Zvezdomir P. Zamfirov, MD
Janet Ascione, NP-C
Patrick Comegys, PA

ALL STAR
Pain Management & Regenerative Medicine

Pain Management
Musculoskeletal Sports Medicine
Regenerative Medicine

# Patient Registration

Patient Full Name:_____ DOB:_____

SS#:_____ Sex: ☐ male ☐ female Email:_____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Address:_____
Street City/State/Zip

Emergency Contact:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

Previous Pain Management:_____ Phone:_____

**PREFERRED PHARMACY:** All Star Pain Management and Regenerative Medicine e-prescribes non-narcotic medication as mandated by federal laws. In order to comply, we need accurate pharmacy information. All controlled substances must be obtained at the same pharmacy, where possible. Should you need to change pharmacies, our office must be informed ahead of time. Please provide your pharmacy information where you expect to fill any prescription written by the practitioners at All Star Pain Management and Regenerative Medicine.

Preferred Pharmacy:_____ Phone:_____

Address:_____ City/State:_____

Mail Order Pharmacy (if applicable):_____

**PRIMARY INSURANCE COMPANY:** _____ Member ID #: _____

Group #: _____ Employer Name: _____

Subscriber: ☐self ☐ other: Name _____ DOB: _____ Relationship:_____

**SECONDARY INSURANCE COMPANY:** _____ Member ID #: _____

Group #: _____ Employer Name: _____

Subscriber: ☐self ☐ other: Name _____ DOB: _____ Relationship:_____

**WORKERS COMP/AUTO ACCIDENT COMPANY:** _____ Claim #: _____

Claim and Billing Address:_____

Date of Injury: _____ Body Part Injured and covered by claim: _____

Employer Name: _____ Adjuster Name and Phone: _____

*The given information is true to the best of my knowledge. I authorize my insurance benefits above to be paid directly to All Star Pain Management and Regenerative Medicine for services rendered by the physician in this practice. MEDICARE ONLY: I request that payment of authorized Medigap benefits be made on my behalf to All Star Pain Management and Regenerative Medicine for any services furnished to me by the physicians in this practice. I authorize any holder of medical information about me to my Medigap insurer that is needed to determine benefits and benefits payable to relatable services.*

SIGNATURE: _____ DATE: _____

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# Policies

## Cancellation and No Show Policy:

I understand I will be responsible for cancellation and no show fees. Fees must be paid in FULL before the patient's next appointment and are patient's sole responsibility. If you do not cancel 24 hours prior to your office visit or do not show without notice, you will be subject to a $30.00 fee. If you do not cancel 24 hours prior to your scheduled injection or do not show without notice you will be subject to a $100.00 fee.

## Communication Policy:

I give All Star Pain Management and Regenerative Medicine and their authorized representative to communicate with me by mail, email and text message with respect to confirming appointments, medical claims submitted to my insurance company as well as any balances not covered by insurance, coinsurance, deductibles or any other balance deemed patient responsibility. I understand that I have the option to receive any communication on paper or non-electronic form. I understand that my consent is continuous. However, I further understand that I may terminate my consent to email communication at any time.

Please check the following methods of communication that ARE acceptable: ☐ text ☐ email

## Scribe Policy:

I understand and agree to All Star Pain Management and Regenerative Medicine's use of a scribe during my appointments. A scribe is a HIPAA-compliant trained staff member who transcribes pertinent patient information as directed by the provider into our electronic medical record system.

## Protected Health Information/Notice of Privacy Practices Policy:

I authorize All Star Pain Management and Regenerative Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. I authorize this practice to obtain my medical information from other physicians and pharmacists for my continued care and treatment. I agree that this practice may request and use my prescription medication from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I may revoke my consent in writing to the extent the practice has already made disclosures in the reliance upon my prior consent.

WE CANNOT DISCUSS YOUR PROTECTED HEALTH INFORMATION (PHI) WITH ANYONE OTHER THAN YOURSELF UNLESS YOU AUTHORIZE US TO DO SO. Please list name(s) and phone number(s) below of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

I am aware that I can request a copy of All Star Pain Management and Regenerative Medicine's Notice of Privacy Practices at any time, which states how we may use and/or disclose your health information.

## Consent for Assignment of Benefits Policy:

I authorize this practice to apply for benefits from my primary insurance carrier and my secondary insurance carrier, if applicable, and further authorize payment directly to All Star Pain Management and Regenerative Medicine for services rendered by the physician in this practice. Medicare Only: I request that payment of authorized Medigap benefits be made on my behalf to All Star Pain Management and Regenerative Medicine for any services furnished to me by physicians. I authorize the release of medical information required by my insurance carrier (or, in the case of Medicare Part B Benefits, to the Social Security Administration and the Health Care Financing Administration) or its designated review agent, or (if applicable) my employer's worker's compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of this practice. This authorization may be revoked at any time in writing.

I hereby assume financial responsibility for and agree to make payment in full to this practice for any and all charges for services or medical supplies received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Payment is to be made within 30 days as statements are presented with settlement in full, or payment arrangements to be made with the Billing Office. I certify that the financial information given is true, accurate, and complete to the best of my knowledge, and further authorize, All Star Pain Management and Regenerative Medicine to investigate any and all financial information given concerning this or related claims. I further understand that this practice reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys and that I am responsible for any fees and/or court costs incurred by this practice during the collections process.

I also agree to notify the practice of any changes in my billing address or telephone and/or my health insurance carrier information as they occur. This entire authorization is valid for all episodes of care rendered by all and any providers associated with the practice. I permit a copy of this authorization and agreement to be used in place of the original.

I agree to all of the above policies.

SIGNATURE: _____ DATE: _____

PRINTED NAME:_____ DOB:_____

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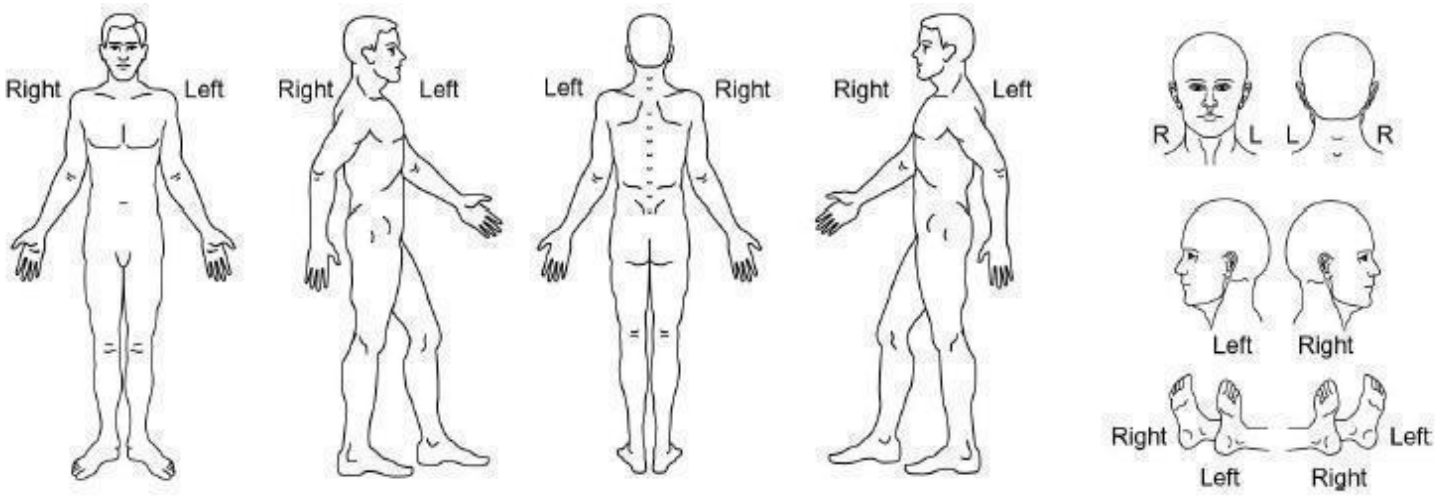
# NEW PATIENT HEALTH HISTORY

**Patient Name:**_____ **DOB:**_____

## PAIN HISTORY

Chief Complaint (reason for your visit): _____

**Use the following diagram to indicate the area of your pain. Mark the location with an "X"**




Check all of the following that describes your pain:

☐ Aching ☐ Cramping ☐ Dull ☐ Hot/Burning ☐ Numbness ☐ Throbbing
☐ Pins & Needles ☐ Pressure/Tightness ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Currently: _____ the worst it gets: _____ the best it gets: _____

## ONSET OF SYMPTOMS and DESCRIPTION OF PAIN

Approximately when did this pain begin? _____

What caused your current pain episode? _____
*Examples: motor accident, due to fall, exercise, prolong sitting, etc.*

**Pain Began:** ☐ Gradually ☐ Suddenly **Frequency:** ☐ Constant ☐ Intermitting ☐ Infrequent ☐ Rare ☐ Seldom

**Check all of the associated symptoms:**

☐ Muscle cramps ☐ Frustration ☐ Need for sleeping pills to sleep ☐ Recent fever chills or sweats ☐ Depression
☐ Tingling ☐ Unable to fall asleep ☐ Restriction of activities ☐ Numbness ☐ Non-restful sleep
☐ Involuntary loss of bowel/bladder ☐ Difficulty staying asleep ☐ Increased pain with coughing/sneezing

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**WORSENING FACTORS** – Please check factors that increase your pain:

☐ Changing Positions ☐ Bending ☐ Standing Straight Up ☐ Lifting ☐ Prolonged Standing ☐ Sneezing

☐ Turning to the Right ☐ Coughing ☐ Prolonged Sitting ☐ Movement ☐ Turning to the Left ☐ Lying Flat

☐ Increased Activity ☐ Standing Straight Up ☐ Turning Side to Side ☐ Going Up/Down Stairs

**RELIEVING FACTOR** – Please check factors that relieve your pain:

☐ Assistive Devices ☐ Lying Flat ☐ Cold/Ice ☐ Changing Positions ☐ Exercise ☐ Heat

☐ Physical Therapy ☐ Massage ☐ Rest ☐ Manipulation ☐ Injections ☐ Sitting

☐ Walking ☐ Standing Other:_____

**SURGICAL HISTORY** – Please list all your past surgeries

Surgery: _____ Date: _____ Doctor/Hospital: _____

Surgery: _____ Date: _____ Doctor/Hospital: _____

Surgery: _____ Date: _____ Doctor/Hospital: _____

**PRIOR TREATMENTS** – Let us know if you have had any previous treatments related to pain and if they were effective:

| PROCEDURE | WHEN/WHERE | | Effective? |
|---|---|---|---|
| Trigger Point injection | _____ | YES | NO |
| Epidural Steroids | _____ | YES | NO |
| Nerve Blocks | _____ | YES | NO |
| Facet Blocks | _____ | YES | NO |
| Sacroiliac Joint Injection | _____ | YES | NO |
| Spinal Cord Stimulator | _____ | YES | NO |
| Physical Therapy | _____ | YES | NO |
| Aqua therapy | _____ | YES | NO |
| Chiropractor | _____ | YES | NO |
| TENS | _____ | YES | NO |
| DME: | _____ | YES | NO |
| Steroid: | _____ | YES | NO |
| Other | _____ | YES | NO |
| Other: | | YES | NO |

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**MEDICATION ALLERGIES:** Do you have any drug/medication allergies? ☐Yes ☐No

If so, please list all medications you are allergic to:

| | Medication Name | Allergic Reaction |
|---|---|---|
| 1. | _____ | |
| 2. | _____ | |
| 3. | _____ | |
| 4. | _____ | |
| 5. | _____ | |

**Topical Allergies:** ☐ Latex ☐ Iodine ☐ Adhesives ☐ IV Contrast

**BLOOD THINNERS, ASPIRIN OR ANTI-INFLAMMATORY MEDICATIONS** – Please list any medications that are considered blood thinners or anti-inflammatory medications, including Aspirin below. Please include the prescribing physician's information.

| Medication Name | Dose | Prescribing Physician's Name and Phone Number |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**SOCIAL HISTORY**

Does your pain stop you from the things you enjoy (Y/N)? _____
Do you smoke (Y/N): _____ if so, how many cigarettes a day do you smoke? _____
Do you drink alcohol (Y/N): _____ if so, how often? Daily, Weekly, Socially? _____

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**PERSONAL AND FAMILY MEDICAL HISTORY:** Please check the boxes if you or the following family members have or are currently suffering from the following conditions

| | PERSONAL | MOTHER | FATHER | SISTER | BROTHER |
|---|---|---|---|---|---|
| ALCOHOLISM | | | | | |
| ANEMIA | | | | | |
| ANXIETY | | | | | |
| ARTHRITIS | | | | | |
| ASTHMA | | | | | |
| BLEEDING DISORDER | | | | | |
| BREAST LUMP | | | | | |
| CANCER | | | | | |
| CATARACTS | | | | | |
| COPD | | | | | |
| CIGARETTE ADDICTION | | | | | |
| DEPRESSION | | | | | |
| DIABETES | | | | | |
| DRUG DEPENDENCE | | | | | |
| DVT/PE | | | | | |
| EPILEPSY | | | | | |
| FIBROMYALGIA | | | | | |
| GERD | | | | | |
| GLAUCOMA | | | | | |
| GOUT | | | | | |
| HEART DISEASE | | | | | |
| HEART ATTACK | | | | | |
| HEPATITIS | | | | | |
| HIGH BLOOD PRESSURE | | | | | |
| HIGH CHOLESTEROL | | | | | |
| HIV/AIDS | | | | | |
| KIDNEY DISEASE | | | | | |
| KIDNEY STONES | | | | | |
| LIVER DISEASE | | | | | |
| MIGRAINE HEADACHES | | | | | |
| MONONUCLEOSIS | | | | | |
| OSTEOPENIA | | | | | |
| OSTEOPOROSIS | | | | | |
| PACEMAKER | | | | | |
| PNEUMONIA | | | | | |
| POLIO | | | | | |
| PROSTATE PROBLEMS | | | | | |
| PSYCHIATRIC | | | | | |
| STROKE | | | | | |
| SUICIDE ATTEMPT | | | | | |
| THYROID | | | | | |
| TREMORS | | | | | |
| TUBERCULOSIS | | | | | |
| ULCERS | | | | | |

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**MEDICATION HISTORY** – Please select any medication you have tried in the past; including dates and discontinue reasons:

| MEDICATION | DATE | DISCONTINUED (WHY) OR CURRENTLY TAKING |
|---|---|---|
| Abilify | | |
| Amitiza | | |
| Amitriptyline | | |
| Baclofen | | |
| Citalopram (Celexa) | | |
| Clonazepam (Klonopin) | | |
| Celecoxib (Celebrex) | | |
| Carisoprodol (Soma) | | |
| Codeine | | |
| Cyclobenzaprine (Amrix, Flexeril) | | |
| Cymbalta | | |
| Depakote/depakote ER | | |
| Desipramine | | |
| Diazepam (Valium) | | |
| Duloxetine (Cymbalta) | | |
| Escitalopram (Lexapro) | | |
| Fentanyl/actiq | | |
| Fiorcet (Butalbital) | | |
| Fiorianol (butalbital) | | |
| Fluoxetine (Prozac) | | |
| Hydrocodone | | |
| Hydromorphone (Dilaudid, Exalgo) IR | | |
| Lorazepam (Ativan) | | |
| Lyrica | | |
| Morphine Sulfate ER (MS Contin, Kadian, Arymo) | | |
| Morphine Sulfate IR (Embeda) | | |
| Naldemedine (Symproic) | | |
| Naloxegol (Movantik) | | |
| Neurontin/gabapentin | | |
| Nortriptyline | | |
| Osmotic Laxative (OTC) | | |
| Oxymorphone (Opana) ER | | |
| Oxycodone | | |
| Oxycodone ER (Oxycontin; Xtampza) | | |
| Oxymorphone (Opana) IR | | |
| Paroxetine ( Paxil, Prexeva) | | |
| Pristiq | | |
| Protriptyline | | |
| Setraline (Zoloft) | | |
| Stimluant Laxative (OTC) | | |
| Sumatriptan (Imrex, Sumavel, Treximat) | | |
| Trazadone | | |
| Tramadol ER (Ultram ER, Conzip) | | |
| Tramdol (Ultracet, Ultram) | | |
| Vanlafaxine (Effexor) | | |
| Other: | | |
| Other: | | |