Consultants in Pain Medicine, P.A.

4680 Lockhill Selma Rd # 200
San Antonio, TX 78249

Phone (210) 546-1470 Fax (210) 546-1479

DATE:_____

Dear Mr./Mrs./Ms._____,

You have been referred to Mark Moran, M.D., with Consultants in Pain Medicine by your physician. Please complete the enclosed information regarding your pain on the patient intake form provided for you. You must bring the questionnaire completed to the office on_____, _____ at _____ a.m./p.m. at our
(*arrival time)*

_____ location.

(*see map attached*) .

If you do not arrive on time as stated above, it is at the discretion of the physician to have you reschedule your appointment or not. As we try to stay on time for all of our patients, you may have to wait longer or be seen later if you do not arrive on time.

Please be aware that you are liable for any applicable co-pays at office and facility visits. Please follow up with your insurance company to be prepared for the cost that may possibly be incurred. Please bring your insurance card to your appointment. If you do not understand the questions and require assistance arrive an hour prior to your office appointment and inform out staff that you need assistance.

We appreciate your cooperation and if you have any questions or require further assistance, please feel free to contact our office.

Thank you,

Scheduler
(210) 546-1470 ext. 3702

Consultants in Pain Medicine, P.A.

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

I, the undersigned, authorize payment of medical benefits to Consultants in Pain Medicine for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Consultants in Pain Medicine to release to my insurance company, referring physician and other consultants on my case information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date_____ Signed_____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Consultants in Pain Medicine for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Date_____ Signed_____

CERTIFICATION

Consultants in Pain Medicine, P.A. is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation. We will be happy to assist you in this process. Also, if this is a litigation case, our office needs to be informed before services are rendered.

I _____ hereby certify that I am /am not seeking treatment for an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.

MVA / Date of Incident_____ If applicable, Attorney's Name_____ Phone #_____

_____ _____

Patient Signature Date

Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Consultants in Pain Medicine, P.A.

_____ _____

Print Patient Name Date

_____

Patient Signature

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I hereby authorize Consultants in Pain Medicine, Inc., to take my photograph for inclusion in my medical chart retained by the clinic. I understand this photograph is solely for the purpose of identification and familiarization by the office staff and the clinic physician(s).

_____
Patient Signature

I hereby authorize the release of medical information to the following persons:

1._____
2._____
3._____
4._____

This entitles them to call the office and get any medical information with my permission, or have the office talk to them with my permission.

_____
(patient signature)

Information Form

DATE:_____

Name:_____ Date of Birth:_____Age:_____

Employer:_____ Occupation:_____

Do you work now? Yes No Part Time

What does your work involve?_____

Name of Doctor who referred you?_____

List of other Doctors you have seen for this pain problem:_____

Names of other Doctors you see for other medical reasons:_____

How long have you had your pain? _____

Give details of injury or circumstances causing your pain:_____

Were you injured on the job? Yes No Is there an attorney involved? Yes No How and when were you treated for this problem?_____

_____

_____

_____

Have you had surgery for this problem? Yes No

If yes, give:	Date	Hospital	Name of surgeon
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Tests performed: X-Rays MRI CT Scan EMG Bone Scan Discogram Other Tests

Where & When:_____

What is your pain status now? Worse Better Same Has it changed?_____

How?_____

_____

What other treatments have you received? (i.e., bedrest, physical, therapy, hypnosis, chiropractic manipulation, acupuncture, injections) Please list details:

Treatment:_____

Where:_____

When:_____

MEDICATIONS

Please list medications to which you are ALLERGIC, and the type of reaction to each (i.e. rash, upset stomach, etc.….): _____

Please list medications you have previously taken for pain:

MEDICATION	HELPFUL?	REASON FOR STOPPING USE

Please list medications you are CURRENTLY TAKING FOR PAIN:

MEDICATION	DOSAGE	TIMES/DAY	HELPFUL?

Please list other medications you are CURRENTLY TAKING (include vitamins, etc.): MEDICATION HELPFUL? DOCTOR

PERSONAL HISTORY:

Married? Yes No

How many children do you have?_____

Level of Education?_____

What type of work do you do?_____

Have you lost or gained weight in the last six months? Yes No

How many pounds? Lost_____lbs. Gained_____lbs.

Do you: Drink alcoholic beverages? Yes ___ No____ Smoke? Yes ___No____

Have you ever been treated for addiction to alcohol or any other substance? Yes No Do you currently take any illegal drugs or have you taken any narcotics in a non-prescribed manner? Yes No

FAMILY HISTORY (Circle all that apply TO YOUR BLOOD RELATIVES)

ASTHMA	GENETIC DISORDERS	KIDNEY PROBLEMS
ARTHRITIS	HEADACHES	LUNG PROBLEMS
CANCER	HEART PROBLEMS	SEIZURES
DIABETES	HIGH BLOOD PRESSURE	TUBERCULOSIS

Other:_____

Please circle any of the following that APPLY TO YOU

ANXIETY	CONSTIPATION	GI BLEED	HEART PROBLEM
ARTHRITIS	DEPRESSION	GLAUCOMA	TUBERCULOSIS
ASTHMA	DIABETES	HEPATITIS	LUNG PROBLEMS
CANCER	GENETIC DISORDER	HEADACHES	IMPOTENCE
SEIZURES	KIDNEY PROBLEMS	HIGH BP	STOMACH ULCER

Other:_____

PLEASE LIST ALL PREVIOUS SURGERIES:

DATE	PROCEDURE	SURGEON	HOSPITAL
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		
_____	_____		