Pain Management

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. To better serve you, please complete the required paperwork before your visit with our physicians. If you are not able to fill out the paperwork 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 documents for appointments in the Wyomissing and Pottsville locations can be mailed to 2201 Ridgewood Road, Suite 200, Wyomissing, PA 19610 or faxed to 484-509-2933. For appointments in the Philadelphia, Coatesville or Limerick office documents can be mailed to 2701 Holme Ave, Suite 205, Philadelphia, PA 19152 or faxed to 215-338-3606.

Once again, please do not hesitate to call us at 610-375-6626 for appointments in the Wyomissing and Pottsville office and for appointments in the Philadelphia, Coatesville and Limerick offices please call 215-338-1811.

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: _____/_____

PROCEDURE	DATE	PROCEDURE	DATE

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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 incident? YES NO

Motor Vehicle Insurance Carrier: _____

Date of Injury: _____

Claim #: _____

Adjustor's Name: _____

Adjustor's Phone#: _____

Policy #: _____

Policy Holder's Name: _____

Policy Holder's Address: _____

Relationship to Policy Holder: _____

Do You Have an Attorney? YES NO

Name of Attorney: _____

Attorney's Phone/Fax Number: _____

Patient Signature: _____ **Date:** _____

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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: _____

For All Patients

I understand I am responsible for all co-pays and insurance deductible payments and balances not paid by my insurance.

Beneficiary Signature: _____ Date: _____

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CONSENT TO RELEASE RECORDS

Phone 215-338-1811

Fax 215-338-3606

2701 Holme Ave, Suite 205, Philadelphia, PA 19152

213 Reeceville Road, Suite 14, Coatesville, PA 19320

649 N Lewis Road, Suite 220, Royersford, PA 19468

Phone 610-375-6226

Fax 484-509-2933

48 Tunnel Road, Pottsville, PA 17901

2201 Ridgewood Road, Suite 200, Wyomissing, PA 19610

Name: _____

Date of Birth: _____

Address: _____

_____

Patient Signature: _____

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NAME: _____

DOB: _____

PHARMACY INFORMATION

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

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

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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/FAX NUMBER: _____

PRIMARY PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE/FAX NUMBER: _____

OTHER PHYSICIAN:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE/FAX NUMBER: _____

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Comprehensive Intake Form (page 1)

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: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PREVIOUS INJURY: _____

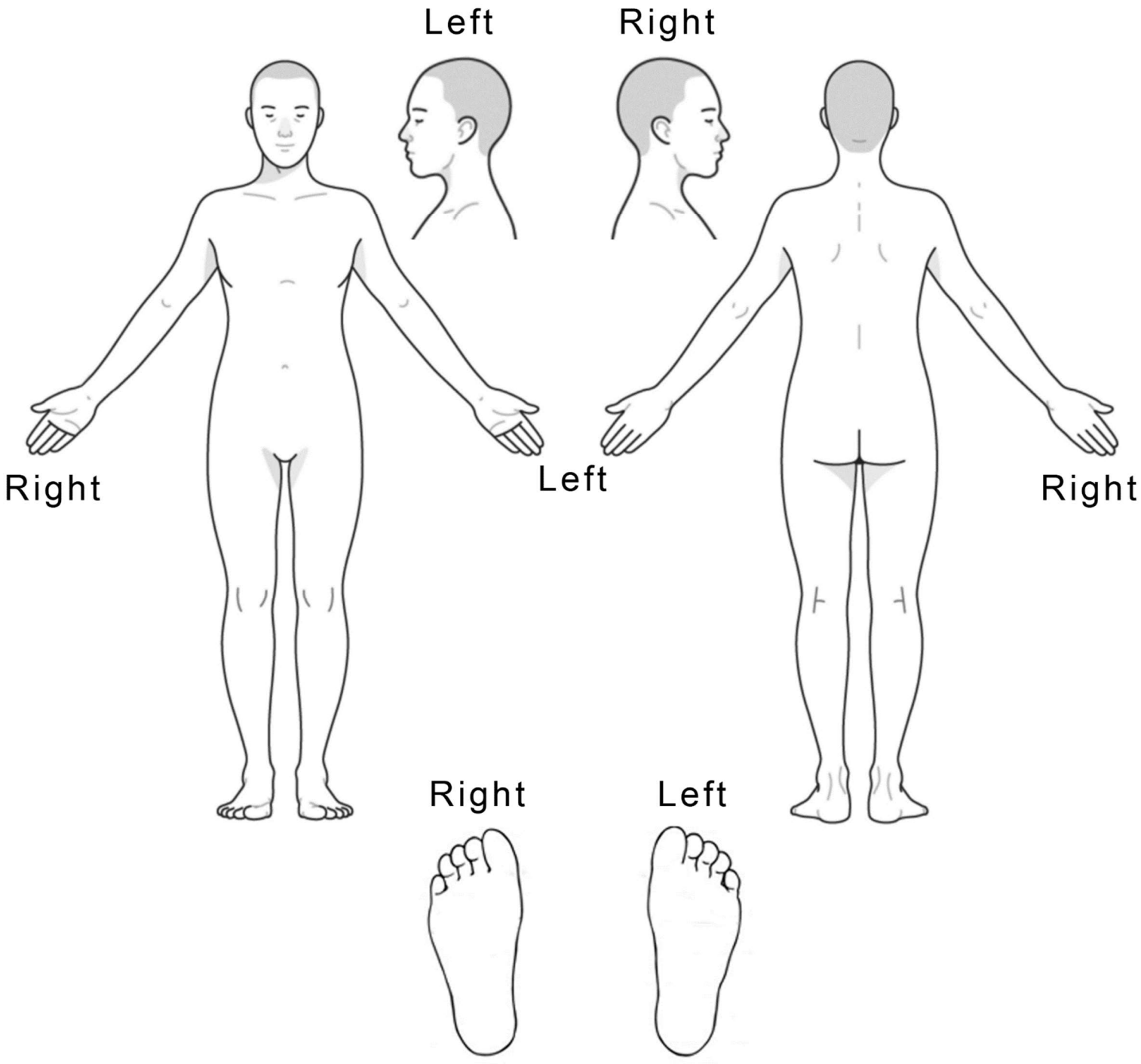
MRI: _____

CT Scan: _____

EMG: _____

Comprehensive Intake Form (page 2)

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



FOR PHYSICIANS USE ONLY – DO NOT WRITE BELOW 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 Pain
2 – Discomforting
3 – Distressing
4 – Horrible
5 – Excruciating

PREVIOUS MEDICATIONS (Check appropriate boxes below if you have ever used these types of medications for your current pain problem).

- ☐ **Narcotics** (i.e., Tramadol, *Morphine, Dilaudid, Hydrocodone, Methadone, Percocet,* Oxycodone *Codeine, Fentanyl Patch, Methadone, Suboxone)*
- ☐ **NSAIDS** (i.e., *Aspirin, Motrin, Ibuprofen, Toradol, Advil, Naprosyn, Diclofenac)*
- ☐ **Sedatives** (i.e., *Ativan, Xanax, Valium, Klonipin*)
- ☐ **Sleep Medications** (i.e., *Ambien, Restoril, Benadryl, Lunesta*)
- ☐ **Antidepressants** (i.e., *Cymbalta, Effexor, Amitriptyline, Trazadone, Prozac, Zoloft, Paxil)*
- ☐ **Anticonvulsants** (i.e., *Neurontin, Lyrica, Horizant, Gralise*)
- ☐ **Muscle Relaxors** (i.e., *Baclofen, Flexeril, Metaxalone, Methocarbamolol, Chloroxazone)*

Comprehensive Intake Form (page 4)

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

- ☐ Acupuncture
- ☐ Chiropractor
- ☐ Biofeedback
- ☐ Traction
- ☐ Warm Heat
- ☐ Massage
- ☐ TENS Unit
- ☐ Physical Therapy
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Other (Specify) _____
  _____

*PAST SURGICAL HISTORY (Please indicate date/type of surgery/Physician's name)

DATE	SURGERY	SURGEON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*ROS (Please check if you are experiencing any of the following)

- ☐ Fever, weight loss, sweats
- ☐ Cough, sputum production, shortness of breath, wheeze
- ☐ Weakness or paralysis of arms OR legs
- ☐ Headache
- ☐ Swelling, rash
- ☐ Change in bladder habits (frequency, pain on urination)
- ☐ History of easy bruising or using blood thinners
- ☐ Lightheadedness, dizziness, or vision changes
- ☐ Chest pain, palpitations
- ☐ Abdominal pain, change of bowel habits, nausea
- ☐ Pregnancy
- ☐ Other (Specify): _____

*PMH (Please check box if you have any history of)

- ☐ High blood pressure
- ☐ Heart failure
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Migraines
- ☐ COPD/asthma
- ☐ Liver disease
- ☐ Cancer
- ☐ Kidney disease
- ☐ Obstructive Sleep Apnea
- ☐ Heart attack/Chest pain
- ☐ Problems with Anesthesia
- ☐ Thyroid disease
- ☐ Depression/anxiety
- ☐ Gastrointestinal illness
- ☐ Other: _____

Are you currently taking Blood Thinners? N or Y (If yes, which: _____)

- ☐ No other relevant PMH (For physician use only)

Comprehensive Intake Form (page 5)

FAMILY HISTORY: 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)

Aspirin: NO or YES Dose: _____

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 ☐ Self-employed ☐ Unemployment due to pain

☐ Employed part-time ☐ Retired ☐ Unemployment due to other reasons

Present or most recent occupation: _____

Marital History: ☐ Single ☐ Married ☐ Remarried ☐ Divorced ☐ Widowed

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

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

FOR PHYSICIANS USE ONLY

UDS Results: _____ Hx of illicit drug use: _____

Comprehensive Intake Form (page 6)

FOR PHYSICIANS USE ONLY – DO NOT WRITE BELOW LINE

PHYSICAL: Temperature:

BP Pulse Resp. Ht. Wt.(lbs)

_____

General: _____

_____

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

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

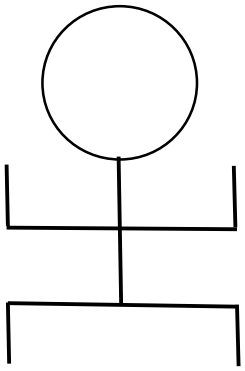
Neurologic: Cr. Nerves II-XII

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

Gait: Non-Antalgic / Antalgic

FOCUSED EXAM

Cervical ROM: _____

Lumbar ROM: _____

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

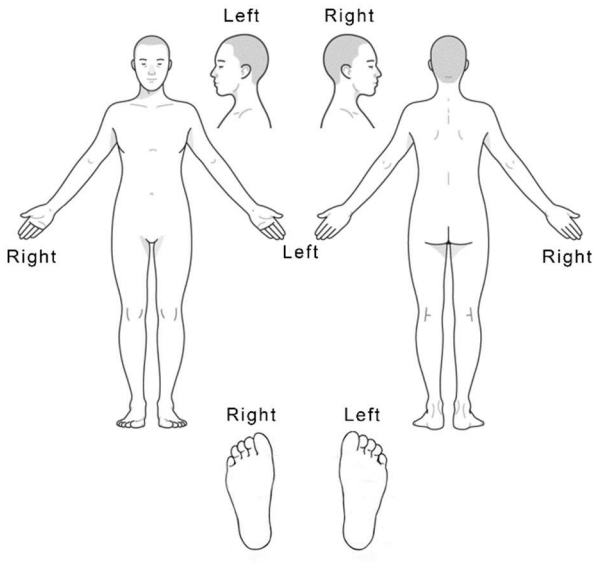
Straight Leg Raise: Left +/- Right: +/-

Tenderness to palpitation:

Facet: _____

SI Joint: _____

Muscle: _____



Comprehensive Intake Form (page 7)

FOR PHYSICIANS USE ONLY – DO NOT WRITE BELOW LINE

IMPRESSION:

1st Dx: _____

R/O (other Dx's): _____

Comment:

PLAN:

Risk/Decision Making:

☐ Minimal ☐ Low ☐ Moderate ☐ High

Counseling:

Attending Signature: _____

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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: _____