PAIN MANAGEMENT CENTERS
215-771-1179
TRICOUNTYPMC.COM

New Patient Intake

Name: ______________________________ Age: _____ Date of birth: ____________ Date: __________
LAST FIRST MIDDLE

Address: ______________________________ Social Security #: ____________________ ☐ Male ☐ Female

City, State, Zip: ______________________________ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children __________

Home Phone (_____) ______________________________ Work Phone (_______) ____________________

Cell Phone (_____) ______________________________ Email address: ____________________

Employer: ______________________________ Occupation: ____________________

In case of emergency, notify ____________________ Relationship: ____________ Phone (_______) __________

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR HEALTH INSURANCE COMPANY: ______________________________

Address: ______________________________ Insured: ______________________________

Date of Birth: ____________________ Policy #: ____________________ SS#: ______________

Telephone: (______) ____________________ Fax: (_______) ____________________

2) YOUR HEALTH INSURANCE COMPANY: ______________________________

Address: ______________________________ Insured: ______________________________

Date of Birth: ____________________ Policy #: ____________________ SS#: ______________

Telephone: (______) ____________________ Fax: (_______) ____________________

Current Symptoms: 1.______________ 2.______________ 3.______________ 4.______________

5. ______________ 6. ______________ 7. ______________ 8. ______________

When did your symptoms begin? ______________________________

In general what makes your symptoms better? ______________________________

In general what makes your symptoms worse? ______________________________

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): ____________________

Are your symptoms local or do they travel to another area? (If they travel, to where?) ____________________

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

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Patient's Name: ______________________________ Date: ______________

Please list all medications and dosage:

1.______________ 2.______________ 3.______________
4.______________ 5.______________ 6.______________

List any allergies to medications, foods or other: ______________________________

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	High Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes
COPD	☐ Yes	Migraine Headaches	☐ Yes	Neck Pain	☐ Yes	Back Pain	☐ Yes

Past Surgical History: Date:__________ Procedure:______________________
Date:__________ Procedure:______________________
Date:__________ Procedure:______________________
Date:__________ Procedure:______________________

Family History

Please list any conditions your parents or siblings may have:______________________________

____

____

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED RECENTLY:

☐ *Headache*	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ *Bruised Chest*	☐ *Radiating Pain*	☐ *Dizziness*
☐ *Sleep Disruption*	☐ *Bruising Anywhere*	☐ Tingling in Legs	☐ *Loss of Smell*
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ *Loss of Taste*
☐ *Anxiety*	☐ *Sensitivity to Light*	☐ *Jaw Pain (TMJ)*	☐ *increased Thirst*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Difficulty Walking*
☐ *Muscle Spasms*	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Shortness of Breath*
☐ *Suicidal Thoughts*	☐ Fatigue	☐ Bowel/Bladder Changes	☐ Weight Change

Current Work Status: ☐Retired ☐Working ☐Disability ☐ Other:____________

Do you smoke? ☐ Yes ☐ No; ____ pack(s) per day

Do you drink alcohol? ☐ Yes ☐ No; ___ drink(s) per day

Do you live in a: House___ Apartment____; List other household members:______________________

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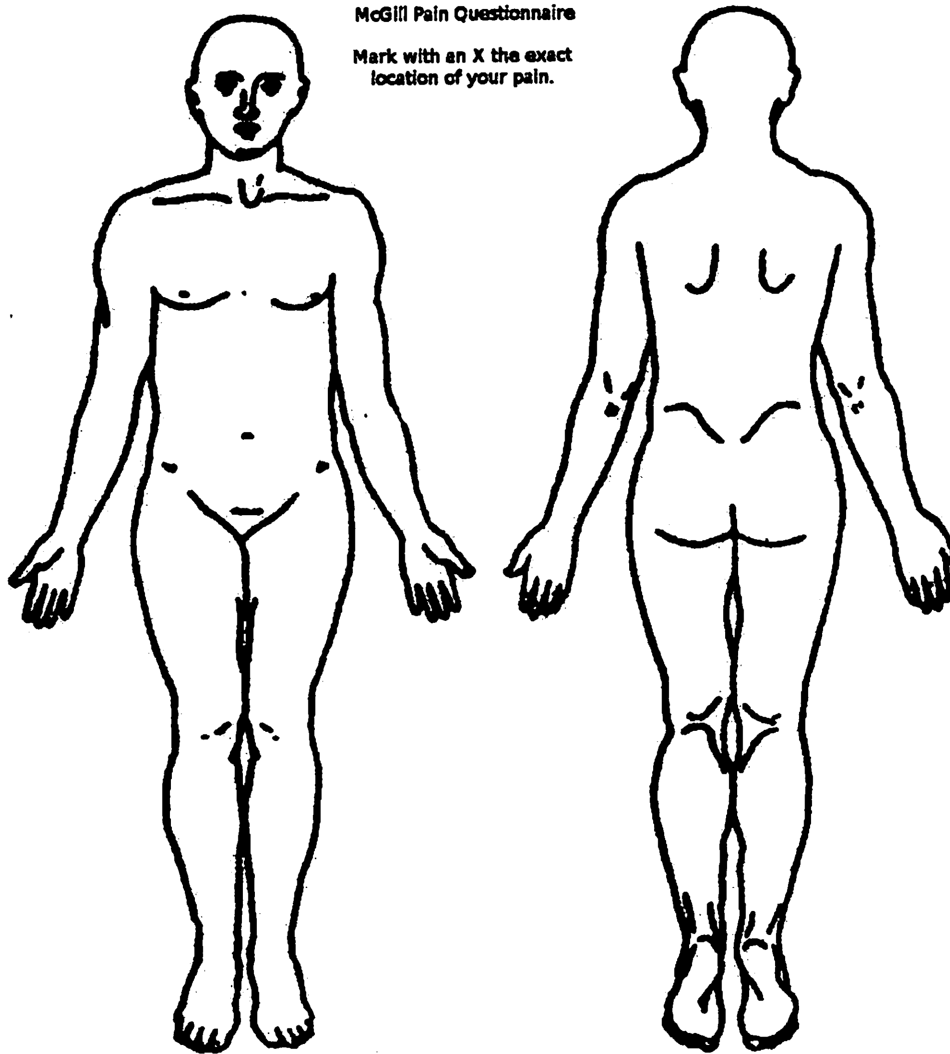
PAIN MANAGEMENT CENTERS
PAIN CHART

Mark the diagram with an X over any area of pain.



Patient Signature:____ **Date:**____/____/______

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CONSENT TO TREAT and ADMINISTRATIVE AUTHORIZATION

1. Authorization for Treatment and Diagnostic Procedures: I voluntarily authorize, request and consent to outpatient care services, including procedures, examinations, and medical treatment as ordered by my physicians, his/her assistants, or other health care provides. I understand that, except in emergency situations, this consent does not include surgical procedures or other procedures or treatment that may require separate consent. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of any procedures, treatments or examinations.

2. Assignment of Insurance Benefits to Tri County Pain Management Center: I authorize payment of health care benefits directly to Tri County Pain Management Center. In making this assignment, I understand and agree that I may be financially responsible to Pain Management Center for charges not paid under my insurance policy(ies). I permit a copy of this authorization to be used in place of the original. I authorize payment of authorized Medicare or other payor benefits to be made to me or on my behalf, to the physician or supplier for any services provided to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby certify that I have read and fully understand the above consent. I have sufficient opportunity to ask whatever questions I might have, and they have been answered to my satisfaction. I voluntarily and freely consent to the above and accept its term.

Signature: ______________________________ Date: ______________

Printed Name: ____

CONSENT TO TREAT A MINOR:

I hereby authorize the doctors of the Pain Management Centers, and/or whomever they may designate as assistants to administer treatment as deemed necessary to

____

Signature of Parent or Legal Guardian: ______________________________________

Printed name: ______________________ Date: ________ Relationship: ____________

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature:______________________________________Date:____________

Please answer the following questions:

Yes / No Leave a message regarding your appointment on your voicemail, email or with your spouse, apparent, or other member of your household (or at work, if this is the number you provide us with).

Yes / No Leave a message regarding test results on your voicemail, email, or with your spouse, a parent, or other member of your household (or at work, id this is the number you provide us with).

Yes / No Give test results to your spouse, a parent or to other designated family member or friend. If yes, please specify:______________________________________.

___ I request the above restrictions to the use or disclosure of my Protected Health Information (PHI).

FOR OFFICE USE ONLY

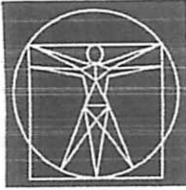
We attempted to obtain written acknowledgement of our Notice of Privacy Practices and use of PHI, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Specify:____)



Pain Management Centers

TriCountyPMC.com
Phone: 215-771-1179 Fax: 877-884-6224

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.