REGISTRATION

Patient Information (PLEASE PRINT)

Name_____ Sex: ❑ M ❑ F

Date of Birth _____/_____/_____ Patient's SS # _____

Street Address _____

City _____ State _____ Zip _____

Cell Phone _____ Email_____

In case of emergency, who should be notified? _____

Pharmacy Name and Address: _____

If pain/injury is related to Automobile Accident or Worker's Compensation, please provide all claim numbers, case manager's name, attorney name and phone numbers in order for our office to verify this information. Each service will be authorized prior to treatment.

Primary Insurance: (Skip if you Provided a Copy of Your Insurance Card)

Name of Primary Insurance _____

Policy/Claim # _____

Attorney/Case Manager Info: _____

Secondary Insurance:

Name of Secondary Insurance _____

Policy/Claim # _____

Referral Information:

How did you learn of our practice? _____

Primary Care Provider: _____

Assignment and Release

I hereby authorize Greater Atlanta Pain and Spine LLC, to release any information concerning treatment of the undersigned patient to any insurance company for the purpose of determining eligibility for payment of insurance benefits and to secure those payments. This includes information on substance abuse and/or HIV. I authorize assignment of group insurance, hospital, surgical, medical and any other insurance benefits payable directly to Greater Atlanta Pain and Spine LLC. I understand that I am financially responsible for any charges not paid by insurance. Should the account be referred to an attorney or collection agency, I shall pay reasonable attorney's fees and collection expenses. I certify that the information I have given in applying for payment under Title V, XVIII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid claim.

Patient Signature: _____
Date:_____

NEW PATIENT PAIN HISTORY

1. Reason for visit today: _____

2. Date pain began: _____

3. Where is your pain: _____

4. What caused your pain? ❑ Work Injury ❑ Auto Accident ❑ Home Injury ❑ Unknown

5. Description of Injury: _____

6. Rate your pain on a scale from 1 to 10 (10 being the worst pain)? _____

7. What type is your pain? ❑ Sharp/Stabbing ❑ Shooting ❑Burning ❑ Electric ❑ Dull/Aching

8. How frequent is your pain? ❑ Constant ❑ Sometimes How often? _____

9. Do you experience the following? ❑ Pins & Needles ❑Numbness ❑ Weakness

10. If you answered yes to #9, where do you feel it? _____

11. Is your pain related to activity? ❑ Yes ❑ No

12. What makes your pain better? ❑ Nothing ❑ Lying on your back ❑ Lying on your side ❑ Sitting ❑ Bending

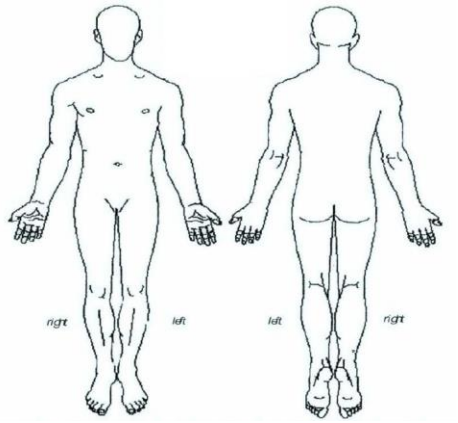
13. What makes your pain worse? ❑ Sitting ❑ Standing ❑Walking ❑ Lifting ❑ Coughing❑ Sneezing

14. Which do you have? ❑ Trouble sleeping ❑ Urine Leakage ❑ Bowel Leakage ❑ Sexual dysfunction

15. Does your pain cause you to feel any of these symptoms? ❑Depressed ❑ Anxious ❑ Angry

16. Please mark the area(s) of injury or discomfort as shown in the example below.

16. Please mark the area(s) of injury or discomfort as shown in the example below.



MEDICAL HISTORY

High Blood Pressure ❑ Yes ❑ No

Chest Pain/Angina ❑ Yes ❑ No

Headaches ❑ Yes ❑ No

Heart Attacks ❑ Yes ❑ No

Osteoporosis ❑ Yes ❑ No

Arthritis ❑ Yes ❑ No

Bleeding Disorder ❑ Yes ❑ No

Thyroid Problems ❑ Yes ❑ No

Diabetes ❑ Yes ❑ No

Liver Problems ❑ Yes ❑ No

Night Pain ❑ Yes ❑ No

High Cholesterol ❑ Yes ❑ No

Kidney Problems ❑ Yes ❑ No

Stroke ❑ Yes ❑ No

Convulsions/Epilepsy ❑ Yes ❑ No

HIV/AIDs ❑ Yes ❑ No

Loss of Weight ❑ Yes ❑ No

Fever ❑ Yes ❑ No

History of Cancer in Patient ❑ Yes ❑ No _____

Problems with bladder or bowel control❑ Yes ❑ No _____

Any other medical conditions?

_____

ACTIVITIES OF DAILY LIVING

Do you smoke? ❑ Yes ❑ No Do you drink? ❑ Yes ❑ No Drugs? ❑ Yes ❑ No

Any difficulty concentrating? ❑ Yes ❑ No

Any difficulty walking up and down stairs? ❑ Yes ❑ No

Any difficulty changing clothes or bathing? ❑ Yes ❑ No

Do you have any difficulty doing errands alone? ❑ Yes ❑ No

Pain Management Procedures:

Steroid Injections/Branch Blocks/RFA? ❑Yes ❑ No If so, when?

_____

Physical Therapy? ❑ Yes ❑ No If yes, when was last time?

_____

Medications Tried for pain? _____

_____

MRI/XR/CT? ❑Yes ❑ No If yes, where?

_____

MEDICATIONS

Current Medications: (if there is not enough space, please continue on back of the paper)

Name of Medication	**Dosage**	**Frequency**

Previous Surgeries: ❑ Yes ❑ No

Type of Surgery/Dates:

_____

PLEASE LIST ALLERGIES: (include reactions)

Family History

Please check any of the following symptoms/diseases your family has experienced and/or are currently experiencing

❑ Heart Attack ❑ Heart Failure ❑ Thyroid Disease/Goiter ❑ Diabetes ❑ Hepatitis ❑ High Blood Pressure ❑ Stroke/TIA ❑ Cancer

I understand that the information I have given today is correct to the best of my knowledge. I also

understand this information will be held in the strictest confidence and it is my responsibility to inform

this office of any changes in the information stated above (Address, Phone, Insurance, Medication,

Allergy, and etc.)

Patient's Signature:

_____

Date:

_____

Review of Systems Checklist

Please put a check mark by any symptoms that you have had recently. Please check "none" if you have not noticed any of the symptoms listed in that category.

Cardiovascular:

- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Swelling of the feet
- ❑ Racing pulse
- ❑ Irregular heart beat
- ❑ Is your blood pressure under control?
  - o Yes
  - o No
  - o Unsure
- ❑ None

Constitutional:

- ❑ Fever
- ❑ Weight loss
- ❑ Fatigue
- ❑ Loss of appetite
- ❑ Chills
- ❑ Night sweats
- ❑ Poor appetite
- ❑ None

Endocrine:

- ❑ Excess thirst
- ❑ Excessive urination
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Hair loss
- ❑ Dry skin
- ❑ Is your blood sugar under control?
  - o Yes
  - o No
  - o Unsure
- ❑ None

Gastrointestinal:

- ❑ Abdominal pain
- ❑ Nausea
- ❑ Diarrhea
- ❑ Bloody stools
- ❑ Stomach ulcers
- ❑ Constipation
- ❑ Trouble swallowing
- ❑ Jaundice/yellow skin
- ❑ None

Genitourinary:

- ❑ Genital sores or ulcers
- ❑ Kidney failures/problems
- ❑ Kidney stones
- ❑ Painful/difficult urination (prostatitis)
- ❑ Testicular pain
- ❑ Urinary discharge
- ❑ None

Hematology/oncology:

- ❑ Easy bruising
- ❑ Prolonged bleeding
- ❑ None

HENT:

- ❑ Hearing loss
- ❑ Sore throat
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Jaw claudication (pain in jaw when chewing)
- ❑ Ear ache
- ❑ None

Integumentary (Skin):

- ❑ Rash
- ❑ Change in mole
- ❑ Skin sores
- ❑ Skin cancer
- ❑ Severe itching
- ❑ Loss of hair
- ❑ None

Musculoskeletal:

- ❑ Muscle aches
- ❑ Joint pain
- ❑ Difficulty lying flat due to muscle pain
- ❑ Back pain
- ❑ None

Neurologic:

- ❑ Weakness
- ❑ Headaches
- ❑ Scalp tenderness
- ❑ Dizziness
- ❑ Paralysis of extremities
- ❑ Tremor
- ❑ Stroke
- ❑ Numbness or tingling
- ❑ Seizures or convulsions
- ❑ Fainting
- ❑ None

Respiratory:

- ❑ Wheezing
- ❑ Cough
- ❑ Coughing up blood
- ❑ Severe or frequent colds
- ❑ Difficulty breathing
- ❑ None

Name: _____ Date: _____

The Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back ore leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply to you, but please just mark the box that most closely describes your present-day situation.

Section 1: Pain Intensity

- ❑ I have no pain at the moment
- ❑ The pain is very mild at the moment
- ❑ The pain is moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Section 2: Personal Care (e.g. washing, dressing)

- ❑ I can look after myself normally without causing extra pain
- ❑ I can look after myself normally but it causes extra pain
- ❑ It is painful to look after myself and I am slow and careful
- ❑ I need some help but can manage most of my personal care
- ❑ I need help every day in most aspects of self-care
- ❑ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights but it gives me extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ❑ I can only lift very light weights
- ❑ I cannot lift or carry anything

Section 4: Walking

- ❑ Pain does not prevent me from walking any distance
- ❑ Pain prevents me from walking more than 2 kilometers
- ❑ Pain prevents me from walking more than 1 kilometer
- ❑ Pain prevents me from walking more than 500 meters
- ❑ I can only walk using a stick or crutches
- ❑ I am in bed most of the time

Section 5: Sitting

- ❑ I can sit in any chair as long as I like
- ❑ I can only sit in my favorite chair as long as I like
- ❑ Pain prevents me sitting more than one hour
- ❑ Pain prevents me sitting more than 30 minutes
- ❑ Pain prevents me sitting more than 10 minutes
- ❑ Pain prevents me from sitting at all

Section 6: Standing

- ❑ I can stand as long as I want without extra pain
- ❑ I can stand as long as I want but it gives me extra pain
- ❑ Pain prevents me from standing for more than 1 hour
- ❑ Pain prevents me from standing for more than 30 minutes
- ❑ Pain prevents me from standing for more than 10 minutes
- ❑ Pain prevents me from standing at all

Section 7: Sleeping

- ❑ My sleep is never disturbed by pain
- ❑ My sleep is occasionally disturbed by pain
- ❑ Because of pain I have less than 6 hours of sleep
- ❑ Because of pain I have less than 4 hours of sleep
- ❑ Because of pain I have less than 2 hours of sleep
- ❑ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ❑ My sex life is normal and causes no extra pain
- ❑ My sex life is normal but causes some extra pain
- ❑ My sex life is nearly normal but is very painful
- ❑ My sex life is severely restricted by pain
- ❑ My sex life is nearly absent because of pain
- ❑ Pain prevents any sex life at all

Section 9: Social Life

- ❑ My social life is normal and gives me no extra pain
- ❑ My social life is normal but increases the degree of pain
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ❑ Pain has restricted my social life and I do not go out as often
- ❑ Pain has restricted my social life to my home
- ❑ I have no social life because of pain

Section 10: Traveling

- ❑ I can travel anywhere without pain
- ❑ I can travel anywhere but it gives me extra pain
- ❑ Pain is bad but I manage journeys over two hours
- ❑ Pain restricts me to journeys of less than one hour
- ❑ Pain restricts me to short necessary journeys under 30 minutes
- ❑ Pain prevents me from traveling except to receive treatment

SOAPP Version 1.0-14Q

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	0	1	2	3	4
2.	How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4.	How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5.	How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6.	How often have you attended an AA or NA meeting?	0	1	2	3	4
7.	How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
8.	How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9.	How often have your medications been lost or stolen?	0	1	2	3	4
10.	How often have others expressed concern over Your use of medication?	0	1	2	3	4
11.	How often have you felt a craving for a medication?	0	1	2	3	4

SOAPP Version 1.0-14Q

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Patient Health Questionnaire – 9
(PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems? (Check mark to indicate your answer).	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: 0 + _____ + _____ + _____

= Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all ❑	Somewhat difficult ❑	Very difficult ❑	Extremely difficult ❑

HIPAA Authorization for the Release of Medical Records

Date: _____

The Patient. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____

DOB: _____

Social Security Number: _____

Authorization. I authorize the below office:

Office Name: _____

Address: _____

Phone: _____

Fax: _____

To disclose the following medical records (check one):

___ All of my medical-related information

___ My medical information ONLY related to: _____

___ My medical-related information from _____, 20___ to _____, 20___

Disclosure. The above office has my authorization to disclose medical records to the following office:

Name: Greater Atlanta Pain and Spine

Address: 3840 Peachtree Industrial Blvd. Ste 225 Duluth, GA 30096

Phone: 678-730-9202

Fax: 855-592-2998

Acknowledgement of Rights. I understand that I have the right to revoke this authorization, in writing and at any time except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance. I understand that it is possible that medical records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards. I will receive a copy of this authorization upon request and understand a copy is as valid as the original.

Signature: _____ Printed Name: _____

Date: _____

NO SHOW/LATE CANCELLATION POLICY

Our office is committed to providing timely and efficient medical care to all our patients.

No-show appointments disrupt the flow of the office, hinder other patients from accessing medical care and are considered disrespectful to our staff. While we understand unforeseen circumstances may arise, we have implemented the following policy:

• No Show Fees:

• A $30 no-show fee will be assessed for missed office visits.

• A $150 no-show fee will be assessed for missed procedure appointments

or if not provided with a 24-hour notice to cancel or reschedule.

• Cancellation/Rescheduling Notice:

• We require a 24-hour advance notice for cancellations or rescheduling of

appointments.

• Fee Collection:

• No-show fees will be collected before scheduling any future appointments.

• Dismissal from Practice:

• Multiple no-show instances may be grounds for dismissal from the

Practice.

By signing below, you attest that:

• This policy has been explained to you.

• You have read and understand your personal responsibilities.

• You have had adequate time to review the policy.

• Any questions pertaining to the policy have been answered.

• You have been provided with a copy of this form.

The original will be filed in your medical record.

Patient's Signature: _____ Date: _____