

VALLEY PAIN SPECIALISTS

Patient Registration Form

Please complete this form as completely as possible

Date _____

Patient's Name _____

Address _____

City _____ State _____ Zip Code _____ Home Phone (_____) _____

Patient's Employer _____ Work Phone (_____) _____

Employer Address _____

Social Security # _____ Date of Birth _____ Sex _____ Marital Status _____

Responsible Party Information: Self _____ Spouse _____ Parent _____ Other _____

Guarantor's Name _____

Address _____

City _____ State _____ Zip Code _____ Home Phone (_____) _____

Relationship to Patient _____ Date of Birth _____ Social Security # _____

Guarantor's Employer _____ Work Phone (_____) _____

Employer Address _____

Referring Physician _____ Phone _____

Primary Care Physician _____ Phone _____

Who may we contact in case of emergency or if we need to change an appointment and cannot reach you?

Name _____ Relationship _____

Address _____

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

Insurance Information

Primary Carrier: Name _____ Group # _____

Address _____

Insured's Name _____ Relationship to Patient _____

Policy # _____

Secondary Carrier: Name _____ Group # _____

Address _____

Insured's Name _____ Relationship to Patient _____

Policy # _____

Workman's Comp: Carrier _____

Address _____

Date of Injury _____ Claim # _____

Claim Representative _____ Phone (_____) _____

Employer _____

Valley Pain Specialists

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment rendered to my child or me during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to Valley Pain Specialists insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services rendered on my behalf or my dependents.

Signature of Patient or Parent, if a minor

Date

Printed Name of Patient / Minor

CONSENT TO RELEASE INFORMATION TO FAMILY

I hereby give my consent to release information from my medical and/ or financial records from Valley Pain Specialists to whomever requests it and identifies themselves as an immediate family member, including spouse, sibling, children, grandchildren, and anyone specifically listed below.

I Specifically DENY permission to release information to anyone without my written consent.

Signature of Patient or Parent, if a minor

Date

Printed name of Patient/ Minor

CONSENT TO RELEASE INFORMATION TO PHYSICIAN

I hereby give consent to release information regarding my treatment and/or copies of my medical record to my referring physician and/or primary care physician as listed on the Patient Registration Sheet.

Signature of Patient or Parent, if a minor

Date

Printed Name of Patient/ Minor

VPS Authorization to Release

Valley Pain Specialists

New Patient Health History and Pain Questionnaire

Patient Name: _____ Age _____

Male Female Right handed Left handed Ambidextrous

History of Problem for which you are being seen:

Reason for visit: _____

Expectations from treatment: _____

Type of injury: job accident sports injury other: _____

Car accident: Driver Passenger Seat belted: Yes No Airbag: Yes No

Date injury/symptoms started: _____

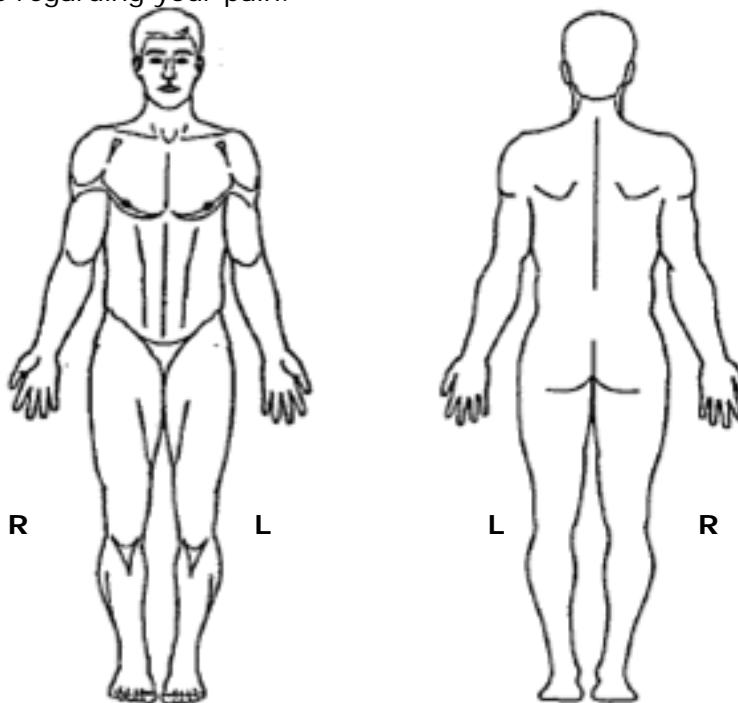
Do you have Cancer? Yes No Cancer Type: _____

Stage of Cancer: _____

Have you had chemo or radiation? _____ Where? _____

On the Diagram below, shade the areas where you feel pain. Put an "x" where it hurts the most. Check all that applies regarding your pain:

- Aching
- Burning
- Stabbing
- Shooting
- Constant
- Transient
- Sharp
- Dull
- Mild
- Moderate
- Severe
- Unbearable



Rate your pain by circling the one number that best describes your pain at its **worst**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain worst imaginable

Rate your pain by circling the one number that best describes your pain at its **least**:

0 1 2 3 4 5 6 7 8 9 10
No Pain Pain worst imaginable

Rate your pain by circling the one number that best describes your pain on the **average**:

Renal

- Dialysis
- Renal Insufficiency
- Kidney stone
- Prostate problems

Neurological

- Stroke
- Transient ischemic attack
- Seizures
- Nerve damage

Infectious

- Valley fever
- Tuberculosis
- HIV/AIDS
- Polio

Hepatic

- Jaundice
- Cirrhosis
- Hepatitis
- Gall bladder

Gastrointestinal

- Hiatal hernia
- GERD
- Gastric ulcers
- Colitis

Endocrine

- Thyroid Disease
- Parathyroid disease
- Diabetes mellitus

Psychological

- Depression
- Bipolar
- Addiction
- Schizophrenia

General

- Anemia/bleeding
- Arthritis
- Obesity
- Alcoholism

Past Surgical History:

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

Serious Injury:

Serious injuries you have sustained: _____

Allergies to Medications:

- Yes No (if yes indicate below drug and reaction)

| Drug | Reaction |
|-------|----------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Current Medications Include vitamins, antacids, birth control, etc. (Attach list if necessary):

| Name: | Dose: | How often: |
|----------|-------|------------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |

Family History: _____

Social History:

- Occupation: _____
- Are you currently working? Yes No Part time Full time
- Education: Grammar High school College Graduate school
- Marital Status: Married Widowed Divorced Single Significant other
- Children: how many? _____
- Are there any lawsuits pending? Yes No
- Are you on disability? Yes No
- Do you use tobacco? Yes No Packs per day _____ Workman's Comp? Yes No
- How many years _____

Do you use alcohol? Yes No Bottles per day _____ How many years _____
Do you use illicit substances? Yes No What? _____

Review of Systems:

- General:** Weight change Fatigue Weakness
 Fever/chills Loss of appetite No problems
- Skin:** Dry Skin Changes in Hair or Nail Eczema/itching
 Changes in skin color Recurrent Rashes No Problems
- Heent:** Sinus Problems Difficulty Swallowing Headaches/Migraines
 Jaw/mouth Problems Vision changes Dizziness
 Hoarseness Dry Mouth No Problems
- Respiratory:** Cough Shortness of Breath Wheezing
 Hemoptysis No Problems
- Cardiac:** Chest pain/Angina Shortness of Breath Palpitations
 Peripheral Edema No problems
- Gastrointestinal:** Diarrhea Reflux Constipation
 Change in appetite Abdominal pain Nausea/Vomiting
 Loss of bowel control Blood or black stool No Problems
- Genitourinary:** Difficulty urinating Painful urination Blood in urine
 Loss of bladder control No Problems
- Neurological:** Blackouts/fainting Weakness/paralysis Numbness
 Hallucinations Dizziness Gait difficulties
 Tremors Confusion No problems
- Psychiatric:** Depression Suicidal ideation Anxiety
 Drug Abuse Homicidal ideation No Problems
- Endocrine:** Heat/cold intolerance Excessive sweating Excessive urination
 Excessive thirst No problems
- Musculoskeletal:** Muscle cramps Joint stiffness/swelling Muscle atrophy
 Joint Redness/heat No problems
- Toxins:** Asbestos Industrial chemicals Lead
 Pesticides Drug use No Problems

Patient Signature

____/____/____
Date

Reviewed by: _____
Provider Signature

____/____/____
Date

VALLEY PAIN SPECIALISTS

Dear Patient _____,

Due to all the various HMO and PPO insurance plans now available in the marketplace, it has become a very complicated process to become familiar with each plan. All the various companies and plans have their individual requirements for various procedures.

It has therefore become necessary to request that all patients provide all information needed from their insurance company, and that they assume responsibility for giving this information to our office, and to any other health facility involved in their particular treatment or illness, including hospitals. Patients must also notify their insurance company of any changes in their care or treatment so that proper handling and payment will be made by their insurance company.

You may receive a pre-certification or authorization number from your insurance company. Please remember that this does not guarantee that your insurance company will pay for the procedure. It is your responsibility to call your insurance benefits department to see if you have any pre-existing or routine testing clauses in your contract which would prevent your insurance company from paying the bill.

We have always filed and will continue to file claims for patients, but you must share equal responsibility for obtaining and giving the doctor or insurance company the necessary information needed to get your claim processed and paid within a reasonable time period.

We realize that patients are not always given all the information required by their insurance company or agent, but it is still your responsibility to call and obtain this information before receiving treatment and before filing claims for treatment. We cannot emphasize enough how important this is, in order for you to receive the proper benefit you are entitled to under your insurance plan or contract.

We are requesting your cooperation so that we may better serve you and give you the health care you deserve, without having to spend an exorbitant amount of time dealing with your insurance company. You should have and know all the information required by your individual plan(s) of insurance to avoid any confusion on your behalf of what services are covered by your insurance policie(s).

Thank you for your cooperation.

Patient Signature or Parent of Minor

Date

VALLEY PAIN SPECIALISTS

CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT PAYMENT OR HEALTHCARE OPERATIONS.

As set forth more fully in our Notice of Privacy Practices, we are permitted to obtain your Consent for any use or disclosure of your health information to carry out treatment, payment, or health care operations. In our Notice of Privacy Practices, we provide you information about how this office can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this Consent.

We reserve the right to change the terms of our Notice of Privacy Practices at any time. If we change our Notice of Privacy Practices, you can review and/or obtain a revised copy by contacting our Privacy Officer, Dean Smith, M.D., or Pat Durlam, RN, MAOM, Practice Administrator at 1850 N. Central Avenue, Suite 1600, Phoenix, AZ 85004, or by telephone at 602-262-8903.

By signing this form below, you consent to our use and disclosure of your health information for treatment, payment or health care operations. You have the right to request that we restrict how your health information is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree with your requested restrictions; however, if we do agree to your restrictions, we are bound to follow them.

You have the right to revoke this Consent at any time, except where we have already used or disclosed your health information in reliance of your existing consent. If you would like to revoke this Consent, you must do so in writing.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, please describe the authority of Legal Representative to sign for patient:
