PPMRC
Physiatric Pain & Medical Rehab Clinic, P.A.

New Patient Registration

Patient Name:			Date:
Gender: ☐M ☐F	Date of Birth:	Social Security Number:	
Street Address:			
City:		State:	Zip:
Home:	Cell:		Fax:
Email:			
Employer:			Phone:
Emergency Contact:			Phone:

Medical Information

Current Medications:	
Allergies:	
Primary Physician:	Phone:
Physician's Fax:	
Pharmacy Name:	Phone:

Insurance Information

Company Name:	Plan Number:
Group Name:	Phone:

For Office Use Only
Vitals: Height _____ Weight _____ BP_____ HR_____ Temp_____

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For Office Use Only
Initials ____ Rm. # _____

Name:_____ Today's Date: _____

Reason For Visit _____ Date Of Birth:_____

Patient Initial Assessment

➢ Where is your pain located?

Check: Circle:

☐ Low Back Left Or Right
☐ Mid Back Left Or Right
☐ Neck Left Or Right
☐ Leg Left Or Right
☐ Arm Left Or Right
☐ Other _____

➢ Any new pain? _____

_____

➢ How long have you had this pain?_____

➢ What is your pain level?

0- 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 -10

➢ When is your pain the worst?

Check all that apply:

☐ Morning ☐ Daytime
☐ Evening ☐ Night

➢ Can you describe your pain?

Check all that apply:

☐ Aching ☐ Burning
☐ Constant ☐ Intermittent
☐ Deep ☐ Dull
☐ Improving ☐ Increasing
☐ Numbness ☐ Shooting
☐ Pinching ☐ Pressure
☐ Sharp ☐ Stabbing
☐ Stiffness ☐ Tender
☐ Throbbing ☐ Tingling
☐ On and Off ☐ Localized
☐ Radiation (To:_____)

➢ What makes the pain worse?

_____

_____

➢ What makes the pain better?

_____

_____

➢ Have you experienced any side effects with your medications or therapy?

_____

_____

➢ Any concerns you would like to discuss with Dr.N?

_____

_____

➢ List current medications:

(Name, Dosage and Frequency)

_____

_____

_____

_____

_____

_____

➢ Allergies _____

_____

_____

Follow Up Visits

Any changes to your current address or phone number? ☐ Yes ☐ No (If Yes, please fill below)

Address:_____

Home Phone #: _____ Cell Phone # :_____

Any Changes to your insurance information? ☐Yes ☐ No (If Yes, please present card to front desk.)

Insurance Co.: _____ Policy # :_____

Patient Signature: _____

OFFICE USE ONLY:
Reviewed w/Patient ? ☐Yes ☐No _____

882 S. KirkmanRoad.Suite 305.Orlando, Florida. 32811 (407) 291-3077 Fax (407) 291-3122

In **GREAT** detail, please describe how your **pain** occurred:

Past History

Prior Accidents:
Prior Medical Problems :
Surgical History:

Please indicate which diagnostic tests you have had to evaluate the medical conditions you are experiencing today.

	Date		**Date**		**Date**
Regular X-Ray		C.T, Scan		MRI	
Bone Scan		Arthrogram		Sleep Study	
Myelogram		EMG/NCV		Other	

Circle the Medication that you currently take for pain

Advil	Aspirin	Skelaxin	Codeine	Robaxin	Demerol
Dilaudid	Duragesic	Valium	Toradol	Vicodin	Fioricet
Flexeril	Xanax	Klonopin	Lorcet	Lortabs	Methadone
Tylenol #3	Naprosyn	Neurontin	Norflex	Oxycodone	Oxycontin
Soma	Percocet	Ultram	Prosac	Relafen	
Others:					

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Rate your pain by circling the number that best describes your pain in the **last month**.

	NONE										BAD AS YOU CAN IMAGINE
a) Pain at its worst last month	0	1	2	3	4	5	6	7	8	9	10
b) Pain at its best last month	0	1	2	3	4	5	6	7	8	9	10
c) Pain at its average last month	0	1	2	3	4	5	6	7	8	9	10
d) Pain right now	0	1	2	3	4	5	6	7	8	9	10

What position(s) / activities make the pain **WORSE?**

☐ Sitting	☐ Standing	☐ Bending	☐ Coughing	☐ Walking
☐ Bowel Movements	☐ Other (explain):			

What position(s) / activities make the pain **BETTER?**

☐ Sitting	☐ Standing	☐ Bending	☐ Lying Down	☐ Walking
☐ Home Remedies	☐ Other (explain):			

Circle the ONE number that best describes how during the **PAST WEEK** pain has interfered with your:

	NONE										COMPLETELY
1) General Activity	0	1	2	3	4	5	6	7	8	9	10
2) Mood	0	1	2	3	4	5	6	7	8	9	10
3) Normal Work	0	1	2	3	4	5	6	7	8	9	10
4) Sleep	0	1	2	3	4	5	6	7	8	9	10
5) Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
6) Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
7) Relations with Other People	0	1	2	3	4	5	6	7	8	9	10
8) Stress / Anxiety	0	1	2	3	4	5	6	7	8	9	10

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SOCIAL HISTORY
Married ☐ Single ☐ Divorced ☐ Widowed ☐ # of Children _____
Do you smoke? _____ If yes how many packs per day? _____
Do you drink? _____ If yes How much? _____ Social Drinker_____
Illicit Drug Use? _____

FAMILY HISTORY			
Father _____			
Mother _____			
# of Brother and Sisters _____			
Place an (X) next to any of the following conditions that you have <u>now</u> or <u>have ever had.</u>			
☐ High Blood Pressure	☐ Nausea	☐ Anemia	☐ Other_____
☐ Heart Disease	☐ Vomiting	☐ Blood clotting problem/DVT	
☐ Chest Pain	☐ Abdominal Pain	☐ HIV+	
☐ Shortness of Breath	☐ Diarrhea	☐ RA/OA	
☐ Fever/Chills	☐ Fatigue	☐ Dizziness	
☐ Swelling of ankle/feet	☐ Diverticulitis	☐ Drug Addiction	
☐ Stomach/Duodenal Ulcer	☐ Kidney disease	☐ Kidney Stone	
☐ Stroke	☐ Gallbladder disease	☐ Liver Disease	
☐ Headaches/Migraines	☐ Chronic Cough	☐ Asthma	
☐ Seizures/Fainting Spells	☐ Diabetes	☐ Seasonal Allergies	
☐ Numbness/Tingling	☐ Hypoglycemia	☐ Psychiatric diagnosis	
☐ Bipolar disorder	☐ Depression	☐ Suicide Attempt	
☐ Thyroid disorder	☐ Anxiety	☐ High Cholesterol	
☐ Alcohol/substance abuse	☐ Urinary Tract Infections	☐ Excessive Hunger	
☐ Excessive Thirst	☐ Indigestion	☐ Rapid Heartbeat	
☐ Anorexia/Bulimia	☐ Cancer	☐ Glaucoma	
☐ Pacemaker	☐ Pneumonia	☐ Prostate Problems	

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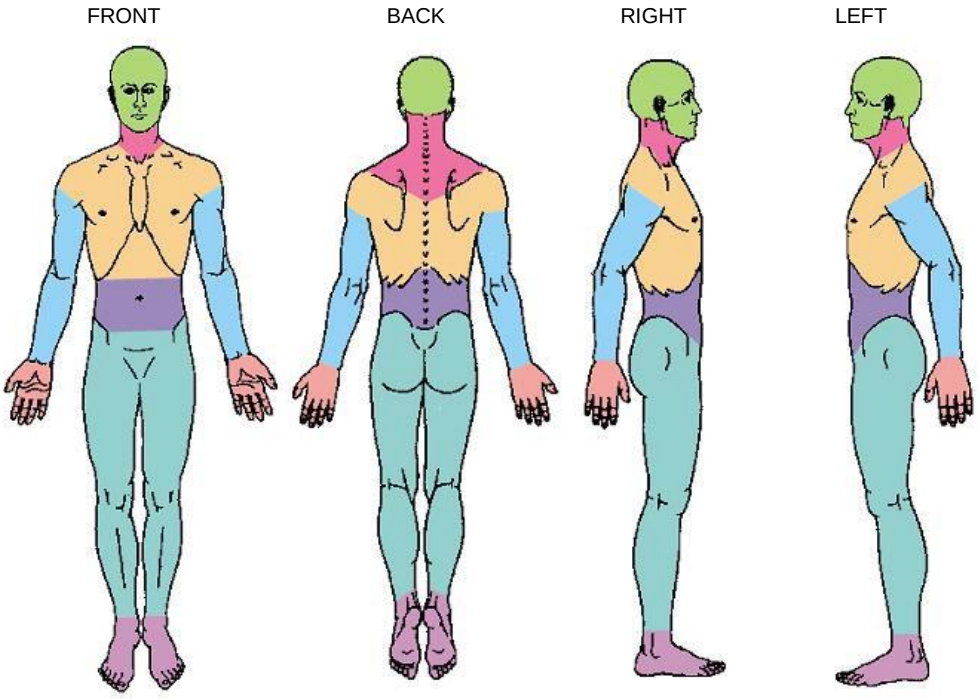
Pain Diagram

Please **circle** the area where your pain is at.



Name _____ SS# _____Today's Date _____

Height _____ Weight _____ Birth Date _____Age _____ Claim # _____

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□ Release Patients Diagnostic & Medical Records
□ Request Patients Diagnostic & Medical Records

I _____hereby authorize **Physiatric Pain & Medical Rehabilitation Clinic** to request and release all information, (including all medical reports, diagnostic reports, physical therapy notes, EMG report studies, trigger point injection records, prescriptions and patient ledgers) regarding my medical treatment and diagnosis, to the above Doctor/Attorney/ Clinic/ Hospital and/or medical facility.

- □ X-Ray
- □ MRI
- □ CT Scan
- □ Bone Scan
- □ EMG Reports
- □ Operative Notes
- □ Medical Evaluation Reports
- □ Physical Therapy Notes
- □ Trigger Point Injections
- □ Rx Prescriptions
- □ Consult Reports
- □ Laboratory
- □ All Medical Rec's

Date:____-_____-_____

Facility Name:_____

Facility Address:_____

Phone: ( )_____ **Fax**: ( ) _____

Patient Information:

Patient Name:_____
First **MI** **Last**

Address:_____
City **State** **ZipCode**

Date Of Birth:_____-_____-_____

Patient Signature:_____

The Patient's express authorization is required to release certain types of records, including alcohol and/or drug abuse treatment and information, HIV testing and treatment, and psychiatric treatment. To authorize release of this information, please read and sign the following:

I_____, authorize the release of alcohol and/or drug abuse treatment and information. Confidentiality is protected by FL Statute 397.053 and 396.112 and the Federal Alcohol and Drug Abuse Act.

I_____, authorize the release of HIV test results and/or HIV treatment information, and related conditions. Confidentiality is protected by FL Statute 381.609(2).

I_____, authorize the release of psychiatric information. Confidentiality is protected by FL Statute 394.459(g).

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PRIVACY ACKNOWLEDGE FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____**Birthdate**_____

Signature_____

Date_____

* **All New Patients must complete and sign all paperwork.**

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Assignment of Benefits

I hereby assign all rights, title, and interest from any and all automobile, health, or casualty insurance which provides medical benefits or no fault benefits to PPMRC (Assignee). I hereby authorize the insurance company to pay directly to assignee the amount of current, future bills for services rendered on my behalf and to release any requested information that is pertinent to my case to my legal representative and insurance company.

Assignment of Cause Action

In the event my insurance company fails to pay or refusing to make timely, accurate payments to the assignee (PPMRC), I authorize the assignee (PPMRC) to prosecute said cause of action in my name or the assignees (PPMRC) name and further authorize assignee (PPMRC) to compromise, settle, and resolve said action as they see fit.

Direction of Payment

I hereby authorize and direct you, my insurance company / my attorney to pay directly to PPMRC, P.A (assignee) such sums as maybe due and owning assignee (PPMRC) for service rendered on my behalf both by reason of accident or illness.

I also agree to pay in a current manner any differences between the total changes and the around paid by the insurance company directly to the assignee (PPMRC). I agree to pay any applicable deductible or copayment not covered by the insurance. In the event that I don't carry insurance coverage, I am fully responsible for payment for services rendered.

PIP Log Request

I hereby authorize the assignee (PPMRC) to request a copy of the current insurance policy, declaration page, and PIP log. I hereby authorize the assignee (PPMRC) to periodically request a copy of my PIP log as they deem necessary.

Reservation of Benefits

Please be advised that I am here by placing you on notice pursuant to Florida case law that should the insurance company / carrier deny, reduce, or fail to pay any part or an entire bill that was duly timely billed, on my behalf from PPMRC (assignee) I am requesting that you reserve, hold aside, the same amount until this dispute is resolved. Should the remaining amount of benefits approach an amount that would be deemed insufficient or an exhaustion of benefits; please notify the assignee (PPMRC) promptly.

Severability Clause

If any term of this assignment or application thereof to any person or circumstances shall be determined to be invalid or unenforceable, the remainder of this assignment shall not be affected thereby and each term and provision of assignment, lien, and authorization shall be valid and enforced to the fullest extent of the law.

Effective February 1, 2012

PPMRC does not accept Medicaid, Staywell, and Healthease, Amerigroup or any state funded insurance. All Medicare patients with the above mentioned secondary insurances you will be responsible for their 20% co-payment. If you have Medicare with a commercial secondary insurance, no co-payment will be collected at the time of your office visit; unless it is otherwise stated on your card.

Effective January 1, 2013

All copays, deductibles, and Co-insurance are due at the time of your visit. Please make sure that you have your payment at the time of your visit, or your appointment will be rescheduled.

Patients Signature: _____ Date: _____

Printed Name: _____