PAIN MANAGEMENT CENTERS
215-771-1179
TriCountyPMC.com

New Patient Intake and Accident Questionnaire

Name: _____ (LAST / FIRST / MIDDLE) Age: ____ Date of birth: _____ Date: _____

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 AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (____) _____ Insured: _____

Claim #: _____ Policy #: _____

Claim Representative: _____

Telephone: (_____) _____ Fax: (_____) _____

Med-Pay Benefits: _____ Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

Telephone: (_____) _____ Fax: (_____) _____

4) ATTORNEY: _____ Legal Assistant: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

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

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

5._____ 6._____ 7._____ 8._____

Date of Crash/Accident: _____ Time: _____ ☐ AM ☐ PM

Specific Location of Crash/Accident: _____

Describe in detail, in your own words, how the crash/accident happened: _____

_____

_____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, bum, 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

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

_____

AUTOMOBILE/MOTORCYCLE ONLY

In the crash/accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Your vehicle: ☐ Car ☐ Pick-up Truck ☐ Van ☐ SUV / Other vehicle: ☐ Car ☐ Pick-up Truck ☐ Van ☐ SUV

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only:** ☐Left Side ☐ Right Side

Were you rendered unconscious as result of accident? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No Did the airbags deploy? ☐ Yes ☐ No

Please list any recent x-rays, MRIs, lab or other tests: **Date** **Facility/Doctor**

_____

_____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: _____ to _____

Where did you go after the crash/accident? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?** _____

Have you done any of the following since the crash/accident?

☐ Ice ☐ Rest ☐ Medication (name) _____

☐ Heat (any kind) ☐ Exercise ☐ Other _____

PAIN MANAGEMENT CENTERS

To our patients and their attorneys:

The doctors and staff at Pain Management Centers are dedicated to serving your medical needs related to your work and personal injuries. To help us with this endeavor we are asking that you sign this form. Your signature will help ensure that your outstanding balance with our Practice will be paid and appropriate medical treatment administered.

In the event that you make a claim for workers' compensation benefits or make a claim against a third party for personal injury compensation, your signature below will act as a guarantee that your outstanding balance with our Practice will be satisfied. By signing this form you agree to protect the interests of Pain Management Centers. Pain Management Centers will submit all your bills to the appropriate insurance company for payment. If for any reason the insurance company does not pay it will by your responsibility to submit your bills to your attorney. Additionally, you agree and direct your attorney to submit the Practice's medical bills into evidence, pursuant to the applicable laws of any auto or workers' compensation proceeding or third party personal injury action.

By signing below, you also agree to pay any outstanding medical bills from any settlement or recovery you obtain in either your workers' compensation claim or your third party personal injury action. Payment will be made directly by your attorney to Pain Management Center upon distribution of the proceeds. Your signature below authorizes your attorney to distribute a payment, or direct distribution by another entity when applicable, to our Practice equal to your outstanding balance at the time of distribution.

I, _____, agree and affirm that I, and my attorney, will protect the interests of Pain Management Center in any auto or workers' compensation proceeding or in any third party personal injury proceeding. My signature also authorizes and directs my attorney to submit payment equal to my outstanding balance with Pain Management Center at the time of distribution of my auto or workers' compensation settlement or recovery or my third party personal injury settlement or recovery.

_____ _____

Patient's Signature Date

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

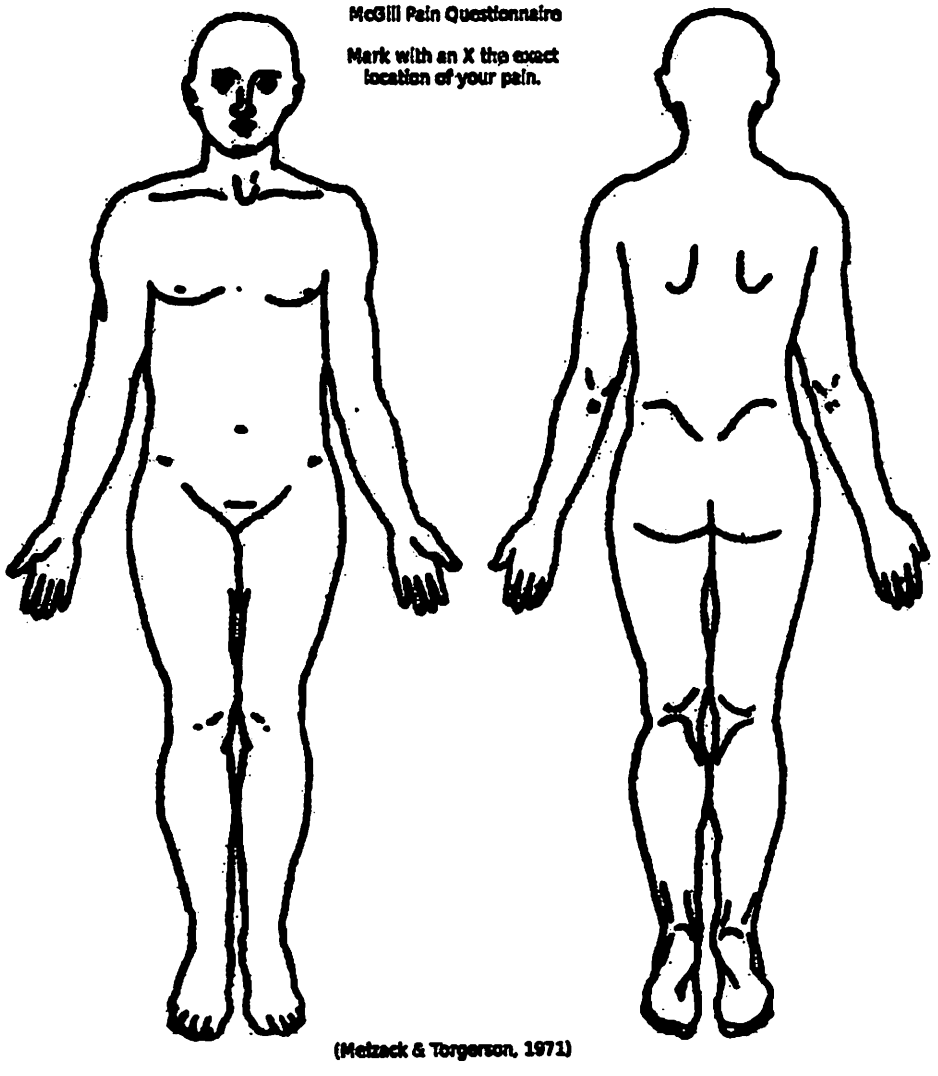
Do you live in a: House____ Apartment____; List other household members:_____

Have you ever been involved in a previous Automobile or Work accidents? Please describe:

Date	Injuries Sustained
___/___/____	_____
___/___/____	_____
___/___/____	_____
___/___/____	_____

PAIN MANAGEMENT CENTERS
Pain Chart

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



Patient Signature:_____ Date:___/___/_____

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.