VALLEY PAIN CENTERS

CONFIDENTIAL PATIENT INFORMATION – PLEASE PRINT LEGIBLY

Referring Physician _____ Today's Date _____

First Name _____ MI _____ Last Name _____

Physical Address _____ Home Phone ( ) _____

City _____ State _____ Zip _____ Cell Phone ( ) _____

Mailing Address If Different _____

City _____ State _____ Zip _____

Social Security Number _____ Date of Birth ___/___/_____ Age _____ Sex: F M

Marital Status (Circle One) Married - Widowed - Divorced - Single - Separated

Email: _____

Occupation _____ Employer _____

Office Address _____ Work Phone ( )_____

Emergency Contact Name _____ Phone ( )_____

Do you have/need an advance directive? Yes / No *Valley Pain Centers does not recognize advanced directives*

CONFIDENTIAL INSURANCE INFORMATION – PLEASE PRINT LEGIBLY

Insured First Name _____ MI _____ Last _____

Relation to Patient _____ Birthdate ____/___/_____ Soc Sec# _____/____/_____

Address if different then patient: _____

Employer _____ Occupation _____

ASSIGNMENT, RELEASE AND INFORMED CONSENT

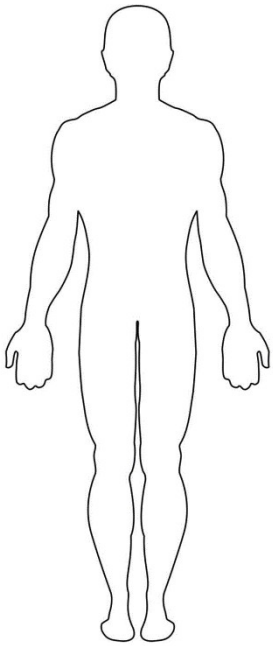
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Valley Pain Centers and/or Southwest Pain Specialists all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I have been informed of facility fee schedule that will be billed to my insurance. In the event the payment is not made, and this account is referred for collection, I will pay the cost of collection. If suit or action by an attorney is instituted, I will pay reasonable attorney fees in said suit or action. Invoice payments will be due upon receipt and are considered past due thirty (30) days from date of invoice, including acceptable lien cases. Interest at the rate of 1.5% monthly will apply to past due amounts. Additionally, I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and acknowledge receipt of Privacy Notice given to me
(Federal HIPPA Privacy Practices).

X Patient / Responsible Party Signature _____. DATE _____

Intake Form

Name: _____ Date of Birth: _____ Date: _____

Referring Physician: _____ **(Circle Any Problematic Areas)**



Height_____ Weight_____

Symptoms List (Circle all that apply):

Neck Pain	Right / Left / Both
Low Back Pain	Right / Left / Both
Shoulder Pain	Right / Left / Both
Hip Pain	Right / Left / Both
Knee Pain	Right / Left / Both
Foot/Ankle Pain	Right / Left / Both
Headaches	
Other: _____	

_____

Are you on any blood thinners besides aspirin? **Y / N** If so what medication?

_____

Medication Allergies (Circle all that apply):

No Known Allergies / Latex / Adhesives / Iodine / Other:

_____

Past Surgical History: (List Any History) _____

_____

Other therapies you have tried (Circle all that apply):

Chiropractic / Physical Therapy / Acupuncture / Epidurals / Corticosteroids / Radio Frequency Ablations (RFA)

Past Medical History/ROS (Circle all that apply):

Heart: Hypertension / Vascular Disease / Heart Attacks / Arrhythmia / Bleeding Problems / High Cholesterol / Stroke

Lung: Sleep Apnea / COPD / Smoker / Asthma / Emphysema

Nervous System: Anxiety / Depression / Nerve Pain / Back Pain / Neck Pain / Headache / Migraines / Fibromyalgia / Seizures

Gastric/Endocrine: Reflux / Heart Burn / Diabetes / Hormonal Problems / Hyper/Hypo Thyroid

General: HIV / Hepatitis / Auto-Immune Disease / Cancer / Chronic Pain / Arthritis / Obesity / Musculoskeletal

Social History:

Do you Drink Alcohol, Smoke (Marijuana / Cigarettes), Chew Tobacco? If so, how often? _____

Are you currently or is there any chance you may be pregnant? Y / N

Family History (Circle all that apply):

Bleeding problems / Anesthesia problems / Cancer / Stroke / Substance Abuse / Other: _____

MEDICATION RECONCILIATON

PATIENT NAME: DATE OF BIRTH:

PHARMACY NAME:_____PHONE NUMBER :_____

****Please complete this record. Please list all medications prescribed by a physician as well as any over the counter medication, supplements, and vitamins you take regularly. ****

Please list current drug allergies and their reaction

ALLERGY/REACTION	ALLERGY/REACTION
1.	7.
2.	8.
3.	9.
4	10.
5.	11.
6.	12.

MEDICATION	DOSE	ROUTE	FREQUENCY	INDICATION	DATE LAST TAKEN
1.					
2.					
3.					
4.					
5.					
6.					
7					
8.					
9.					
10.					
11.					
12					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

Medication information given by patient and recorded by :_____

Medication Reconciliation Verified by RN : _____ Date/Time: _____