Pain Management Physicians

Dr. Ratner ◦ Dr. Rosenthal ◦ Dr. Lincow

To New Patients of Pain Management Physicians:

We would like to take this opportunity to thank you for scheduling an appointment with Pain Management Physicians. In order to better serve you, please complete the required paperwork before your visit with our physicians. If you are not able to fill out the paper work ahead of time, please arrive 15 minutes before your scheduled appointment to do so.

If your insurance requires referrals or co-pay please bring it with you to your appointment. **You will not see the doctor if you are not prepared.**

- **New Patient Evaluation**: Your new patient evaluation will last approximately 30 minutes. It will consist of a history and evaluation.
- **Physicians:** All staff physicians are board certified under the auspices of the American Board of medical Specialties.
- **Fees:** Our office will charge for any forms to be filled out. You must give 72 hour notice for a form to be completed.
- **Cancellation**: If you are unable to make your appointment, please call 24 hours before to cancel.

Note: Please ensure that all necessary records pertaining to your condition(s) are either **mailed or faxed to (484) 509-2933** prior to your visit. Otherwise, please bring them with you the day of your new patient evaluation.

*Once again, thank you for scheduling an appointment with Pain Management Physicians. If you have further questions concerning your visit, please do not hesitate to call us at **610-375-6226** Monday - Friday from 8 A.M. to 4 P.M. We look forward to serving you.*

OUTPATIENT INFORMATION WORKSHEET

PATIENT DATA

DEMOGRAPHIC INFORMATION

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____

WORK PHONE: _____

OTHER: _____

SEX: M F AGE: _____

MARITAL STATUS: _____

SOCIAL SECURITY#

PATIENT: _____

SPOUSE: _____

DATE OF BIRTH

PATIENT: _____

SPOUSE: _____

DIAGNOSIS: _____

INSURANCE INFORMATION

COMPANY: _____

ID# _____

GROUP# _____

PHONE# _____

2ND

COMPANY: _____

ID# _____

GROUP# _____

PHONE# _____

COPAY: _____

PRECERT/AUTH# _____

WC/AUTO DOI: _____

COMPANY: _____

CLAIM# _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____

ADJUSTER: _____

EMPLOYER: _____

VERIFIED: _____/_____

OFFICE VISIT	DATE	PROCEDURE	DATE

Pain Management Physician

Is this a work related injury? YES NO

Name of Employer: _____
Employer Address: _____
Employer Phone#: _____
Name of Supervisor: _____
Workers Compensation Carrier _____
Date of Injury _____
Claim# _____
Adjustor's Name: _____
Adjustor's Phone# _____

Is your injury due to a motor vehicle accident? YES NO

Motor Vehicle Insurance Carrier _____
Date of Injury _____
Claim # _____
Adjustor's Name _____
Adjustor's Phone # _____
Policy # _____
Policy Holders Name _____
Policy Holders Address _____
Relationship to Policy Holder _____

Do you have an attorney? YES NO

Name of attorney: _____
Attorneys Phone# _____

Patient Signature _____ Date _____

Pain Management Physicians

The following is for the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Pain Management Physicians.

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Pain Management Physicians.

Signature _____Date: _____

For patients with medicare only (In addition to the above)

I request payment of authorized Medicare benefits be made to Pain Management Physicians for any services furnished to me by the provider. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____Date: _____

For Patients with Medicare and Supplemental Insurance (In addition to the above)

I hereby give Pain Management Physicians permission to ask for Medicare Supplemental Insurance payments for my medical care.
I understand that my Supplemental Insurance Carrier needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to my Supplemental Insurance Carrier. I request that the Supplemental Insurance Carrier make the payment of authorized Medicare Supplemental benefits to Pain Management Physicians for any and all services rendered to me. I authorize any holder of medical information regarding me, to release to my Supplemental Insurance Carrier any information to determine and pay these benefits.

Beneficiary Signature _____Date : _____

Pain Management Physicians

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Patient's Name: _____ **Date:** _____

If you would like the following physicians to receive reports, this form *must be completed with* their *correct* mailing address.
Without this information, your physician *will not* receive copies.

REFERRING PHYSICIAN: (Physician who referred you to Pain Management Physicians)

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____

PRIMARY PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____

OTHER PHYSICIAN:

NAME: _____

SPECIALTY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE NUMBER: _____

Name:

DOB:

Pharmacy Information

Name:_____

Address:_____

Phone Number:_____

If you use two pharmacies, or need to change your pharmacy information please let us know.

Pain Management Physicians

Comprehensive Intake Form

Patient's Name: _____

Date: _____ Referring Physician: _____

Age: _____ Sex: _____ Reason for Consult: _____

1st Complaint: _____ Date of onset: _____

2nd Complaint: _____ Date of onset: _____

History of Present Illness: _____

Precipitating Event: _____

Clinicians, Diagnosis, Studies/Treatments, Outcome, Action Taken: _____

_____

_____

_____

_____

_____

_____

_____

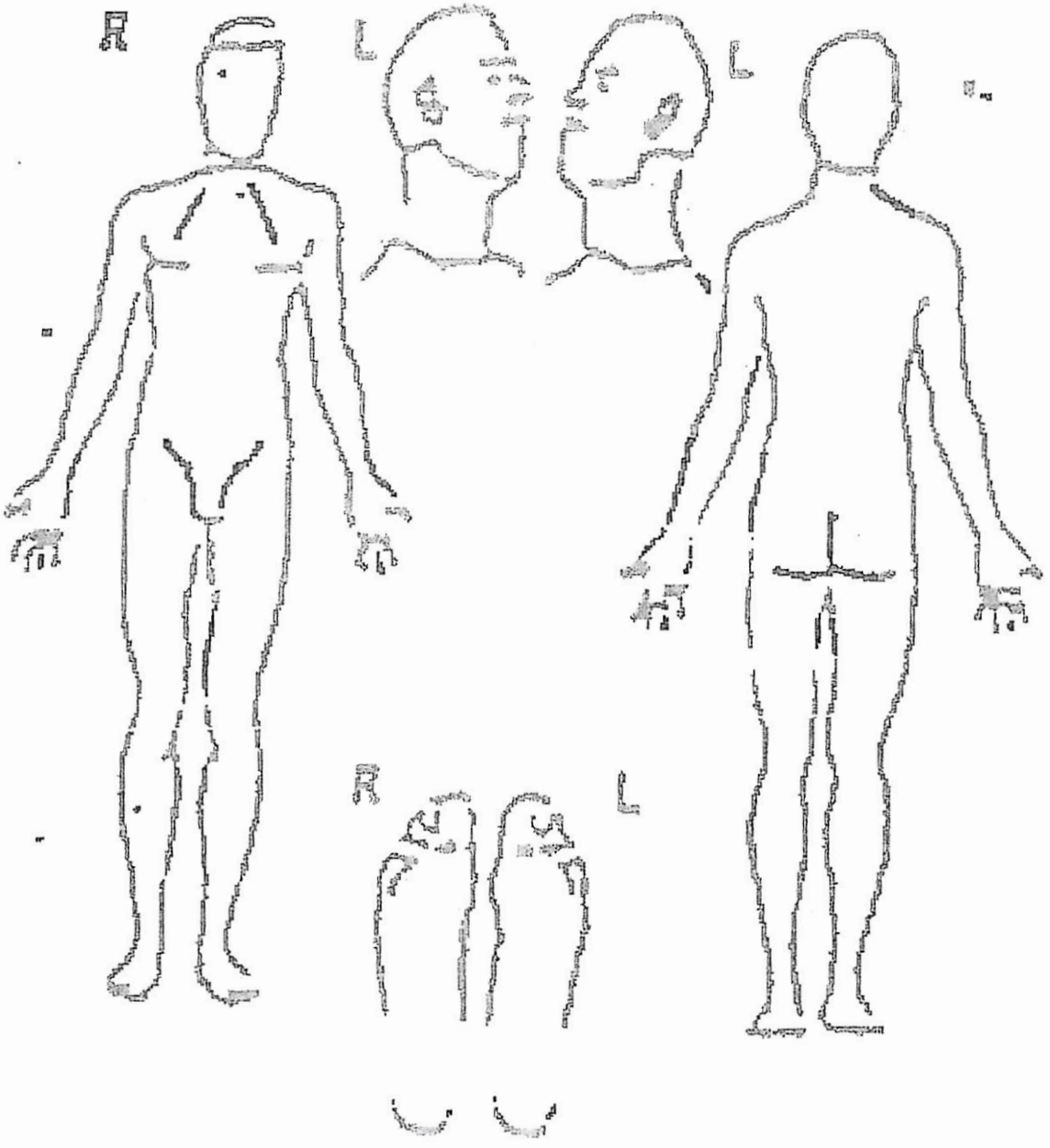
_____

MRI: _____

CT Scan: _____

EMG: _____

* Shade in painful areas in the diagram below. (Please circle the one most painful area)



FOR PHYSICIAN'S USE ONLY - DO NOT WRITE BELOW THIS LINE

PAIN: _____

ASSOCIATIONS: _____

WORSE: _____

BETTER: _____

SLEEP: _____

BOWEL / BLADDER: _____

***CHECK APPROPRIATE BOXES THAT DESCRIBE YOUR PAIN (Check only one box within each category)**

	None	Mild	Moderate	Severe
Throbbing	☐	☐	☐	☐
Shooting	☐	☐	☐	☐
Stabbing	☐	☐	☐	☐
Sharp	☐	☐	☐	☐
Cramping	☐	☐	☐	☐
Gnawing	☐	☐	☐	☐
Hot-burning	☐	☐	☐	☐
Aching	☐	☐	☐	☐
Heavy	☐	☐	☐	☐
Tender	☐	☐	☐	☐
Splitting	☐	☐	☐	☐
Tiring-exhausting	☐	☐	☐	☐
Sickening	☐	☐	☐	☐
Fearful	☐	☐	☐	☐
Punishing-cruel	☐	☐	☐	☐

Please circle the level of your present pain intensity:

0 - No pain.
1 - Mild.
2 - Discomforting
3 - Distressing
4 - Horrible
5 - Excruciating

***PREVIOUS MEDICATIONS** (Check (3) appropriate boxes below if you have used these types of Medications for your current pain problem)

☐ **Narcotics** (i.e., Demerol, Morphine, Dilaudid, MS Contin, Methadone, Darvon, Percocet, Percodan, Talwin, Vicodin, Codeine, Tylenol 3, Tylox, Fentanyl Patch.
☐ **NSAIDS** (i.e., Aspirin, Motrin, Ibuprofen, Dolobid, Toradol, Advil, Naprosyn, Relafen, Orudis.
☐ **Sedatives/Relaxants** (i.e., Ativan, Xanax, Valium, Librium, Flexeril, Parafon Forte)
☐ **Sleep Medications** (i.e., Halcion, Ambien, Restoril, Benadryl)
☐ **Antidepressants** (i.e., Elavil, Pamelor, Desipramine, Effexor, Desyrel, Prozac, Zoloft, Paxil)
☐ **Anticonvulsants** (i.e., Neurontin, Klonopin, Tegretol, Dilantin)
☐ **Neuropathic Pain Mediations** (i.e., Baclofen, Mexitil, Hytrin, Phenoybenzamin)

***PREVIOUS TREATMENTS** (Please check (3) all pain therapies you have used or are currently using)

☐ Acupuncture ☐ Traction ☐ TENS Unit ☐ Psychiatrist

☐ Chiropractor ☐ Warm Heat ☐ Physical Therapy ☐ Other (Specify) _____

☐ Biofeedback ☐ Massage ☐ Psychologist _____

***PAST SURGICAL HISTORY** (Please indicate date, type of surgery and physician's name)

DATE	SURGERY	SURGEON

***ROS:** Please check (3) box if you are currently experiencing any of the following:

☐ Fever, weight loss, sweats ☐ Swelling, rash ☐ Chest pain, palpitations

☐ Cough, sputum production Shortness of breath, wheeze ☐ Abdominal pain, change of bowel habits, nausea ☐ History of easy bruising or using blood thinners ☐ Change in bladder habit (frequency, pain on urination)

☐ Weakness or paralysis of arms Or legs ☐ Lightheadedness, dizziness, headache or vision changes ☐ Pregnancy

☐ Headache

☐ Other (Specify) _____

***PMH:** Please check (3) box if you have a history of:

☐ High blood pressure ☐ Angina ☐ Heart attack ☐ Diabetes

☐ Heart failure ☐ Emphysema or asthma ☐ Chest pains

☐ Stroke ☐ Liver disease ☐ Thyroid disease

☐ Rheumatologic disease ☐ Cancer ☐ Depression or anxiety

☐ Problems with anesthesia ☐ Kidney disease ☐ gastrointestinal illness

☐ Other (Specify) _____

☐ No other relevant PMH (For physician use only)

FOR PHYSICIAN'S USE ONLY - DO NOT WRITE BELOW THIS LINE.

PMH: Mother: Living / Deceased Cause: _____

Father: Living / Deceased Cause: _____

Drug Allergies:

☐ NKDA ☐ YES (Describe) _____

Drug Intolerance: _____

***MEDICATIONS** (Please fill out all medications that you are using at this time)

DRUG NAME	DOSE	HOW MANY TIMES / DAY

***SOCIAL HISTORY** (Please complete information below)

Do you drink alcohol? ☐ No ☐ Yes (Specify quantity) _____

Do you smoke cigarettes? ☐ No ☐ Yes (Specify quantity) _____

Current employment status: ☐ Employed full-time ☐ Employed part-time ☐ Retired

☐ Self Employed ☐ Unemployed due to pain ☐ Unemployed due to other reasons

Present or most recent occupation: _____

Marital history: ☐ Single ☐ Married ☐ Remarried ☐ Divorced ☐ Separated ☐ Widowed

Litigation history: *Is there any litigation in progress in regard to your pain condition?* ☐ Yes ☐ No

With whom do you live with? ☐ Self ☐ Spouse ☐ Children ☐ Parents ☐ Friends ☐ Other: _____

FOR PHYSICIAN'S USE ONLY - DO NOT WRITE BELOW THIS LINE.

Illicit Drug Use: _____

PHYSICAL

BP Pulse Resp Ht. Wt. (lbs.)

General: _____

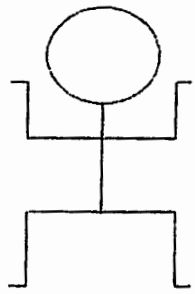
HEENT: ☐ NC / AT Neck: ☐ Supple Lungs: ☐ Clear Cor: ☐ RRR Abd: ☐ Soft, non-tender
☐ PERRLA/EOMI

GU: ☐ NL External Skin: ☐ Clear Extremities: ☐ WNL LE Pulses R PT DP L PT DP
☐ Deferred

Neurologic: Cr. Nerves II-XII

Sensory: UE: R L
LE: R L

Reflexes



C5	C6	C7	C8	T1
Elb Flex	Wrist Ext	Elb Ext	Finger Ext	Finger Abd

Motor: UE: R
L

L2	C3	L4	L5	S1
Hip Flex.	Knee Ext.	Foot Dorsiflex	Hallux Dorsiflex	Hallux Plantarflex

LE. R
L

Babinski: _____
Clonus: _____
Hoffman's _____

Gait: Non Antalgic/ Antalgic

FOCUSED EXAM

Cervical ROM: _____

Lumbar ROM: _____

Patrick's Test: Left: + / - Right: + / -

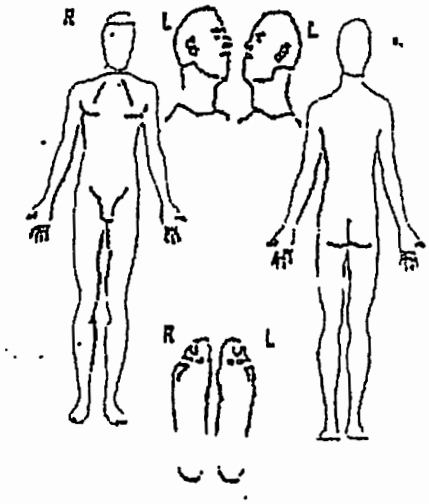
Straight Leg Raise: Left: + / - Right: + / -

Tenderness to palpation:

Facet - _____

SI Joint - _____

Muscle - _____



IMPRESSION:

1st Dx: _____

R/O (other dx's): _____

Comment:

PLAN:

Risk / Decision Making

☐ Minimal ☐ Low ☐ Moderate ☐ High

Counseling: Subject

Pain Management Physicians

Medical Information Release Form
(HIPAA Release Form)

Name: _____

Date of birth: _____/_____/_____

I, _____, have received a copy of the Pain
Print Name
Management Physicians notice of privacy practices.

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

[ ] Spouse_____ _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information may not be released to anyone.

_____ _____
Signature of Patient Date