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Welcome to our practice. Please fill out the information below to the best of your ability.

PATIENT INFORMATION

Date: ___________________________

Name: ____________________________ DOB: _________ Age: ____ Sex: M/F Soc. Sec #: ____________________

Address:
___________________________________City:________________________Stated:________Zip:______________

Home Phone: ______________________ Cell Phone: ______________________Email:_________________________

Occupation: ____________________________ Married______ Widowed _________ Single ________ Other______

Race:

___ American Indian or Alaska Native
___ Asian ___Other Pacific Island
___ Black or African American
___ Native Hawaiian ____ More than one race
___ White ____ Refused to answer

Ethnicity:

____Hispanic or Latino
____ Not Hispanic or Latino
____ refused to answer

Preferred Language:

____ English
____ Spanish
_____Other:

Meaningful use is the name of a new nationwide initiative to improve the health of our nation. As part of this initiative Metropolitan Pain and Spine. LLC is required to gather information for compliance with the Meaningful use guidelines. Part of this information includes adding patients' Race, Ethnicity and Preferred Language to our electronic medical record. The government requires we gather this information to better identify possible disparities in access and quality of healthcare based on race and ethnicity on a national level. If you have additional questions please visit the office of the National Coordinator for Health Information Technology at www.health.hhs.gov and search Meaningful Use.

INSURANCE INFORMATION

Do you have health insurance? ___________

Name of Policy Holder (if different from the patient): ________________________________

Relationship: __________________ DOB: _________ SSN: ___________________

Primary Insurance: _____________________________ ID # ____________________Group: _________

Secondary Insurance (if any):____________________ ID # ___________________ Group; __________

Is this injury auto or work related? ○ **Yes** ○ **No** **Injury date:** ________________

Automobile carrier or Accident Insurance Carrier: ____

Carrier phone: ______________________ Claim number: _____________________________________

Attorney's Name: ____________________________ Attorney's Phone: __________________________

Emergency contact: ____
(Name, number, relationship)

Pharmacy (name, location, phone) ____
PLEASE NOTE: Prescription refills will only be authorized Monday –Friday, 8:00am-4:00pm
Please Initial: __________

Referred by: ____

Primary Care Physician: _________________________________

EMPLOYER

Employer Name: ______________________________________

Work Number: _________________________

****Primary Insurance claims will be filed on your behalf with correct insurance information****
****please provide our office with a copy (front & back) of your insurance card(s) ****

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I hereby consent for **Metropolitan pain PA and Spine** to provide me with medical treatment. I authorized the release of medical information contained in my chart to my insurance company, in order to process any bills. I authorize the use and disclosure of my private health information for the purpose of treatment. Payment and Healthcare Operations. I authorize payment from me, and the insurance company directly to Metropolitan Pain P.A and Spine and any assisting physician for services rendered. Should my insurance company deny or not cover charges for ANY reason, I am financially responsible for the full amount of the bill. Should my account be referred to an outside collection agency, I agree to pay the collection fees in the event of default I agree to pay all cost of collection, and responsible attorney fees.

_______________________________ _______________________________

Signature of Patient Today’s Date

_______________________________ _______________________________

Signature of personal representative today’s Date
I patient authorized

Family Medical History:

	Age	Conditions or Diseases	If Deceased, cause of Death
Father	_______	_______________________________	_______________________________
Mother	_______	_______________________________	_______________________________
Sibling	_______	_______________________________	_______________________________

Review of System: Please write "Y" for yes, "N" for no if you have any of the following:

Constitutional Symptoms		**Integumentary (Skin/Breast)**		**Ear/Nose/Mouth/Throat**	
Bad general health lately		Rash or itching		Hearing loss or ringing	
Weight: Loss(Y/N) Gain (Y/N)		Changes in skin color		Earaches or drainage	
Fever		Varicose veins		Chronic sinus pain	
Fatigue		Breast pain		Nose bleeds	
Headaches		Breast lump		Bleeding gums	
Loss of appetite					
Eyes		**Respiratory**		**Cardiovascular**	
Eye disease or injury		Chronic or frequent coughs		Heart trouble	
Wear glasses/contact lenses		Spitting up blood		Chest pain or angina pectoris	
Blurred or double vision		Wheezing		Palpitations	
Visual loss/disturbance		Shortness of breath		Cold extremities	
		Difficulty breathing		Swelling in hands, feet, ankles	
Gastrointestinal		**Genitourinary**		**Musculosketal**	
Abdominal Pain		Frequent urination		Joint pain	
Nausea or vomiting		Burning or painful urination		Joint stiffness or swelling	
Frequent diarrhea		Blood in urine		Weakness of muscles or joints	
Constipation		Incontinence or dribbling		Muscle pain or cramps	
Rectal bleeding, blood in stool		Female-Number of pregnancies		Back pain	
		Female-Number of deliveries			
Neurological		**Psychiatric**		**Endocrine**	
Light headed or dizzy		Memory loss or confusion		Excessive thirst or urination	
Numbness or tingling		Nervousness		Swollen glands in neck	
Tremors		Depression		Heat or cold intolerance	
Paralysis/weakness		Insomnia		Skin becoming dryer	

Unsteadiness, difficulty walking		Anxiety/Panic attacks			
Memory loss					
Stroke					
Seizure					

Hematologic/Lymphatic **Allergic/Immunologic**

Slow to heal after cuts		List food/environment allergic	
Bleeding or bruising tendency			
Anemia			
Enlarged glands			

Pain Questionnaire for back and Neck Patients

Location ____

Type o Burning o Aching o Numbness o Stabbing o Pins & Needles

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_________________________________ _____________________________

Signature of Patient or Parent of minor Date

HEALTH HISTORY FORM

Today's Date: _____________
Patient name _______________________________
Chief complaint (Reason for your visit)

Past Medical History
Have you ever had any of the following? Please check all pertinent circles:

O Aids or HIV +
O Diabetes
O Low Blood Pressure
O Smallpox
O Anemia
O Diphtheria
O Measles
O Stroke
O Arthritis
O Epilepsy/seizure
O Migraine Headaches
O Thyroid disease
O Asthma

o Glaucoma
o Mitral Valve Prolapse
o Tuberculosis
o Back Trouble
o Heart Disease
o Mumps
o Ulcer
o Hepatitis: A/B/C/D/E (Please Circle)
o Bladder Infections
o Hemorrhoids
o Pneumonia
o Venereal Disease
o Bleeding Tendency

o Polio
o Whooping Cough
o Blood Transfusions
o High Blood Pressure
o Rheumatic Fever
o Sleep Apnea
o Bronchitis
o Infectious Mono
o Scarlet Fever
o Chicken Pox
o Kidney Disease
o other (please list) _______________

Previous Hospitalization/Serious Illnesses ___________________________________

Medications: (please include non-prescription) & Herbal Supplements

Drug name	Dosage	Frequency	Drug name	Dosage	Frequency

Allergies:

Medication	Reaction	Medication	Reaction

Tape allergy? Yes No **Latex Allergy? Yes No**

Past Surgical History
Please list date, type, hospital and complications.

____

____

Patient Social History: (Please circle the appropriate response)

Marital Status	**Use of alcohol**	**Use of Tobacco**	**Living situation**	**Dominant Hand**
Single	Never	Never	With Family	Right
Married	Rarely	previously, but quit	With Friends	Left
Divorced	Moderate	Currently	Alone	
Widowed	Daily	Other		
Separated		Packs per day _______		

Pain Management Narcotic Agreement

(This agreement does not indicate that narcotic medication will be used, but is available upon future need if any)

The purpose of this agreement is to prevent misunderstanding about certain medicines you may be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals in the event that narcotic medications are used.

The long-term use of such substances as opioids/narcotics, benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of the uncertainty regarding the extent to which they provide long-term benefits. There is also the risk of an addictive disorder developing or a relapse occurring in a person with a prior addiction. Although it is felt that this risk is small, the extent of risk is not certain. Benzodiazepines, tranquilizers, and barbiturates shall not be prescribed by this office. **Narcotic medication shall be limited to short term duration of use only, with a duration of use no longer than 90 days.**

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. I am aware that chronic pain is complex problem with several forms of treatment; of which narcotic medication represent only one mode of therapy. **It is expected that I will engage in all forms of interventional treatment felt to be of benefit and agree-upon as part of my pain management treatment, failure to do so may lead to dismissal from the pain program.** Repeated or prolonged absence or lack of compliance will interfere with the safe and effective use of medication, and may require my physician to discontinue these medications.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. It is assumed

that the medication will be of benefit at dose felt appropriate by the prescribing physician, if this is not so the medication may possibly be discontinued. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

I will not use any illegal controlled substances, including marijuana, cocaine, etc. labeled precautions should be followed, including the fact that when combined with alcohol or sedative medication extreme somnolence and drowsiness may occur. The use of dangerous equipment, and driving should only be performed when you have become accustomed to the medication or dose adjustment. I will notify my physician if I learn that I am pregnant as there is a risk of giving birth to a child who will be physically dependent upon opioids at birth.

I will not share, sell or trade my medication with anyone. I will not attempt to obtain any controlled medicines; including opioids pain medicines, controlled stimulants, or antianxiety medicines from any other doctor or emergency room.

I will safeguard my pain medicine from loss or theft. **Lost or stolen medicines will not be replaced.**

I agree that refills of my prescription for pain medicine will be made only at the time of a monthly office visit during regular office hours. **No refills will be available during evenings or on weekends. <u>No early refills will be given under any circumstance.</u>**

I understand that a prescription may be issued early if the physician or patient will be out-of-town when the refills is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

I agree to use one pharmacy,
Located at ____
Telephone number ____________________________________, for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine. I also agree psychological

evaluation if requested by my doctor, and based on psychological evaluation it may or may not be decided that I am not a candidate for continued narcotic therapy.

I agree that I will use my medication at a rate no greater than prescribed rate and that use of my medicine at greater rate will result in my being without medication for a period of time, and may lead to the discontinuation of these medications by my physician.

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this ________________________day of _________________

Patient signature: ____

Physician signature: ____

Metropolitan pain P.A/Spine	**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE FORM**
Effective Date: January 1, 2006	**REFERENCED POLICY:** NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices:

_X__ Paper
____ Electronic Mail

____
Print Patient Name

____
Signature if Individual Acknowledging NPP

____ Patient
____ Personal Representative
____ Healthcare Surrogate

____
Employee Witness

____
Date

FOR OFFICE USE ONLY

This Medical Practice was Unable to attain patient acknowledgment of the Notice of Privacy Practices explain below circumstances of the patient's refusal to acknowledge the Notice of Privacy Practices in the section provided below.

______________________ ______________________ ______________________
Name of Employee Employee Signature Date

Levi Pearson III, MD

Patient's Name: _________________________________ DOB: ________________________

It is preferred that patients do not drive immediately following their procedures, but if you wish to drive yourself after the procedure please review and sign the form below.

I release **CCSC, MLSC, Metropolitan Pain P.A. and Metropolitan Spine, and Dr. Pearson** from any responsibility since I will drive myself after my procedure.

Patient's signature; ____

Date: __________________________