



**Elite Pain Management Inc.**  
**2010 E. First St., #100, Santa Ana CA 92705 - 4086**  
**PHONE : 714 556-7246**  
**FAX: 714 556-7247**

\_\_\_\_\_  
Signature of patient                      Print Name                      Date:

Patient DATE OF BIRTH: \_\_\_\_\_

I authorize \_\_\_\_\_ to release health information to:

Elite Pain Management Inc.  
2010 East First St. Suite 100  
Santa Ana, CA 92705  
Tel: 714 556-7246 Fax: 714 556-7247

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Please specify the health information you authorize to be released:

- MEDICAL
- MENTAL HEALTH  HIV  Drug/Alcohol

Date(s) of treatment: \_\_\_\_\_

The purpose of this release is for (check one or more):

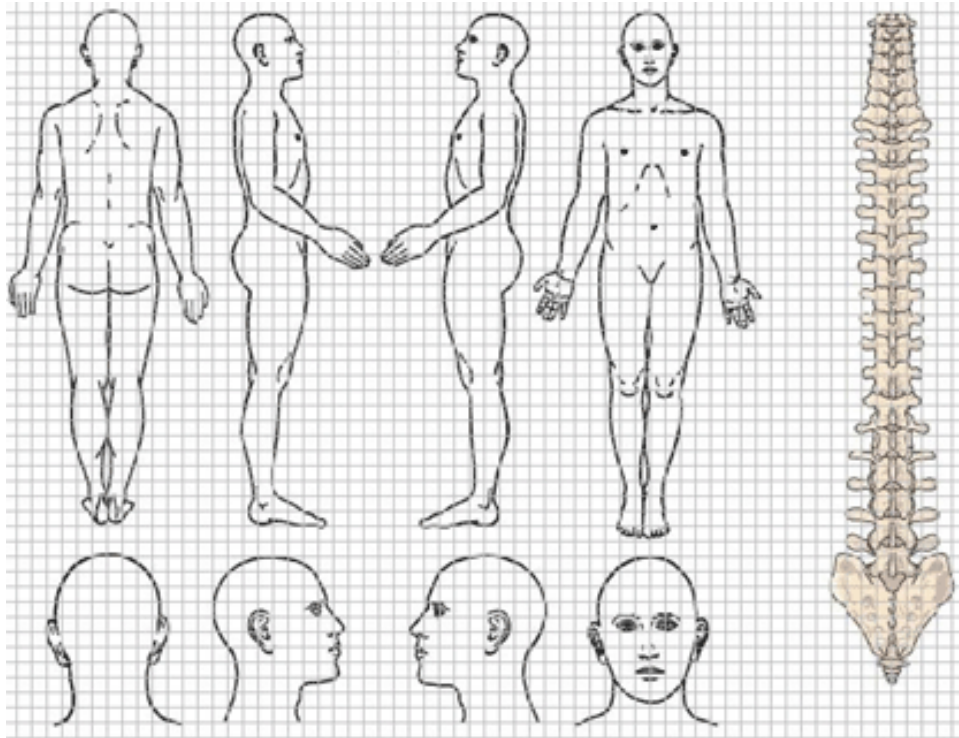
- At the request of the patient/patient representative.
- Other (state reason) \_\_\_\_\_

**Patient Information Sheet**

Email Contact:		Driver's License/ID Number	
Name (Last, First)		Home Telephone (    )	Cellular Telephone (    )
<input type="checkbox"/> Text message reminder for your appointments. <input type="checkbox"/> Voice messages on your phone.			
Address		City	State                      Zip Code
Social Security No.		Date of Birth	
Employer		Work Telephone (    )	
Employer Address		City	State                      Zip Code
Spouse Name		Work Telephone (    )	Cellular Telephone (    )
Please list any persons you authorize to have access to your appointment, billing, and protected health information: <input type="checkbox"/> Include my spouse		Relationship	Telephone

Referring Physician		Family Doctor		Other Doctor	
Primary Insurance Name	Subscriber ID	Subscriber Name	Date of Birth	Social Security Number	
Primary Insurance Name	Subscriber ID	Subscriber Name	Date of Birth	Social Security Number	

Please place an "X" on location of your pain:



Name:		Age:			
Systolic:	Diastolic:	Height:	Weight:	Heart Rate:	Resp. Rate:
Medical Problems:					
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stroke	

Do you have an Advanced Directive:  Yes  No (Please provide a copy if applicable)

List <b>ALL</b> Surgeries in the past:

**Drug Allergies** and reaction: \_\_\_\_\_

Please list all your Medications

**Social History**

Smoking status: <input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Currently everyday <input type="checkbox"/> Currently some days
Do you use alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1-5 times per week <input type="checkbox"/> Once a month <input type="checkbox"/> Once a year <input type="checkbox"/> Socially
Do you use recreational drugs <input type="checkbox"/> Yes <input type="checkbox"/> No

What is your current occupation? \_\_\_\_\_

Education: Grade School   High School   College   Post-Graduate   Vocational

Marital Status: Single   Married   Divorced   Separated   Widowed

**Family History**

Age    Health Problem

Mother     Living     Deceased

Father     Living     Deceased

Brother(s)  Living     Deceased

Sister(s)     Living     Deceased


**HPI:** What is the reason you are coming to see the doctor?

\_\_\_\_\_

\_\_\_\_\_

How long have you had the pain? \_\_\_\_\_

When did it start? \_\_\_\_\_

What were you doing when the pain started? \_\_\_\_\_

How long does the pain last?     Constant     Intermittent

Does the pain occur at specific times?     Yes     No

If Yes, describe when:

Please check all that apply with your pain:

<input type="checkbox"/> Aching	<input type="checkbox"/> Burning (Hot)	<input type="checkbox"/> Cramping	<input type="checkbox"/> Fearful	<input type="checkbox"/> Heavy
<input type="checkbox"/> Gnawing	<input type="checkbox"/> Punishing (Cruel)	<input type="checkbox"/> Sharp	<input type="checkbox"/> Shooting	<input type="checkbox"/> Sickening
<input type="checkbox"/> Splitting	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Tender	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Tiring (Exhausting)

Describe your pain at its **WORST** 0 1 2 3 4 5 6 7 8 9 10 (Most)

Describe your pain at its **BEST** 0 1 2 3 4 5 6 7 8 9 10

Describe your pain at its **AVERAGE** 0 1 2 3 4 5 6 7 8 9 10

What makes the pain WORSE?

Bending

Coughing

Standing a long time

Lifting

Sneezing

Sitting a long time

Defecation

Sexual Intercourse

What else makes it worse?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What makes it better?

Lying on your back

Lying on your side

\_\_\_\_\_  
\_\_\_\_\_

Other associated problems? i.e.  Difficulty sleeping?  Feeling depressed?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatment History**

How many times have you visited a physician?

0-5

6-10

Cannot Remember

Too many to count

Which kind of doctor have you seen for the pain?

Pain Physician

Orthopedic Surgeon

Rheumatologist

Neurologist

Acupuncture

Chiropractor

Other \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Studies?  MRI  CT Scan  X-ray  Other

Which medicine have you tried for this pain?

<input type="checkbox"/> Tylenol/acetaminophen	<input type="checkbox"/> Neurontin/Gabapentin	<input type="checkbox"/> Norco
<input type="checkbox"/> Motrin/Ibuprofen	<input type="checkbox"/> Lyrica	<input type="checkbox"/> Morphine
<input type="checkbox"/> Flexeril/Soma/Zanaflex	<input type="checkbox"/> Cymbalta	<input type="checkbox"/> Other
	<input type="checkbox"/> Oxycodone	_____

Have you taken any of the following for pain?  Marijuana  Other Illicit Drug (specify)

\_\_\_\_\_

Have you had any of the following procedures?

<input type="checkbox"/> Epidural Injections	<input type="checkbox"/> Discogram	<input type="checkbox"/> Spinal Cord Stimulator
<input type="checkbox"/> Trigger point injection	<input type="checkbox"/> Ultrasound <input type="checkbox"/> TENS/nerve stimulator	<input type="checkbox"/> Discogram
<input type="checkbox"/> Facet Injections	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Sacroiliac joint injections		How many sessions (PT)?

Communication

Preferred Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other language (please specify)
What is your Race?	
What is your Ethnicity?	<input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Hispanic <input type="checkbox"/> Other (please specify if Other)

**Review of Systems** Please check all that apply

<b>Constitutional Symptoms</b>	<input type="checkbox"/> weight loss	<input type="checkbox"/> appetite	<input type="checkbox"/> fatigue
	<input type="checkbox"/> physical strength		
<b>Eyes</b>	<input type="checkbox"/> corrective lenses	<input type="checkbox"/> changes in vision	
<b>HEENT</b>	<input type="checkbox"/> headache	<input type="checkbox"/> dizziness	<input type="checkbox"/> deafness/hearing loss
			<input type="checkbox"/> change in smelling sense
<b>Cardiovascular</b>	<input type="checkbox"/> hypertension	<input type="checkbox"/> limb swelling	<input type="checkbox"/> arrhythmia
	<input type="checkbox"/> heart attack	<input type="checkbox"/> phlebitis	<input type="checkbox"/> difficulty breathing laying down
<b>Respiratory</b>	<input type="checkbox"/> chronic cough	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> asthma
	<input type="checkbox"/> COPD/Emphysema		
<b>Gastrointestinal</b>	<input type="checkbox"/> nausea	<input type="checkbox"/> diarrhea	<input type="checkbox"/> constipation
	<input type="checkbox"/> reflux	<input type="checkbox"/> bloating	
<b>Genitourinary</b>	<input type="checkbox"/> blood in urine	<input type="checkbox"/> kidney stones	<input type="checkbox"/> difficult urination
<b>Musculoskeletal</b>	<input type="checkbox"/> joint swelling	<input type="checkbox"/> abnormal joint	<input type="checkbox"/> fractures
	<input type="checkbox"/> arthritis	<input type="checkbox"/> joint limitation	<input type="checkbox"/> muscle wasting
	<input type="checkbox"/> muscle weak	<input type="checkbox"/> muscle pain	<input type="checkbox"/> night cramps
	<input type="checkbox"/> atrophy	<input type="checkbox"/> posture abnormal	
<b>Skin and Breast</b>	<input type="checkbox"/> rash	<input type="checkbox"/> scar	<input type="checkbox"/> mass
	<input type="checkbox"/> discoloration	<input type="checkbox"/> hair loss	
<b>Neurological</b>	<input type="checkbox"/> blackouts	<input type="checkbox"/> gait disturbance	<input type="checkbox"/> stroke
	<input type="checkbox"/> seizures	<input type="checkbox"/> headaches	<input type="checkbox"/> loss of coordination
	<input type="checkbox"/> memory loss	<input type="checkbox"/> involuntary movement	<input type="checkbox"/> spasticity
<b>Psychiatric</b>	<input type="checkbox"/> depressed	<input type="checkbox"/> anxiety	<input type="checkbox"/> trouble sleeping
<b>Hematologic</b>	<input type="checkbox"/> abnormal bleeding	<input type="checkbox"/> anemia	<input type="checkbox"/> easy bruising
<b>Allergies</b>	<input type="checkbox"/> medications	<input type="checkbox"/> latex	<input type="checkbox"/> other allergies
<b>Endocrine</b>	<input type="checkbox"/> excessive thirst	<input type="checkbox"/> heat or cold intolerance	<input type="checkbox"/> excessive urination



**NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

By signing below I acknowledge that I have been advised of the Notice of Privacy Practice and consent to the use and release of my medical information per the office Privacy Practice.

Signature:

Relationship of Witness (if not the patient):

\_\_\_\_\_  
(Patient or Appropriate Representative)

\_\_\_\_\_  
(Name) (Title/Office Position)

Release of Information: The physician office may disclose all or any part of the patient's protected health information, with certain limits and protections, for **treatment** (providing, coordinating, or managing health care and related services), **payment** (reimbursement for those services) and **health care operations activities** (accreditation, certification, licensure, professional education, peer review, auditing services, business planning, provider contracting, etc).

**BILLING AND PAYMENT POLICIES****I FAILURE TO KEEP APPOINTMENT**

A. In order to have an efficient and orderly office, we request your consideration of the physician's time by asking that you provide us with Twenty-Four (24) hour notice if you cannot attend a scheduled appointment. This will allow other patients who are waiting for a cancellation to be notified. We understand situations may arise that are out of our control, and Twenty-Four (24) hour advance notice may not be feasible. However, in these situations, we ask that you notify our office as soon as possible.

Patients who fail to inform the office of the above or fail to show for a scheduled appointment will be charged a fee up to Fifty (\$50) dollars and/or the specialty office visit copay. This charge will be collected at the time of your next scheduled appointment and/or will be billed to you directly. We will not bill your insurance company for missed appointments.

When a patient repeatedly misses scheduled appointments, it becomes an inconvenience to the office. Therefore, if a patient misses three consecutive appointments without proper notification, he/she may be subjected to dismissal from our office, at the discretion from the treating physician. A letter will be sent to the patient informing him/her of the decision.

**II MANAGED CARE (AND MEDICARE MANAGED CARE)**

- A. All managed care patients are expected to know their policy requirements and participate actively with our staff to ensure that policy guidelines are met.
- B. Patients are required to obtain the necessary referral forms and present them at the time of their scheduled visit(s).
- C. All co-payments are due and collected at the time of the visit.
- D. **Patients presenting for consults or treatment visits who are unable to meet their co-payment requirement at the time of service or who have neglected to bring a required referral form will be required to re-schedule their visit.**

**Note: Our contractual agreements with the various managed care plans obligate us to adhere to the rules of these plans. We make every effort to do so, but often these rules are confusing to our staff as well as the patient(s). Please work with us so that your care plan is properly approved and we can all have confidence that reimbursement will be expedited by your plan, and no unexpected payments required by you, the patient.**

**III STANDARD INDEMNITY INSURANCE**

- A. Any co-payments and applicable deductibles will be due and collected at the time of visit.
- B. Pre-authorization will be obtained for all surgery.
- C. Unpaid deductibles and co-payment requirements relative to surgery will be due and payable prior to the scheduled date for surgery.

**IV MEDICARE (STANDARD)**

- A. We are participating providers with Medicare, and will bill all claims for Medicare patients.
- B. Medicare patients are expected to pay their full co-payment amount, unless you have a Medi-gap policy. Our office will then also bill your Medi-gap policy.
- C. Medicare patients are expected to pay their annual deductible, in the event it is not covered by the Medi-gap policy.
- D. For Medicare patients who participate in a managed care or HMO Medicare plan, please note that the policies applicable are those listed in Category II, above.

**V SELF PAY**

**A. For those patients without insurance, payment in full is required at the time of service. The estimated fees for your visit will be provided in advance (by phone or at the front desk upon check in). Full payment will be expected before the visit. Any balance due after the visit will be calculated at the conclusion of the visit.**

B. In the event a patient anticipates difficulty with this obligation, arrangements for a payment plan must be made in advance of the first visit. We will be happy to provide an estimate for your initial visit charge, by telephone, before your first visit. If you would like to arrange this pre-visit estimate so that you can be prepared, please call our office at 714 556-7246 and ask to be connected to our office manager.

**C. In the event that no payment arrangements have been made and no payment ability is available at the time of the visit, it will be necessary to re-schedule the visit.**

**VI PERSONAL INJURY**

We do not accept personal injury or lien cases.

**VII RETURNED CHECK CHARGES**

A. We fully anticipate that all of our patients are careful in the management of their finances and checkbooks. However, in the event that a patient does present us with a check which is returned by their bank the patient will be charged a \$25.00 returned check handling fee and no checks will be accepted in the future – only cash or credit card payments.

**For payments to be made by patients, we accept personal checks, cash and credit cards.**

My signature indicates that I understand and agree to the above billing policies.

Patient Signature: \_\_\_\_\_

Patient Name:

DOB:

Date: