Anthem Pain Management, LLC

Keith R. Sutton MS, FNP, APRN-BC

41818 N. Venture Dr. Suite 150 Anthem, AZ 85086

Office /Appt: 623-341-8469 Fax: 623-551-6900

Authorization to Leave Personal Health Information by Alternative Means this includes Information Pertaining to Drug and Alcohol Problems and Psychological Conditions

Patient Name:____________________________________ Date of Birth:_________

Patient Mailing Address:____

____

(Please check all that apply)

□ May leave/share message on voicemail at home#: (____)__________________

May leave/share detailed message on voicemail at work# __________________

□ May leave/share information with spouse(name):_________________________

□ May leave/share info with other family named __________________________

□ May leave/share detailed message on cell phone#:(____)__________________

□ May leave/share detailed message at a different number#___________________

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

____

PATIENT REGISTRATION

(Please print and answer all questions)

Patient____ Single__________

Last Name First Name MI

Married________

If Married, Spouse's Name___________________________________

Other_________

If child, Person responsible for bill_____________________________

Home Address____

____

City State Zip

Phone #_(______)__________________ Age__________ Birth Date_________________

Patients Social Security # ____________________________________ Male __________

Birth date of primary insurance holder___________________________ Female_________

Patient's Employer____________________________________ Patient's Occupation____________________

Patient's Work Phone #_(______)____

If injured, Date___________________________ Injured at Work, Yes________ No_______

Cause of injury____

Person to call in case of emergency: Name____

Phone #_(_______)________________________ Relationship____________________________

Referring Dr. or Patient Name ____

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for and balance due. I authorize the doctor or insurance company to release any information required for this claim.

Signed____ Date:_____________

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Patients Name: Date:

BUPRENORPHINE AND CONTROLLED SUBSTANCE TREATMENT AGREEMENT

I am requesting that Keith Sutton FNP provide buprenorphine treatment for opioid ________________ addiction. Other controlled substances may be used during the course of therapy. The doctor is at liberty to add any requirements or stipulations as he sees fit at any time. This does not have to be in writing. You are free to find a new doctor any time you wish. I freely and voluntarily agree to accept this treatment agreement, as follows:

(1) I agree to keep, and be on time to all of my scheduled appointments with the doctor and/or his assistant. A “no show” fee will be assessed.

(2) I agree to conduct myself in a courteous manner in the physician’s or clinic’s office.

(3) I agree to pay all office fees for this treatment at the time of my visits. Failure to do so is cause for immediate termination of services.

(4) I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the staff will not see me, and I will not be given any medication until my next scheduled appointment. Immediate termination may ensue. Urine drug screens and medication counts will be random (in urina latet veritas).

(5) I agree not to sell, share or give any of my medication(s) to another person. I understand that such mishandling of my medication is a serious violation of this agreement (and the law) and would result in my treatment being terminated without recourse for appeal.

(6) I understand that the use of buprenorphine/naloxone (Suboxone, etc.) by someone who is using opioids could cause them to experience severe withdrawals. Stopping buprenorphine in itself can cause prolonged opiate withdrawals.

Patients Name: Date:

(7) I agree not to deal, steal, or conduct any other illegal or disruptive activities in, or in the vicinity of, the doctor's office.

(8) I agree that my medication (or prescriptions) can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

(9) I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost or stolen medication(s) will not be replaced regardless of the reasons for such loss. It is to be kept out of the reach of children.

(10) I agree not to obtain medications from any physicians, pharmacists, or other sources without informing Keith Sutton FNP. I understand that mixing buprenorphine with other medications, especially benzodiazepines, can result in death or disability. I also understand that a number of deaths have been reported in persons mixing buprenorphine with other drugs or alcohol.

(11) I agree to take my medication as the doctor, or his assistant has instructed, and not to alter the way I take my medication without first consulting the doctor.

(12) I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in a patient education and a relapse prevention program, to assist me in my treatment.

(13) I understand that my buprenorphine and/or other controlled substance treatment may be discontinued, and I may be discharged from the practice if I violate any of this agreement or further requirements requested by the doctor.

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Patients Name: Date:

(14) I understand that there are alternatives to buprenorphine treatment for opioid addiction including:

a. medical withdrawal and drug-free treatment b. naltrexone treatment c. methadone treatment

The doctor will discuss these with me and provide a referral if I request this.

The failure to plan on your part does not constitute an emergency on our part.

Patient's Signature Date

Witness Signature Date

Witness Name

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PATIENT INTAKE: MEDICAL HISTORY

Name____ **Date:**__/__/__

Address____

Phone (W)______________ **(H)**______________ **(C)**______________

DOB________________ **Age**________ **SS#**__________________

Emergency Contact________________________________
Relationship to patient____________________
Phone________________
Primary care physician____________________

Have you ever had an EKG? Y N Date___________

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory
( ) Hypertension
( ) Head trauma
( ) Liver problems
( ) STDs
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Epilepsy or seizure disorder
( ) HIV/AIDS
( ) Pancreatic problems
( ) Abnormal Pap smear
( ) GI disease
( ) Diabetes
( ) Thyroid disease
( ) Nutritional Deficiency

Other (Please Describe)

____
____
____
____

If there is a family history of any of the illnesses listed above, **please put an "F" next to that illness.**

MD NOTES

____
____
____

Date: __/__/__ Patient Name:____________________

Is there a family history of anything NOT listed here? (Please explain)

____

____

____

MD NOTES

____

____

Have you ever had surgery or been hospitalized? (Please describe)

____

____

MD NOTES

____

____

____

Childhood Illnesses
Measles Y N Mumps Y N Chicken Pox Y N

Have you or a family member ever been diagnosed with a **psychiatric or mental illness?**

____

____

Have you ever taken or been prescribed **antidepressants**? ( ) Y ( ) N
If yes, for what reason

____

Medication(s) and dates of use

____

Why stopped

____

____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day). DO NOT include medications you may be currently misusing (that information is needed later).

____

____

Date: __/__/__ Patient Name:________________

Please list all current **herbal medicines, vitamin supplements,** etc. and how often you take them

____

____

MD NOTES

____

____

____

Please list any **allergies** you have (penicillin, bees, peanuts)

____

____

MD NOTES

____

____

Tobacco History

Cigarettes: Now? Y N In the past? Y N

How many per day on average? __________ For how many years? __________

Have you ever been **treated for substance misuse?** (Y) ( ) N (Please describe when, where and for how long)

____

____

____

How long have you been **using substances?**

____

Notes:______________________________________

Date: __/__/__ Patient:________________________

Substance Use History

	No	Yes/Past And/Or Yes/Now	Route	How Much	How Often	Quantity Date/Time of Last Use
Alcohol						
Caffeine (pills or beverages)						
Crystal Meth-Amphetamine						
Cocaine						
Heroin						
LSD or Hallucinogens						
Marijuana						
Methadone						
Pain Killers						
PCP						
Stimulants (pills)						
Tranquilizers /Sleeping Pills						
Ecstasy						
Inhalants						
Other						

____

Did you ever stop using any of the above because of dependence? (Y) (N) (Please list)
____
____

What was your longest period of abstinence? ____________________

Date:__/__/__ Patient Name____________________

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(Circle one) Married Single Long-term relationship Divorced/Separated
Years married/in long-term relationship ____ Times Married ____ Times Divorced_____

Children ( ) N ( ) Y Current ages (list)

____
____

Residing with you? ( ) N ( ) Y If no, where?

____

Where are you currently living?

____

Do you have family nearby? (Y) (N) (Please describe)
____

Education (check most recent degree):

( ) Graduate School ( ) College ( ) Professional or Vocational School
( ) High School Grade ___________________

Are you currently employed? (Y) (N) Where (if "no" where were you last employed?)

____

What type of work do/did you do?

____

How long have/did you work(ed) there? ________________

Have you ever been arrested or convicted? (Y) (N)
( ) DWI/DUI ( ) Drug-related ( ) Domestic violence ( ) Other
Have you ever been abused? (Y) (N)
( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally
( ) Emotionally

Have you ever attended:
AA ( ) Current ( ) Past NA ( ) Current ( ) Past CA ( ) Current ( ) Past
ACOA ( ) Current ( ) Past OA ( ) Current ( ) Past
If you are not currently attending meetings, what factors led you to stop?

____

Have you ever been in counseling of therapy? (Y) (N) (Please describe)

____
____

FOLLOW UP VISIT FOR SUBOXONE

Please Print
Today's date: ___________

Name: ________________________________ **DOB:** ____________________

SYMPTOMS (please circle one)
Stable Worse Improved Unchanged

Have you had any cravings? (please circle)
NO YES (explain)
____

Since your last visit have you relapsed? (if yes please specify which substance and when)
NO YES (explain)
____

Have you attended any AA/NA meetings since your last visit?
NO YES (dates and location)
____
____

Have you established a support network? (family, non-drug using friends, spouse, significant other, etc.)
NO YES (who)
____
____

Medication Changes (please circle)
Any medication changes? YES NO (if yes please list changes below)

List all changes:

Name	Dose(msg,mcg)	Frequency (per day)	Prescribing Doctor

Side Effects/Symptoms (please circle all that apply)

Fever
Chills
Constipation
Nausea
Dizziness
Sedation (sleepiness)
Fluttering of the heart
Abdominal pain
Double/Blurred vision
Sweats