ALL STAR
Pain Management & Regenerative Medicine

PLEASE ARRIVE AT LEAST 15 MINUTES PRIOR TO YOUR APPOINTMENT.

PATIENT INFORMATION

General Information

Patient Name:_____ Social Security#: _____

Date of Birth:_____ Age: _____ Gender: _____

Address:_____

City:_____ State:_____ Zip: _____

Home phone#:_____ Work phone#: _____

Cell phone#:_____ Email:_____

Primary Care Physician (PCP) Information

PCP name: _____

PCP address/phone: _____

Referring Physician (PCP) Information

Referring Physician name: _____

Referring Physician address/phone: _____

Preferred Pharmacy

Pharmacy name: _____

Pharmacy address/phone: _____

Insurance

Carrier:_____ Policy#:_____

Policy Holder (if different than patient):_____ Date of Birth: _____

Insured through Employment? ☐ Yes ☐ No If so, Employer: _____

Secondary Insurance

Carrier:_____ Policy#:_____

Policy Holder (if different than patient):_____ Date of Birth: _____

Insured through Employment? ☐ Yes ☐ No If so, Employer: _____

How did you hear about us: _____

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EMERGENCY INFORMATION AND SERVICE AGREEMENTS

Emergency Contact

Name:_____Relationship: _____

Address:_____

City:_____State:_____Zip: _____

Telephone#: Home _____Cell Phone _____

PATIENT RECORD OF DISCLOSURES

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 authorize the following person(s) to have access to my medical record:
1._____

2._____

Payment is expected at the time services are rendered.

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.

Please read carefully before signing: I hereby authorize All Star Pain Management and Regenerative Medicine to release information acquired during the course of my examination and treatment to Centers for Medicare/Medicaid Services (CMS) and its agents, Medigap or any other third party carrier, as necessary, to secure payment of any benefits due. I hereby assign payment of said benefits to include Medicare and Medigap directly to All Star Pain Management and Regenerative Medicine for any medical procedures performed. I understand that I am responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Patient name: _____

Signature:_____Date: _____

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

☐ I accept

☐ I decline

Signature:_____Date: _____

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NEW PATIENT HEALTH HISTORY

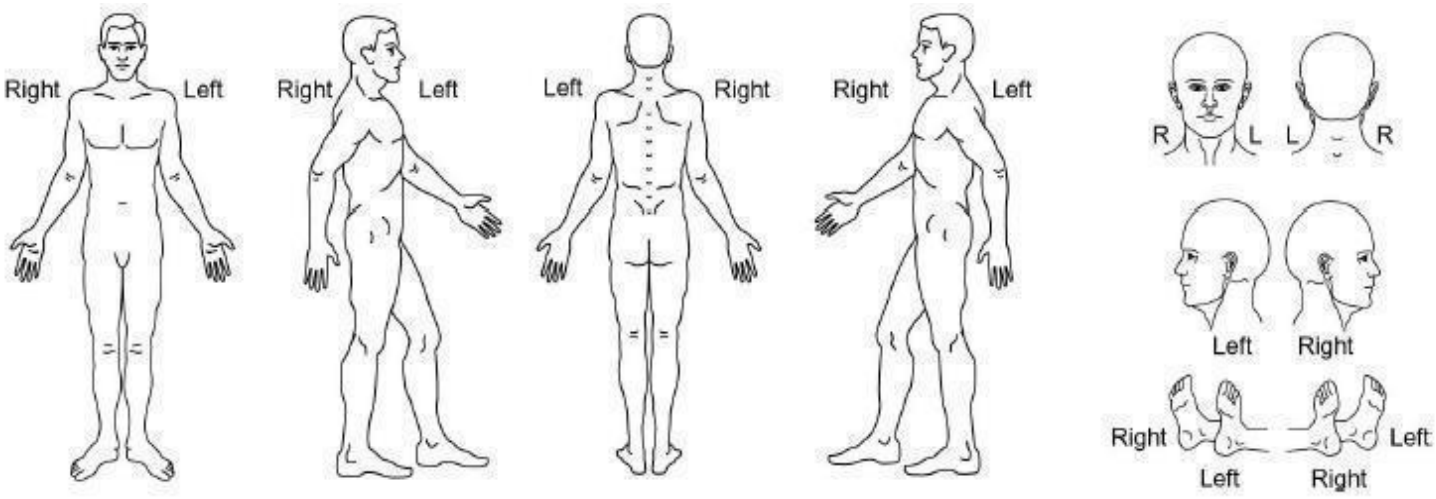
Patient Name_____DOB:_____Hand Dominance: Right Left

Chief complaint: _____

Date of onset:_____

When and how did this problem occur: _____

Use the diagram below to mark areas on the body where you feel that pain or discomfort. Mark the location with an "X".



Describe your pain? _____

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: _____

When do you experience pain? _____

What makes your pain worse? _____

What makes your pain better? _____

What daily activities does this problem affect? _____

Have you received any of the following for this problem? **(circle what you have had done)**

CT Scan MRI EMG X-Rays Injections Surgeries Physical Therapy

Please indicate where any imaging or treatments were performed:

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Review of Systems

CIRCLE any symptoms or findings below that you have experienced recently:

Constitutional: Weight Change Weakness Fatigue Fever Nausea

Eyes: Vision Problems Double Vision

ENMT: Hearing Problems Dizziness Sinus Trouble Sore Throat Ringing Ears

Cardiovascular: Shortness of Breath Chest Pain Leg Swelling Increased Blood Pressure

Respiratory: Cough Coughing Up Blood Wheezing Asthma

Gastrointestinal: Trouble Swallowing Heartburn Vomiting Diarrhea Blood or Black Tar Stools

Genitourinary: Pain with Urination Blood in Urine Urgency Incontinence

Musculoskeletal: Joint Pain/Stiffness Cramps Weakness Loss of Motion

Skin: Rash Itching Dryness Hair Changes Nail Changes

Neurological: Fainting Blackouts Seizures Paralysis Weakness Numbness Memory Loss Headaches

Psychological: Nervousness Tension Mood Changes Depression Anxiety

Endocrine: Heat or Cold Intolerance Sweating Thirst Changes with Hunger

Hematology: Bruising Bleeding Transfusion Reactions

Allergies

Allergies to medications/foods/chemicals?_____

Medications

List medications and dosages, if known, you are currently taking:_____

_____

_____

Medical Illnesses

Check those you have been diagnosed with:

☐ Diabetes ☐ Asthma ☐ High Blood Pressure ☐ Heart Attack ☐ Sleep Disorders ☐ Stomach Ulcers
☐ Cancer ☐ Heart Murmur ☐ HIV/AIDS Hepatitis ☐ Stroke ☐ Anemia ☐ Seizures ☐ Hyper/Hypo Thyroid
☐ Osteoporosis ☐ Deep Vein Thrombosis ☐ Broken Bones ☐ Bowel or Bladder Incontinence ☐ Gout
☐ Osteoarthritis or Rheumatoid Arthritis ☐ Other: _____

Injuries

Indicate broken bones, concussion, motor vehicle accidents, falls, etc: _____

_____

Surgeries

Include Surgeon and dates: _____

_____

Family History of Medical Problems

CHECK those that apply: ☐ Arthritis ☐ Back Problems ☐ Heart Problems ☐ Diabetes ☐ Cancer

☐ Other_____

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Personal and Demographic Information

Current Height:_____ Current Weight:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow

If you have children, how many?_____

Employment Type: (ex: teacher, police officer, retired, etc):_____

Employer:_____

Nature of Work:

☐ Sedentary ☐ Physical Moderate Activity ☐ Heavy Physical Activity ☐ Light Physical Activity

☐ Computer Related Work ☐ Prolonged Standing ☐ Excessive Use of Voice ☐ Highly Stressful

Social History

SOCIAL HISTORY

Does your pain stop you from the things you enjoy (Y/N)? _____

What is your smoking status? ☐ Never Used ☐ Currently Use ☐ History of Use

How many a day? _____

Do you drink alcohol (Y/N): _____ How often? Daily, Weekly, Socially? _____

Do you currently use recreational or street drugs? (Y/N) _____If yes, what kind? _____

Do you have a history of illicit drug use/abuse? (Y/N) _____If yes, what kind? _____

Do you exercise: _____ If yes, type of exercise:_____