PATIENT NAME: ______________________________
DATE OF BIRTH: ______________________________

Dear: ______________________________________

Thank you for choosing All Star Pain Management and Regenerative Medicine for your medical needs.

Your appointment is scheduled for: ___________________Please arrive at _______________________

Appointment time is: ______________________________

Appt. is with: ____________________________________ At **Glen Burnie** **Annapolis**

In preparation for your visit, **please arrive 15 minutes prior to your appointment time.**

All NEW patients must complete a Health History. Please go to our website at www.allstarpainmanagement.com **to print and complete forms to bring to your appointment**. In the event that you do not arrive 30 minutes prior to your appointment to complete the medical intake and check-in process, you may be asked to reschedule your appointment.

Due to unforeseen emergencies, our physicians may be called for emergencies and your appointment may be rescheduled.

- **A registration packet is attached.** Please complete all pages front and back and bring with you to the visit.
- **Please bring any current radiological images and written radiology reports of MRI's, CT Scans, and/or X-rays.**
- Your Insurance card and picture ID (driver's license / or State ID)
- A referral, if your insurance company requires one.
- If your visit is related to a work or auto accident, you must provide us with the name of the workers comp or auto insurance carrier, address to send claim to, claim #, date of injury, name and telephone # of the claims adjuster, the approved diagnosis, and the name and number of an attorney if you have one. You will be asked to sign a lien that protects our financial rights related to providing care.
- Any relevant medical notes (such as pain management notes or operative reports) from previous physicians/ therapists that would help our physicians understand your history.
- Many patients find it helpful to write out their questions ahead of time so they can be comfortable that the physician has answered all of their questions.

OFFICE LOCATIONS

Crain Towers	Conte Building
1600 Crain Highway South	166 Defense Highway
Suite 206	Suite 300
Glen Burnie, MD, 21061	Annapolis, MD, 21401

DIRECTIONS ON FOLLOWING PAGE

PATIENT NAME: ________________________________
DATE OF BIRTH: ________________________________

Directions

Annapolis Office:

From Eastern Shore: Take 50 West over the bay bridge towards Annapolis. Take exit 23B onto MD-450 toward Crownsville. Turn left onto West Street. Turn left onto Defense Highway. The destination is on your right.

From Washington DC: Take I-95 N, merge onto DC-295 N. Take the exit to merge onto US-50 E toward Annapolis. Continue onto John Hanson Highway E. Take exit 23 onto MD-450 toward MD-178, Parole, and keep right toward Crownsville. Turn left onto Defense Highway, and the destination is on your right.

From Baltimore: Take I-95 S. Take exit 49A to merge onto I-695 E toward Glen Burnie, Annapolis. Take exit 4 to merge onto I-97 S toward Annapolis, Bay Bridge. Take exit 23 onto MD-450 toward MD-178, Parole, and keep right toward Crownsville. Turn left onto Defense Highway, and the destination is on your right

Glen Burnie Office:

From Eastern Shore: Take 50 West over the Bay Bridge towards Annapolis. Take exit 21 to merge onto I-97 toward Baltimore. Take exit 12 toward MD-3 Bus, Glen Burnie. Turn Right onto Crain Highway S. Make a U-turn at Oak Manor Drive. The destination is on your right, located in the Crain Towers Building.

From Washington DC: Take I-95 N, merge onto DC-295 N. Take the exit to merge onto US-50 E toward Annapolis. Take exit 21 to merge onto I-97 N toward Baltimore. Take exit 12 toward MD-3 Bus, Glen Burnie. Turn right onto Crain Highway S. Make a U-turn at Oak Manor Drive. The destination is on your right, located in the Crain Towers Building.

From Annapolis: Merge onto US-50 W toward Washington, I-97. Take exit 21 to merge onto I-97 toward Baltimore. Take exit 12 toward MD-3 Bus, Glen Burnie. Turn right onto Crain Highway S. Make a U-turn at Oak Manor Drive, the destination is on your right, located in the Crain Towers Building.

ATTENTION PATIENTS

Prescriptions

All Star Pain Management and Regenerative Medicine's office hours are **Monday-Friday 8:00 am to 4:00 pm.**
For all your medical questions (including medication refill requests) or make your request via the patient portal @ www.allstarpainmanagement.com
Please make every effort to place your call within this timeframe.

If you have a medical emergency, please call 911.

Please note- to ensure the safety of our patients and providers:

NO new prescriptions or prescription refills will be called in during non-business hours.

PATIENT NAME: ________________________________
DATE OF BIRTH: ________________________________

NEW PATIENT REGISTRATION

Please complete your intake paperwork in its entirety and as accurately as possible. These forms help our physicians and other providers to get to know you and your medical history better.

Date: ________________________

IS VISIT RELATED TO A WORK OR AUTO ACCIDENT? ☐ NO ☐YES, it is: ☐WC related ☐Auto related

Last Name: ________________________ Middle Initial: _______ First Name: ______________________

SS#: __ __ - __ __ __ - __ __ __ __ Date of Birth: __ __ / __ __ / __ __ __ __ Sex: ☐Female ☐ Male

Home Address: ____ Apt #: ____________

City: ________________ State: ______ Zip: __________ Email Address: ___________________________

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __

Work Phone: (__ __ __) - __ __ __ - __ __ __ __

Emergency Contact: _________________________________ Phone: (__ __ __) - __ __ __ - __ __ __ __

PRIMARY CARE PHYSICIAN

Name: ____ Phone: (__ __ __) - __ __ __ - __ __ __ __

REFERRING PHYSICIAN

Name: ____ Phone: (__ __ __) - __ __ __ - __ __ __ __

PREVIOUS PAIN MANAGEMENT

Name: ____ 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.

Pharmacy Name: ______________________________________ Phone: (__ __ __) - __ __ __ - __ __ __ __

Address: __________________________________ City: _________________ State: ________ Zip: _______

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

IF YOU ARE NOT THE SUBSCRIBER PLEASE DO NOT FORGET TO ADD THE SUBSCRIBER'S INFORMATION BELOW

PRIMARY INSURANCE COMPANY NAME:	**SECONDARY INSURANCE COMPANY NAME:**
____	____
Group # __________________________________	Group # __________________________________
Policy #: ________________________________	Policy #: ________________________________
Employer Name: ___________________________	Employer Name ___________________________
Subscriber Name If Different Than Patient: ________________________________	Subscriber Name If Different Than Patient: ________________________________
Subscriber DOB: __ __ / __ __ / __ __ __ __	Subscriber DOB: __ __ / __ __ / __ __ __ __
Relationship to Patient: ______________________	Relationship to Patient: ______________________

WORKERS COMPENSATION/ AUTO ACCIDENT INFORMATION

Date of Injury/ Accident: __ __ / __ __ / __ __ __ __ Claim #: ____________________

Body Part Injured (COVERED BY CLAIM): __________________

WC Carriers Name: ____

Claim and Billing Address: ____

Employer Name (company): ____

Name of Adjuster: _________________________________ 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: _________________________

Phone: 443-808-1808 Main Fax: 443-214-5356

166 Defense Highway, Suite 300 Annapolis, MD 21401 * 1600 Crain Highway S, Suite 206 Glen Burnie, MD 21061

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

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 soled responsibility. If you do not cancel 24 hours prior to your office visit, you will be subject to a $30.00 fee. This same fee applies to any patient who does not show for appointment without any notice. If you do not cancel 24 hours prior to your scheduled injection you will be subject to a $100.00 fee. This same fee of $100.00 applies to any patient who does not show for their appointment without any notice.

COMMUNICATION POLICY

I, ______________________________, hereby voluntarily provide my email and cell phone number to All Star Pain Management and Regenerative Medicine.

I hereby give All Star Pain Management and Regenerative Medicine and all its affiliates' entities permission to leave messages and send mail regarding:

- ☐ Medical Information including laboratory test results, among others
- ☐ Appointment Reminders
- ☐ Billing Information

I agree to permit 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 follow up/procedure 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 understand further I may terminate my consent to email communication.

All Star Pain Management and Regenerative Medicine will not sell, share or rent your email address or any other personal information collected on this consent. I understand the above no show and cancellation policy regarding my appointments.

Email Address: ________________________________

Cell Phone #: ________________________________

I UNDERSTAND THE ABOVE POLICIES

____ PATIENT SIGNATURE

_______________________ DATE

ALL STAR
Pain Management & Regenerative Medicine

PATIENT NAME: ______________________________
DATE OF BIRTH: ______________________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTICE TO PATIENT: *We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.*

I, _________________________, authorize All Star Pain Management and Regenerative Medicine to use and disclose any and all findings and information in connection with my examinations, care and treatment at All Star Pain Management and Regenerative Medicine. I authorize All Star Pain Management and Regenerative Medicine to obtain my medical information from other physicians and pharmacists for my continued care and treatment. I agree that All Star Pain Management and Regenerative Medicine may request and use my prescription medication from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

By signing this form, I am consenting to allow 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 (TPO).

I may revoke my consent in writing to the extent the practice has already made disclosures in the reliance upon my prior consent.

____ ________________
Signature of Patient or Legal Guardian Date

____ ________________
Print Patient's Name Date

____ ________________
Print Name of Legal Guardian, if applicable Date

WE CANNOT DISCUSS YOUR PROTECTED HEALTH INFORMATION (PHI) WITH ANYONE OTHER THAN YOURSELF UNLESS YOU AUTHORIZE US TO DO SO. Please list name(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.

____ ____

____ ____

For office use only: *We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but could not obtain due to:*

☐ *Patient refused to sign* ☐ *Emergency Situation, unable to obtain* ☐ *Unable to communicate with patient*

Other: ____

Employee Signature: ____ *Date:* ________________________

Phone: 443-808-1808 Main Fax: 443-214-5356

166 Defense Highway, Suite 300 Annapolis, MD 21401 * 1600 Crain Highway S, Suite 206 Glen Burnie, MD 21061

PATIENT NAME: ________________________________
DATE OF BIRTH: ________________________________

CONSENT FOR ASSIGNMENT OF BENEFITS

I authorize this practice to apply for benefits from ________________________________ (primary insurance carrier) and ____________________ (secondary insurance carrier) and further authorize payment directly to ALL STAR PAIN MANAGEMENT & REGENERATIVE MEDICINE for services rendered by the physician in this practice. **If you are a self-pay individual (meaning you have no insurance), please let us know immediately so that special arrangements can be made with our office.** Medicare Only: I request that payment of authorized Medigap benefits be made on my behalf to ALL STAR PAIN MANAGEMENT & REGENERATIVE MEDICINE for any services furnished to me by physicians. In this practice, I authorize any holder of medical information about me to release to ________________________ (Medigap insurer) any information needed to determine those benefits or benefits payable for related services.

AUTHORIZE FOR RELEASE OF INFORMATION

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 either by me or by the above carrier at any time in writing.

FINANCIAL AGREEMENT

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 & 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.

Patient Name: ____________________________________ Date of Birth: ____________________________

YEAR	SIGNATURE OF PATIENT	DATE OF SIGNATURE
2017		
2018		
2019		
2020		

Phone: 443-808-1808 Main Fax: 443-214-5356

166 Defense Highway, Suite 300 Annapolis, MD 21401 * 1600 Crain Highway S, Suite 206 Glen Burnie, MD 21061

ALL STAR
Pain Management & Regenerative Medicine

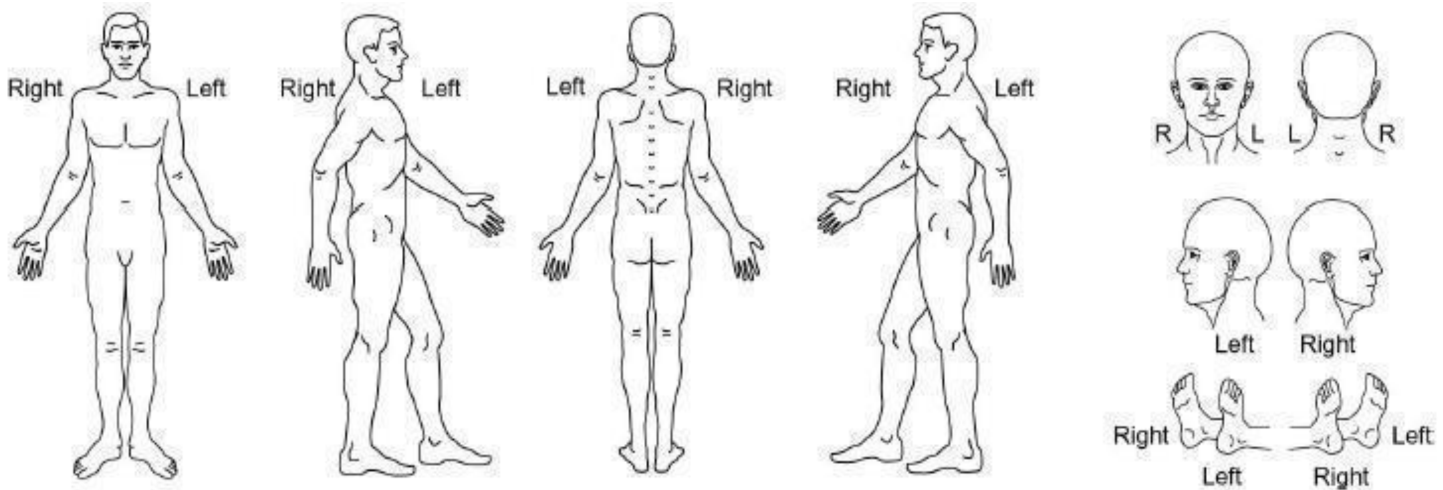
PATIENT NAME: ______________________________
DATE OF BIRTH: ______________________________

NEW PATIENT HEALTH HISTORY

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"



Circle all of the following that describes your pain:

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

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? _______________________

ALL STAR
Pain Management & Regenerative Medicine

PATIENT NAME: ______________________________
DATE OF BIRTH: ______________________________

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.

How did that pain begin? Gradually Suddenly

What is the frequency of your pain? Constant Intermitting Infrequent Rare Seldom

---

ASSOCIATED SYMPTOMS – Please circle the associated symptoms related to your pain:

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

WORSENING FACTORS – Please circle 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 circle 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: ______________________________			

PATIENT NAME: ______________________________
DATE OF BIRTH: ______________________________

SURGICAL HISTORY – Please list all your past surgeries

Surgery: ______________________ Date: _________ Doctor/Hospital: ____________________

Surgery: ______________________ Date: _________ Doctor/Hospital: ____________________

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

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

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ALL STAR
Pain Management & Regenerative Medicine

PATIENT NAME: ______________________________
DATE OF BIRTH: ______________________________

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		

PATIENT NAME: ______________________________
DATE OF BIRTH: ______________________________

MEDICATION HISTORY CONTINUED – Please name additional medications you are currently taking or have discontinued in regards to your pain that is not listed in table

MEDICATION	DATE	DISCONTINUED (WHY) OR CURRENTLY TAKING
Protriptyline		
Setraline (Zoloft)		
Stimluant Laxative (OTC)		
Sumatriptan (Imrex, Sumavel, Treximat)		
Trazadone		
Tramadol ER (Ultram ER, Conzip)		
Tramdol (Ultracet, Ultram)		
Vanlafaxine (Effexor)		
Other:		
Other:		
Other:		
Other:		
Other:		
Other:		
Other:		
Other:		

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

___________________________ __________ ____

___________________________ __________ ____

___________________________ __________ ____

___________________________ __________ ____

___________________________ __________ ____

PATIENT NAME: ___________________________________
DATE OF BIRTH: ___________________________________

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					