

# Osteopathic Pain Management

630 Peter Jefferson Parkway, Suite 170  
Charlottesville, VA 22911

## Patient Registration – 2009

Patient Name: \_\_\_\_\_ Date of Initial Visit: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male / Female

Name of person completing this form (if different from patient): \_\_\_\_\_

If patient is a minor, list Guardian's name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address (if different): \_\_\_\_\_

Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Please list any other specialists you see:

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

How did you hear about us? (please check all that apply)

Friend  Website  Physical Therapist  Massage Therapist  Word of Mouth  Other: \_\_\_\_\_

## FINANCIAL RESPONSIBILITY

Person Financially Responsible for this Account (if other than patient): \_\_\_\_\_ Relationship to Patient: Spouse

Guardian Other: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Position: \_\_\_\_\_

## INSURANCE INFORMATION

Is this visit related to a specific **Motor Vehicle Accident**?     Yes  No    Date of Accident: \_\_\_\_\_

Name of Attorney: \_\_\_\_\_    Attorney Phone #: \_\_\_\_\_

Attorney Address: \_\_\_\_\_

Is this visit related to **Workers' Comp**?     Yes  No    Date of Accident: \_\_\_\_\_

<b>Primary Insurance Company Name:</b>		<b>Secondary Insurance Company Name:</b>	
<b>Policy Holder's Name :</b>	<b>DOB:</b>	<b>Policy Holder's Name:</b>	<b>DOB:</b>
<b>Policy Holder's Employer:</b>	<b>Policy Holder's SSN:</b>	<b>Policy Holder's Employer:</b>	<b>Policy Holder's SSN:</b>
<b>Policy #:</b>	<b>Group #:</b>	<b>Policy #:</b>	<b>Group #:</b>
<b>Address:</b>		<b>Address:</b>	
<b>City, State &amp; Zip:</b>		<b>City, State &amp; Zip:</b>	
<b>Telephone #:</b>		<b>Telephone #:</b>	
<b>Relationship to Patient (circle one):</b> Self Spouse Child Parent Other		<b>Relationship to Patient (circle one):</b> Self Spouse Child Parent Other	

**INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:**

- I certify that the information I have provided with regards to my insurance coverage is correct.
- I authorize the use of this form and any information provided on this form on all insurance submissions.
- I authorize release of medical information to the insurance companies listed above.
- I understand that I am personally responsible for my bill in the event of non-coverage by insurance.
- I authorize Dr. Dean, Dr. Mally, Dr. MacDonald and their staff to act as my agent in helping me to obtain payment from the insurance companies listed above.
- I authorize payments from the insurance companies listed above to be made directly to Dr. Dean, Dr. Mally, and Dr. MacDonald.
- Should my account be not paid promptly, I understand that I may be asked to pay all costs of collection, including but not limited to the agency fees, and to pay interest at the rate of 18% per annum from and after the date of treatment and to pay any necessary and reasonable attorney fees incurred in the collection of my account, whether or not a suit is filed.

**Responsible Party's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Initial** \_\_\_\_\_

**ALLERGY INFORMATION**

Please list any allergies or bad reactions you have to medicines, foods or substances (such as latex, plants, chemicals, shellfish, etc.) and the reactions you have when you come into contact with them.

<b>SUBSTANCE</b>	<b>REACTION</b>


**MEDICATION INFORMATION**

*Please list all **prescription medications, over-the-counter medications, vitamins, herbs and supplements** that you take now, or have taken in the past month.*

<b>Medication Name</b>	<b>Dose</b>	<b>How many times a day?</b>	<b>Reason for taking</b>	<b>When started?</b>

*Please list any medications **recently discontinued**.*

<b>Medication Name</b>	<b>Dose</b>	<b>How many times a day?</b>	<b>Reason for taking</b>	<b>When started?</b>

**Have you ever received prescriptions for pain medications from another provider?**

- Yes  No
- Currently  Previously

**Do you have a medication agreement signed in any other office for controlled substances?**

- Yes  No
- Current  Expired / Terminated

## TRAUMA HISTORY

Have you ever been in a Motor Vehicle Accident?  Yes  No

Details: \_\_\_\_\_

Have you ever been in any major accidents that caused injury?  Yes  No

Details: \_\_\_\_\_

Have you ever been hospitalized?  Yes  No

Details: \_\_\_\_\_

Have you ever had major falls or injuries in childhood or from sports?  Yes  No

Details: \_\_\_\_\_

Please list any other medical or trauma related problems you are aware of, or include additional information about problems listed above:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## PAIN MANAGEMENT HISTORY

*Please circle all that apply and provide details*

Procedure	Body Location	Date	Who Performed the Procedure
Epidural Injection			
Facet Injection			
Trigger Point Injection			

*Please circle all that apply and provide details*

Imaging	Body Location	Where Images were taken <i>(MJH, UVA, Private Office)</i>	Date	Other Details
MRI				
X-Ray				
CT				

Have you ever, or do you currently see any of the following practitioners? *(please list names)*

- Physical Therapist \_\_\_\_\_  Currently  Previously: \_\_\_\_\_  
 Massage Therapist \_\_\_\_\_  Currently  Previously: \_\_\_\_\_  
 Chiropractor \_\_\_\_\_  Currently  Previously: \_\_\_\_\_

When did your pain begin? \_\_\_\_\_

Where is your pain located? \_\_\_\_\_

On a scale of 0 (*no pain*) to 10 (*the worst pain imaginable*) where would you rate your pain  
currently \_\_\_\_\_ at its worst \_\_\_\_\_

Have you tried any of the following to relieve your pain?

- Stretching  No relief  Minimal Relief  Temporary Relief  
 Exercise  No relief  Minimal Relief  Temporary Relief  
 Over-the-counter NSAIDs (Ibuprofen, Aleve, etc.)  No relief  Minimal Relief  Temporary

Relief

- Warm Compresses  No relief  Minimal Relief  Temporary Relief  
 Cold Compresses  No relief  Minimal Relief  Temporary Relief

**PAST MEDICAL HISTORY**

Office Use Only:

Time: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_ SPO2: \_\_\_\_\_

<b>Problem</b>	<b>Yes</b>	<b>No</b>	<b>Date</b>	<b>Details</b>
Herniated Disk				
Pinched Nerve				
Fracture Bone				
Torn Ligament/ Tendon				
Muscle Injury				
Osteoporosis				
Neurological Disorder				
Stroke (CVA)				
Seizures				
Depression / Anxiety				
Psychiatric Disorder				
Heart Attack (MI)				
High Blood Pressure				
Heart Disease				
Diabetes				
Kidney Disease				
Liver Disease				
Asthma				
Ulcers/ GERD				
Cancer				
Other:				

Current Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_

**PAST SURGICAL HISTORY***Please check all surgical procedures that apply, and provide details*

<b>Problem</b>	<b>Yes</b>	<b>No</b>	<b>Surgery Date</b>	<b>Details</b>
Back / Neck / Spine				
Hip / Knee / Ankle				
Shoulder / Elbow / Wrist / Hand				
Tendon / Ligament Repair				

Neurological Surgery				
Hernia Repair				
Stomach / Intestinal				
Appendix				
Gallbladder				
Eye Surgery				
Hysterectomy				
Caesarean Section (C-Section)				
Other:				

Initial \_\_\_\_\_

## SOCIAL HISTORY

Marital Status:     Single     Married     Significant Other     Widowed     Divorced

Is there anyone at home or nearby to help you if needed?     Yes     No

If yes, please describe their relationship to you: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Do you consider yourself to be physically fit?     Yes     No     Partially

Do you participate in Sports or a routine exercise program? Describe: \_\_\_\_\_

Stress Level:     High     Average     Low    Sources of Stress (job, family, etc.): \_\_\_\_\_

Do you use:

tobacco products?     Yes     No     Previously (Quit)

What, and How Often? \_\_\_\_\_

recreational drugs?     Yes     No     Previously (Quit)

What, and How Often: \_\_\_\_\_

alcoholic beverages?     Yes     No     Previously (Quit)

What, and How Often: \_\_\_\_\_

drugs not prescribed by a physician?     Yes     No     Previously (Quit)

What, and How Often: \_\_\_\_\_

## FAMILY HISTORY

Were you adopted?     Yes     No

*If yes, and you have medical information about your biological family, please answer below.*

*Otherwise leave blank.*

Relationship	Living	Deceased	Age	Medical Problems
Mother				
Father				
Brother				
Brother				
Brother				
Sister				
Sister				

Sister				
Child (M / F)				
Child (M / F)				
Child (M / F)				
Child (M / F)				
Child (M / F)				

Initial \_\_\_\_\_

**PRIVACY QUESTIONNAIRE**

*Please list any persons whom you authorize this office to inform about your general medical condition (including treatment, payment and other health care operations).*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Can confidential messages regarding your treatment be left on your telephone answering machine?       Yes  No

Initial \_\_\_\_\_

**CONSENT FOR TREATMENT**

I give consent for treatment and services that are considered medically necessary to my care.

I understand that at any time this office feels in good faith that it can no longer provide me medical care or there is no longer a working doctor-patient relationship, I will be informed of this. Furthermore, I understand that under Virginia statute I will have 30 days to find another physician. Upon written request, this office will then forward my medical records to my new provider.

Initial \_\_\_\_\_

**RECEIPT OF PRIVACY PRACTICES (condensed version)**

I have received a copy of the condensed version of Osteopathic Pain Management's "Notice of Privacy Practices" and have had access to the full version posted in his office. I understand that I can request copies of either version at any time.

I understand my rights and responsibilities with regard to maintaining the privacy of my health records, and know that if I need additional information or if I wish to give further instructions, I can contact the practice privacy officer via 434-975-2555.

Initial \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ DOB: \_\_\_\_\_