COMPREHENSIVE
Pain Clinic, P.C.

677 South Main Street • Cheshire, CT 06410
100 Broadway • North Haven, CT 06473
Phone: (203) 439-0050 • Fax: (203) 439-9490

PATIENT REGISTRATION FORM

Last Name: _____

First Name: _____ Middle Initial:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone: _____ Cell: _____ Marital Status:_____ Sex:____

Soc. Sec. #:_____ Date of Birth:_____ Age:_____

E-mail Address:_____ or N/A:_____

Referring MD: _____

Employer Name: _____

Employer Address: _____

Employer Phone:_____ Employer Fax:_____

Injury Information:

Date of Injury:_____ Description of Injury: _____

Is your injury related to a mother vehicle accident? _____

Is your injury related to a workers compensation case? _____

Is your injury related to a liability case? _____

Attorney Name and Address:_____

Attorney Phone:_____

Insurance information:

Primary Insurance:_____

Company Name: _____

Policy Number:_____

Group Name/Number:_____

Send Claims to:_____

City:_____

State:_____ Zip:_____

Phone:_____ Fax:_____

Subscriber Name:_____

Subscriber Date of Birth:_____

Copay Amount:_____

Secondary Insurance:_____

Company Name:_____

Policy Number:_____

Group Name/Number:_____

Send Claims to: _____

City:_____

State:_____ Zip:_____

Phone:_____ Fax:_____

Subscriber Name:_____

Subscriber Date of Birth:_____

Copay Amount:_____

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PATIENT INFORMATION SHEET

Personal Information:

Name:_____ DOB:_____

Address:_____ Phone:_____

_____ SS#:_____

_____ Marital Status: M S D W

_____

Employed: Yes No Current Employer:_____

Job Title: _____

Emergency Contact:_____

Phone: _____ Relationship:_____

Primary Care Physician: _____ Phone:_____

Address:_____

Other Physicians, Therapists, Psychologists, etc... involved in your care:

_____ Phone:_____

_____ Phone:_____

_____ Phone:_____

Past Medical History
Check the box if you have the following:

Respiratory:	Cardiac:	Gastrointestinal	Spine	Urinary	Neuro
❒ Asthma	❒ Coronary Artery Disease	❒ Reflux	❒ Disc Disease	❒ Prostrate Problems	❒ Seizure Disorder
❒ Bronchitis	❒ Hypertension	❒ Constipation	❒ Degenerative Disc Disease	❒ Difficult Urination	❒ Stroke (TIA) r
❒ COPD	❒ High Cholesterol	❒ Diarrhea	❒ Scoliosis	❒ Incontinence	❒ Brain Tumor
❒ Emphysema	❒ Heart Attack	❒ Blood in Stools	❒ Joint Pain		❒ Alzheimer's
❒ Cancer	❒ Arrhythmia	❒ Mucous in Stools	❒ Arthritis		
		❒ Abdominal Pain			
Endocrine: ❒ Thyroid ❒ Diabetes ❒ Other		❒ Hernia			

Other Medical Problems not listed:

_____

_____

Family History

Illness:_____ Relation:_____

Illness:_____ Relation:_____

Illness:_____ Relation:_____

Illness:_____ Relation:_____

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Please list any surgeries you have had:

GYN:

Last Menstrual Period: _____ Regular:_____ Irregular:_____

Are you pregnant? Yes____ No_____ Are you planning to get pregnant?_____

Do you use contraception? _____

Known Drug and Food Allergies?

Do you take any of the following Medications?

Coumadin_____ Aspirin_____ Blood Thinners_____

Please list:

Do you smoke?

Yes_____ No_____ If yes, how much?_____

Do you drink alcohol?

Yes_____ No_____ If yes, how much?_____

Do you use recreational drugs?

Yes_____ No_____ If yes, how much?_____

Pain History:

Questions:	**Answers:**
Where is your pain?	
How did your pain start?	
Did your pain start suddenly or gradually?	
How long have you had your pain?	
Please describe your pain. Is it sharp, dull, shooting, stabbing, aching, etc.	
Does your pain stay in the same place or does it move or travel? If so, where does the pain move?	
Does tingling or numbness accompany your pain? If so where?	
How long does your pain last?	

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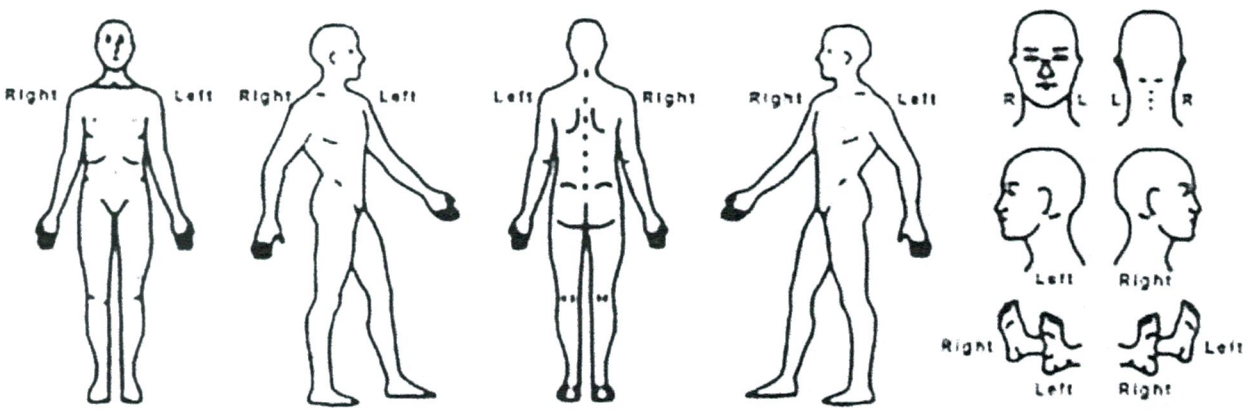
What makes your pain better?	
What makes your pain worse?	
What do you believe is the cause of your Pain?	
What are you expecting from the pain clinic?	
What does the pain stop you from doing?	
What are your goals in coming to the pain clinic?	
What would you be able to do if the pain got better?	
What previous treatments have you had for your pain?	
List Pain Injections, Physical therapy and the results of each if you have had them	
Do you see or have you seen a Psychiatrist or Psychologist?	
If so, please explain the reason and treatment he/she provided.	

Pain Scale: 0 (No Pain) 10 (Most Pain)

Best the Pain gets?_____ Worse the Pain gets?_____ Your Pain now? _____ Accepts/Goal?_____

Please indicate where your Pain is by using the diagram below:



Physician's Signature_____

Date Reviewed_____

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MEDICATION LIST AND RECONCILIATION FORM

Source of Information :_____ Patient Pharmacy:_____ [ ] Unknown

Food Allergy:_____ Drug Allergy:_____

❒ No medications

List ALL Prescriptions, over-the-counter medications, including herbal supplements, vitamins, nutriceuticals, intravenous, topical medications, and oxygen.

DATE	CURRENT MEDICATION	DOSE	ROUTE	FREQUENCY	LAST DOSE	COMMENTS	INITIALS

Initials	Signature	Initials	Signature

FAX TO PHARMACY

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I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to me and my dependents.

I also authorize payment of healthcare benefits otherwise payable to me directly to my doctor as listed above. I understand that I will be held responsible for all charges and services not paid by my insurance company.

X_____ **X**_____

Today's Date | Signature of Patient or Insured

_____ _____

Expiration Date | Witnessed by

The Signature on File (SOF) is valid from this date and expires in one year, A photo copy of this authorization may act as an original.

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name:_____

Date of Birth:_____ Medical Record Number:_____

1. I authorize the use or disclosure of the above named individual's health information ad described below.
2. The type and amount of information to be used or disclosed is as follows:

   ❒ problem list — ALL Dates: ❒

   ❒ medication list — Dates: from_____ to_____

   ❒ immunization record

   ❒ most recent history and physical

   ❒ most recent provider encounter

   ❒ procedure record

   ❒ laboratory results

   ❒ x-ray and imaging reports

   ❒ entire record

   ❒ Other _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
4. This information may be disclosed to and used by the following individual or organization:

   Name: Comprehensive Pain Clinic, P. C. Phone: 203-439-0050 Fax: 203-439-9490

   Address: 677 South Main Street, Cheshire CT, 06410

   Purpose of Release:

   X Medical Care ❒ Legal Representation ❒ Other _____

5. I understand that I have a right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire in one year from the date of authorization.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment by my healthcare providers. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal or state privacy rules. If I have questions regarding the disclosure of my health information by this practice, I can contact the privacy officer.

X_____ **X**_____

Signature of Patient or Legal Representative — Date