment reminders and online access to your records

____

Closest friend or relative not living with you: ____

Address: ____

Daytime Phone: ______________________ Ext: ________ Evening Phone: ______________________

Insurance Information

Primary Insurance Company: ____

Subscriber's Relationship to Patient: SELF SPOUSE PARENT OTHER

Spouse Name: ____
Last First M.

Spouse's Employer: ______________________________ Telephone # ______________________

Spouse SSN: ______________________ Spouse Date of Birth: ______________________

Secondary Insurance Company: ____

Third Insurance, if applicable: ____

Referral Information
(Please tell us how you were referred to our practice)

Referring Physician______________________ Health Plan Provider List ______________________

Other Source__________________________ (W/C Adjuster, Case Manager, Website, Friend etc)

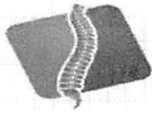
Please read the following authorization. Initial and sign below for our files.

_____ I understand that any appointment changes must be made 24 hours in advance or a $10 fee will be applied.

Signature______________________________________ **Date**______________________

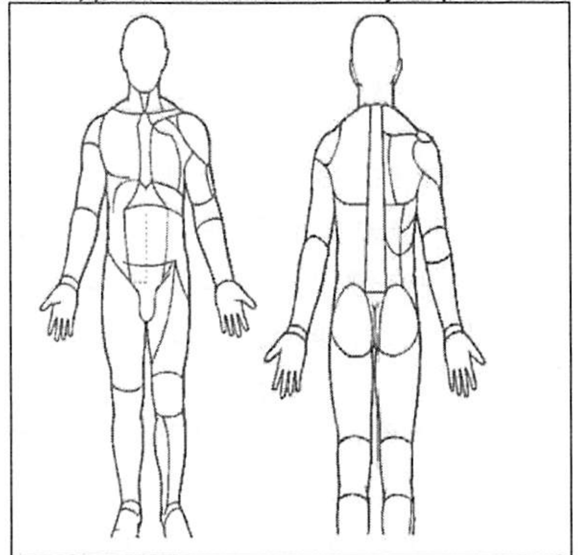
***** Please present this form and all insurance ID cards to the receptionist at this time. *****

Patient Name ______________________ Date of Birth ____________ Age ________ Gender: ____________



PAIN HEALING CENTER

In the diagram below, please shade the areas of your pain



Please answer each question below
If you need more space to answer please write answers in blank space below

Where is your pain?___________________________
How long have you had this pain?___________________________
Did pain start from injury or accident? ___________________________
If yes, how? ___________________________
Does pain radiate into legs or arms? ___________________________
Do you experience any numbness or tingling? ___________________________
How would you describe your pain? ___________________________
What triggers your pain to be worse? ___________________________
What helps your pain? ___________________________
Have you tried injections? ___________________________
If yes, what kind and did they help? ___________________________
Have you tried physical therapy, chiropractor or any other forms of therapy? ___________________________
If yes, how long did you try them and did it help? ___________________________

Pain Medications, Muscle Relaxants, Sleep Aid, Anti-anxiety, and Antidepressants.

Medications	Dose	Frequency

(use back of paper if needed)

____
____
____
____

All Others (including Over-the-Counter) Medications

____
____
____

SURGERIES
(Please list below)

DATE (month/year)

____
____
____

PAIN HEALING CENTER

Patient History: (circle each that apply)

Tobacco:	do not smoke	smoke	________ pack(s) per day
Alcohol:	do not drink	drink	# of drinks per ____ day ____week
Social History:	Married	Single	Divorced
Lives With:	Spouse	Children	Other / Alone

Present	Absent	**hepatitis c**	Present	Absent	**Alcoholism**
Present	Absent	**Anemia**	Present	Absent	**Anxiety**
Present	Absent	**Arthritis**	Present	Absent	**Asthma**
Present	Absent	**Atrial fibrillation**	Present	Absent	**Bipolar disorder**
Present	Absent	**Chronic liver disease**	Present	Absent	**Circulatory system disorder**
Present	Absent	**Congestive heart failure**	Present	**Absent**	**Depression**
Present	Absent	**Diabetes**	Present	Absent	**Emphysema**
Present	Absent	**Fibromyalgia**	Present	Absent	**Gout**
Present	Absent	**Heart attack**	Present	Absent	**Herniated Disc**
Present	Absent	**High blood pressure [hypertension]**	Present	Absent	**High cholesterol**
Present	Absent	**High lipids**	Present	Absent	**Hiv**
Present	Absent	**Hypothyroid**	Present	Absent	**Insomnia**
Present	Absent	**Irritable bowel syndrome**	Present	Absent	**Kidney failure**
Present	Absent	**Migraine**	Present	Absent	**Mitral valve disorder**
Present	Absent	**Multiple sclerosis**	Present	Absent	**Osteoporosis**
Present	Absent	**Reflux (gerd)**	Present	Absent	**Skin disorder**
Present	Absent	**Stroke**	Present	Absent	**Visual impairment**

FAMILY HISTORY

Relation Current State of Health & History of Problems

Mother ____

Father ____

Allergies:____

PAIN HEALING CENTER

Patient Contract for
Using Opioid Pain Medication in Chronic Pain

This is an agreement between ______________________________________ (the patient) and Pain Healing Center concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.

   I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.

3. **Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. '**

4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.

6. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.

7. I agree that the opioids will be prescribed by only <u>one</u> doctor and I agree to fill my prescriptions at only <u>one</u> pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

8. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.

9. I agree not to sell, lend, or in any way give my medication to any other person.

10. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.

PAIN HEALING CENTER

11. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.

12. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

____

Patient signature

____

Date

Assignment Of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Pain Healing Center for medical or surgical services or items rendered to me or my dependent by Pain Healing Center. Should my insurance carrier deny Pain Healing Center payment, I understand that I am financially responsible for the charges. I authorize Pain Healing Center to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It i my responsibility to update any and all personal, insurance and health information.

____

Name Signature Date

Abd Alrahman Benni, M.D.
Pain Management
Board Certified

PAIN HEALING CENTER

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who ma be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to chang its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address listed below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound tc abide by such restrictions.

Print Patient Name: ______________________

Relationship to Patient: ______________________

Signature: ______________________

Date: ______________________