Interventional Spine Pain Consultants, PA

Patient Registration

Name: _____ Date of Birth: _____ Sex: M or F
Last First MI

Address: _____

City: _____ State: _____ Zip Code: _____ SS#: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Who may we speak with about your care:

Name: _____ Relationship: _____ Contact #: (____) _____

Emergency Contact: _____ Relationship: _____ Phone #: (____) _____

Primary Care Physician: _____ Phone # (____) _____

INSURANCE INFORMATION (for billing purposes only):

Primary Health Insurance (to be completed by all patients, including Auto and Worker's Comp injured patients):

Insurance Company Name: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy #: _____

Secondary Health Insurance (to be completed by all patients, including Auto and Worker's Comp injured patients):

Insurance Company Name: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy #: _____

Auto Accident or Worker's Compensation must complete the following in addition to Health Insurance information:

Insurance Company Name: _____

Adjuster Name: _____ Adjuster Phone#: (____) _____ Fax#: (____) _____

Claim Number: _____ Body Part involved: _____ Date of Injury: _____

The State where accident or worker's comp injury occurred: _____

Lawyer's name: _____ Contact #: (____) _____

Worker's Comp only: Employer Name _____ Phone: (____) _____ Fax :(____) _____

I consent to treatment necessary for the care of the above named patient. I authorize release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I acknowledge full responsibility for service rendered by **Interventional Spine Pain Consultants, PA**. I further authorize and request that Medicare benefits and Medigap benefits be made payable directly to Interventional Spine Pain Consultants, PA for any services furnished to me by them. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Privacy Act Given: YES NO Patient Initials: _____

Signed: _____ Date: _____ meg (7/10)

Interventional Spine Pain Consultants, P.A.
Initial Consultation Information

Date:__/___/___ Date of Birth___/___/___ Age:_____
Name:_____
Name of the provider that recommended you to our office?_____
Name of your primary care doctor?_____

Chief Complaint:

Why are you being referred to our office?_____

History of Present Illness: (Please check whatever is appropriate, circle side)

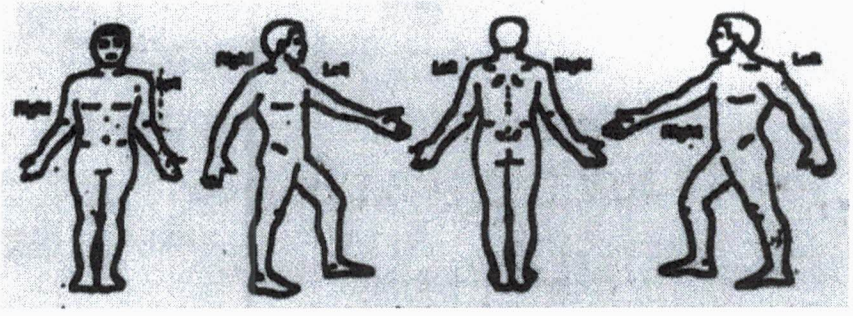
What date did your pain start?_____

Where is your pain?

☐ Head ☐ Neck ☐ Mid-back ☐ Low back ☐ Tailbone ☐ Buttock
☐ Shoulder ☐ Arm ☐ Wrist ☐ Hand ☐ Fingers ☐ Hip (Right or left side)
☐ Leg ☐ Knee ☐ Foot ☐ Toes (Right or Left)
☐ Chest (right or Left) ☐ Groin (right or left)
☐ Abdomen ☐ Hip (Right or left)

☐ Other- please describe_____

Shade in the area/s where you have pain on the diagram below:



Where is your pain the worst? ☐ Neck ☐ Arm ☐ Back ☐ Leg
☐ Other_____

How did your pain problem first start?:

☐ Car accident ☐ Lifting ☐ Trauma/Fall ☐ Work Accident ☐ Unsure
Explain_____
If related to auto or work accident, date of injury_____
Have you ever had this type of pain in the past ☐ Yes ☐ No
Describe _____

Is your pain: ☐ constant ☐ intermittent (comes and goes)

Rate your pain intensity on 0-10 scale _____ (0=no pain 10=worse pain imaginable)

Please complete the following:

In the past 7 days:	1 Not at all	2 A little bit	3 Somewhat	4 Quite a bit	5 Very much
How much did pain interfere with your enjoyment of life?.....	☐	☐	☐	☐	☐
How much did pain interfere with your ability to concentrate?.....	☐	☐	☐	☐	☐
How much did pain interfere with your day to day activities?.....	☐	☐	☐	☐	☐
How much did pain interfere with your enjoyment of recreational activities?..	☐	☐	☐	☐	☐
How much did pain interfere with doing your tasks away from home?... (getting groceries, running errands)	☐	☐	☐	☐	☐

	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
How often did pain keep you from Socializing with others?	☐	☐	☐	☐	☐

What does your pain feel like?

☐ Sharp ☐ Shooting ☐ Dull ☐ Stabbing ☐ Burning ☐ Pounding ☐ Achy ☐ Throbbing ☐ Electrical shock ☐ Crampy ☐ Spasms

☐ Other_____

Do you have numbness/tingling ☐ Yes ☐ No

If yes, where:_____

Do you have weakness? ☐ Yes ☐ No

If yes, where: _____

What makes your pain better:

☐ Rest ☐ Ice ☐ Heat ☐ Sitting ☐ Standing ☐ Walking ☐ Tens Unit

☐ Pain Medication ☐ Nothing ☐ Other_____

☐ NSAID Please Circle: Naproxen, Celebrex, Advil, Tylenol, Motrin

Other_____

What makes your pain worse:

☐ Sitting ☐ Standing ☐ Rest ☐ Walking ☐ Lifting ☐ Stairs ☐ Lifting

☐ Bending backward ☐ Bending forward ☐ Reaching arms over head

☐ Other_____

Has your pain affected your ability to perform:

☐ Work ☐ Sleep ☐ Daily Activities ☐ Sexual Activities ☐ Physical Activities

Which of the following therapies have been used to treat your current pain?

☐ Physical Therapy - location_____
Last treatment date_____
How many weeks of treatment completed?_____
Did/does physical therapy treatment help with your pain? ☐ Yes ☐ No

☐ Nerve block or Injection Name of Physician_____
Last Treatment date_____

☐ Surgery ☐ Chiropractor ☐ Accupuncture ☐ Massage therapy

Have you treated at a pain center(s)? ☐ Yes ☐ No
Name of center_____

Have you ever been prescribed NSAIDS (Naproxen, Celebrex, Voltaren) ☐ Yes ☐ No
Name of NSAID_____
Did/does the NSAID help with your pain? ☐ Yes ☐ No

Diagnostic Testing

What diagnostic testing has been done on your body related to your pain condition:
(Please list which part of the body)

☐ X-ray of _____ Year _____ ☐ MRI of _____ Year_____
☐ Cat Scan of _____ Year_____ ☐ EMG of_____ Year_____
☐ Myelogram of_____ Year_____ ☐ Bone Scan Year_____

Medical History - Have you ever had any problems with the following:

			Comments
Head injury/Concussion	☐ Yes	☐ No	_____
Spinal injury	☐ Yes	☐ No	_____
Stroke/TIA	☐ Yes	☐ No	_____
Seizure/Epilepsy	☐ Yes	☐ No	_____
Thyroid disease	☐ Yes	☐ No	_____
Heart disease			
• Heart attack	☐ Yes	☐ No	_____
• Congestive heart failure	☐ Yes	☐ No	_____
• Chest pain or angina	☐ Yes	☐ No	_____
• Mitral valve prolapse	☐ Yes	☐ No	_____
• Rheumatic heart disease	☐ Yes	☐ No	_____
High blood pressure	☐ Yes	☐ No	_____
Breathing disorder :			
• Asthma	☐ Yes	☐ No	_____

- COPD ☐ Yes ☐ No _____
- Emphysema ☐ Yes ☐ No _____
- Tuberculosis ☐ Yes ☐ No _____

Sleep Apnea ☐ Yes ☐ No _____
Elevated Cholesterol ☐ Yes ☐ No _____
Heart burn or gastric reflux ☐ Yes ☐ No _____
Ulcer or gastric bleeding ☐ Yes ☐ No _____
Irritable bowel / Crohns disease ☐ Yes ☐ No _____
Liver disease or hepatitis ☐ Yes ☐ No _____
Cancer ☐ Yes ☐ No _____
If yes, what type of cancer _____
HIV/AIDS ☐ Yes ☐ No _____
Diabetes (Type I / Type II) ☐ Yes ☐ No _____
Kidney disease ☐ Yes ☐ No _____
Poor circulation ☐ Yes ☐ No _____
Neuropathy (nerve pain) ☐ Yes ☐ No _____
Rheumatoid / Osteoarthritis ☐ Yes ☐ No _____
Fibromyalgia ☐ Yes ☐ No _____
Bleeding problems ☐ Yes ☐ No _____
If yes, what type of bleeding problem _____
Systemic Lupus ☐ Yes ☐ No _____
Multiple Sclerosis ☐ Yes ☐ No _____

Surgical History:

Please list the name and year of your surgeries

Name of Surgery	Year

Medications

Do you take blood thinning medications? ☐ Yes ☐ No
☐ Coumadin (Warfarin) ☐ Plavix (Clopodogrel) ☐ Lovenox
☐ Pradaxa (Dabigatran) ☐ Xarelto (Rivaroxaban) ☐ Eliquis (Apixaban)
☐ Brilinta (Ticagrelor) ☐ Ellieft (Prasugrel) ☐ Other _____
What is the name of the provider that prescribes your blood thinning medication?
_____
Do you have a pacemaker? ☐ Yes ☐ No
Do you have an AICD? ☐ Yes ☐ No
If yes, what is the physician's name that manages? _____

Please list the name and dose of all your medications

Name of Medication	Dose

List all medications you have previously used for pain control

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Allergy History

Do you have any medication allergies: ☐ Yes ☐ No

If so, please list medication name and type of reaction:

Medication Allergy	Type of Reaction

Have you ever had an allergy to: Type of Reaction

X-ray dye ☐ Yes ☐ No _____

Shellfish ☐ Yes ☐ No _____

Iodine ☐ Yes ☐ No _____

Latex ☐ Yes ☐ No _____

Tape ☐ Yes ☐ No _____

Family/Social History

Are you ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Number of children you have_____
Are you currently working ☐ Yes ☐ No
☐ Disabled on _____ (Date)
If no, what date did you stop working?_____
☐ Full-time ☐ Part-time ☐ Not employed ☐ Retired
Your occupation_____
Are you ☐ Right handed ☐ Left-handed
Level of education ☐ High School ☐ College ☐ Other_____
Do you smoke ☐ Yes ☐ No Have you ever smoked ☐ Yes ☐ No
If yes, how much do or did you smoke_____
Do you consume Alcohol ☐ Yes ☐ No
If yes, how many drinks per week____
Do you or did you ever have a drinking problem ☐ Yes ☐ No
Were you ever in detox ☐ Yes ☐ No
Do you or have you ever taken recreational drugs ☐ Yes ☐ No
If yes, check type ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other_____
Are you receiving workman's compensation? ☐ Yes ☐ No
Are you involved in litigation involving your injury/pain? ☐ Yes ☐No
If yes, what is the name of your attorney _____

Family Illness

Has anyone in your immediate family ever had: (please check all that apply and list if it is your mom, dad, sister, brother, etc....)

☐ Heart Attack_____ ☐ Stroke_____
☐ Cancer_____ ☐ Diabetes_____
☐ Epilepsy_____ ☐ Bleeding Disorder_____
☐ Neck/back problems_____ ☐ Kidney Problems_____

Female patients only:

Are you currently pregnant ☐ Yes ☐ No Date of last menstrual cycle___/___

Review of Systems – have you had any of the following symptoms:
(check all boxes that apply)

Constitutional: ☐ recent weight change ☐ fatigue ☐ fever
Eyes: ☐ cataracts ☐ double vision ☐ glaucoma ☐ visual loss
Ears, Nose, Mouth & Throat: ☐ bleeding gums ☐ hearing loss ☐ hoarseness
☐ Nosebleeds ☐ sinus problems ☐ sore throat ☐ ringing ears ☐ loss of balance

Cardiovascular: ☐ chest pain ☐ palpitations
Respiratory: ☐ cough ☐ shortness of breath ☐ difficulty breathing ☐ wheezing
Gastrointestinal: ☐ abdominal pain ☐ bleeding ☐ constipation ☐ diarrhea
☐ bloody stools ☐ nausea/vomiting ☐ trouble swallowing
Genitourinary: ☐ burning or pain on urination ☐ excessive urination
☐ blood in urine ☐ incontinence ☐ difficulty urinating ☐ urgency in urination
Male: ☐ impotence ☐ testicular pain ☐ sexual difficulties
Female: ☐ menstrual problems ☐ sexual difficulties
Musculoskeletal: ☐ muscle pain ☐ joint pain ☐ swelling
Integumentary: ☐ breast lumps ☐ lumps ☐ sores ☐ rashes
Neurological: ☐ headache ☐ migraines
Psychiatric: ☐ anxiety/nerves ☐ depression ☐ nervousness ☐ tension
☐ history of major psychiatric problems
Endocrine: ☐ excessive sweating ☐ excessive thirst or hunger ☐ heat intolerance ☐ cold intolerance
Hematological/Lymphatic: ☐ bleeding ☐ easy bruising ☐ swollen glands
Immunologic disorders ☐ List:_____

Form completed by: ☐ Patient ☐ Family Member (write name)_____
Signature:_____

Pharmacy Information

Patient Name: _____ Date of Birth: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

ISPC staff only:

Information entered into EHR/then filed in chart (date/initials): _____

Interventional Spine Pain Consultants, PA
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Newark, DE 19713
Phone 302-478-7001 * Fax 302-478-7002

Notice of Privacy Practices

Patient Health Information

Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacies who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintenance records of payments from your health plan.
Health Care Operations: We will use and disclose your health care information to conduct standard internal operations, including proper administration of records evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may leave a message on your answering machine. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gun shot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Alternatives: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information require by law to enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensations: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.
In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards or phone to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a charge for these copies.
Amend Information: If you believe that the information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and abide by the terms of the notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make any significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person:

If you have any questions, requests, or complaints, please contact: Kate Rutmayer

Health Information Privacy Officer

ISPC, Suite 111
Newark, DE 19713

302-478-7001

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