Integrity Regional Pain Center

"Get More Out of Life with Integrity"

PLEASE PRINT

Established Patient Yearly Update

Date: _______________

____

Last Name **First Name** **Middle Initial**

_______________________________________ _________________________________

Previous Name(s): e.g. Maiden **Nick Name:**

____

Home Address: **Apt #:**

____

City **State** **Zip Code**

____

Mailing Address (if different than home, e.g. P.O. Box)

Home Phone: ________________________ **Other Phone**: _____________________________

May we leave messages regarding test results, appointments and billing questions on your answering machine?

Yes ___ No___

____

Email Address:

May we contact you by email sending messages regarding test results, appointments and billing questions?

If yes, please provide your email address: ____

Yes ___ No___

Emergency Contact Info: ____

Name/Relationship to Patient **Phone Number**

Check one:

Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Fiancé ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Single

Who may receive information regarding your Protected Health Information?

Relationship to Patient _______________Name: ____

Check one:

Employment Status: ☐ Active Duty Military ☐ Disabled ☐ Employed Full-Time ☐ Employed Part-Time
☐ Homemaker ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Student ☐ Other

____

Employer Name phone number:

____

Employer Address

Primary Care Physician: ______________________________Ph #: ____________________

Date of last visit: _______________________

Primary Insurance:

Ins. Co. Name______________________________ Effective Date:

Policy/ID #: _______________ Group #: ____________

Relation to Patient: _____________ Insured's Name: ______________________________

Insured's Date of Birth: ________________ M / F Insured's SS# ____________________

Insured's Employer: __________________________

Secondary Insurance Company:

Ins. Co. Name______________________________ Effective Date: _________________

Policy/ID #: _______________ Group #: _____________________________

Relation to Patient: _____________ Insured's Name: ______________________________

Insured's Date of Birth: ________________ M / F Insured's SS# ____________________

Insured's Employer: __________________________

Work Comp Injury: ☐ No ☐ Yes (Complete the following)

Date of Injury: __________________

Employer at Time of Injury: ____

Address: ____

City State Zip Code

Contact Person for Work Comp (not employer): ___________________ Contact Person Ph #_____________

Case Number: ____________________ Primary Diagnosis of Injury: _____________

Work Comp Attorney: _____________________________ Ph#: ____________________

Have you had any accidents? (e.g. falls, automobile, etc.) Yes _____ No _____

If yes, is the accident related to your current pain? Yes _____ No _____

If yes, please describe accident:

Type of Accident	Date Occurred	Problem/Symptoms/Pain
_________________________	____________	______________________

If yes, is there any legal proceeding pending? **Yes _____** **No _____**

(Office Staff, please inform billing office of potential pending legal proceeding immediately)

OB/GYN History:

Are you pregnant? **_____ Yes** **_____ No**

Mental Health:

Are you seeing a mental health professional? _____ Yes _____ No

Mental Health Provider Name: ____

Past Personal History:

Have you ever had any medical problems with alcoholism and/or drug abuse (including marijuana)?
Yes _____ **No _____**

If YES, did you receive in-patient or out-patient treatment? **Yes _____** **No _____**

When did you receive this treatment? ______________________________

Are you currently still receiving treatment? **Yes _____** **No _____**

If currently receiving treatment, please state name and phone number of your medical provider

____

Have you ever had any drug related legal problems including but not limited to: possession, sale, distribution; manufacturing; possession with the intent to sell or distribute any illicit drug(s) narcotics and/or controlled substance(s) (including marijuana)?
Yes _____ **No _____**

If yes, please explain:

____

____

Have you in the past pled guilty, been convicted; or pled nolo contendere to any drug related charges including but not limited to: possession, sale, distribution; manufacturing; possession with the intent to sell or distribute any illicit drug(s) narcotics and/or controlled substance(s)? **Yes ______** **No ______**

Have you been sentenced to imprisonment, probation are currently on parole for ANY city, county, state or federal offense(s)? **Yes _____** **No _____**

If yes, please explain include location(s):

____

____

Are you currently on probation or parole? **Yes _____** **No _____**

Do you have or have you in the past used any other names? (e.g.: A.K.A.; maiden; professional)?

Yes _____ **No _____**

If yes, please list: ____

Have you used any illegal drugs (including marijuana) within the past six months?

Yes _____ **No _____**

If YES, please explain:

____

Have you used any prescription drugs for which you did not have a personal prescription within the past six months?

Yes _____ **No _____**

If YES, please explain:

____

____

Are you taking any controlled substances from other Doctors?

Yes _____ **No _____** **If YES**, please list:

____

I certify that the above is true and correct to the best of my knowledge. I understand the penalty for presenting false claims or making false statements on this form will result in immediate termination from the medical group.

_______________________________________ _____________________

Signature of Patient **Date**

Integrity Regional Pain Center Insurance Addendum:

It is Integrity Regional Pain Center's policy to require our patients to have medical insurance covering services provided in our clinics. If for any reasons your insurance is not active or you longer have coverage, Integrity Regional Pain Center allows up to two (2) monthly visits without insurance. At these visits, a payment in full for an office visit will be required by cash or credit card before you will be seen. By signing below, you are aware of our insurance and cash pay policy.

_______________________________________ _____________________

Signature of Patient **Date**

Medical History
Please circle if you have any of the following:

HIGH BLOOD PRESSURE   DIABETES   COPD/ASTHMA/BRONCHITIS   HIGH CHLOSTEROL   GERD

CORONARY ARTERY DISEASE/ANGINA/HEART ATTACK   ANXIETY   DEPRESSION

ALLERGIES:

Are you allergic to any of the following, (If yes please mark the ones that apply)?

Adhesive tape _____   Iodine _____   Latex _____   Contrast Dye _____

Are you allergic to any medications? If yes, please list below and the reaction/side effect.

Medication Name:	Reaction/Side Affect
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Are you allergic to any non-medications (foods etc.)?

Non- Medication:	Reaction/Side Affect
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________