Lake Physical Medicine
Interventional Spine•EMG

Lake Physical Medicine Patient Registration

Last Name:_____ First Name:_____ Mi: ____

Previous Name: _____ Date Of Birth (MM/DD/YYYY)_____

Address: _____City: _____State:____ Zip:_____

Social Security Number _____-_____-_____ Sex: Male Female

Email:_____ Home Phone _____ Cell Phone_____

Marital Status: Single___ Married___ Divorced___ Widowed___ Separated ___

Primary Care Physician:_____ Physician Phone # _____

Employer: _____Responsible Party: _____

Emergency Contact: _____Phone Number: _____

May We Share Your Medical Information With Anyone? _____**Yes** _____**No**

If Yes, Their Name: _____ Relationship to You: _____

Primary Insurance _____Secondary Insurance _____

Work Related Injury: Claim #: _____ Doi: _____

Employer: _____

WE WILL NOT RETROACTIVELY PURSUE WORKER'S COMPENSATION

Other Physicians Involved With My Medical Care Whom I Authorize Ongoing Release Of Information For Continuity Of Care.

Provider: _____Phone_____

Address: _____City: _____ State:___ Zip:_____

1. I Authorize The Release Of All Medical Information To Process Claims For Medical Care Received. I Assign All Medical Benefits, Including Major Medical Benefits To Which I Am Entitled To Lake Physical Medicine, This Assignment To Be Considered As Valid As The Original.
2. I Am Aware Of The Lake Physical Medicine (Hippaa) Privacy Act And I Understand I May Have A Copy Upon Request.

Patient Signature: _____ Date: _____

Lake Physical Medicine, Dr. Patrick T Boylan, MD
9485 Mentor Avenue, 203, Mentor, OH 44060
440-205-9119 | Fax: 440-205-9209 | info@lakephysicalmedicine.com

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Lake Physical Medicine Patient Medical History

Patient's Name: _____Height: _____ Weight _____

Reason for Visit: _____

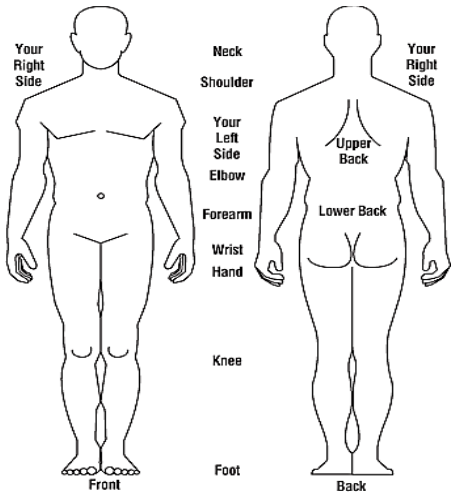
Date the injury or symptoms began: _____

Primary Care Physician: _____

RATE YOUR PAIN

Use the body images to the right to indicate the location of your pain.

No Pain					Moderate					Worst
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐



Medical History

(Please check all that apply)

- ☐ Unremarkable
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer (type) _____
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Esophageal Reflux
- ☐ GI Bleed
- ☐ Heart Attack
- ☐ HIV
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypo Thyroid
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Lupus
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Osteoporosis
- ☐ Poor Circulation
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Ulcer

Previous Treatment

- ☐ Physical Therapy
- ☐ Chiropractic Treatment
- ☐ Spinal Injections
- ☐ Other _____

☐ Vaccine History (this year) ☐ Flu ☐ Pneumonia ☐ Covid 19 Current Date: _____

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Lake Physical Medicine – Review of Symptoms

Please check if you are experiencing any of the following:

General
- □ Chills
- □ Fatigue
- □ Fever
- □ Difficulty Sleeping
- □ Weight Gain
- □ Weight Loss

Ear, Nose, Throat
- □ Hoarseness
- □ Decreased Hearing
- □ Difficulty Swallowing
- □ Ringing in the Ears

Respiratory
- □ Snoring
- □ Cough
- □ Coughing up Blood
- □ Shortness of Breath at rest
- □ Shortness of Breath with Exertion

Cardiovascular
- □ Leg Swelling
- □ Chest Pain
- □ Difficulty Laying Flat
- □ Irregular Heartbeat

Gastrointestinal
- □ Bowel Incontinence
- □ Abdominal Pain
- □ Blood in Stool
- □ Constipation
- □ Throwing up Blood
- □ Nausea
- □ Vomiting

Eyes
- □ Double Vision
- □ Blurry Vision
- □ Dry Eyes

Hematology
- □ Easy Bruising
- □ Prolonged Bleeding
- □ Swollen Glands

Genitourinary
- □ Blood in Urine
- □ Difficulty Urinating
- □ Painful Urination
- □ Incontinence

Musculoskeletal
- □ Joint Stiffness
- □ Painful Joints

Neurologic
- □ Balance Problems
- □ Difficulty Speaking
- □ Dizziness
- □ Headache
- □ Seizures
- □ Tremor
- □ Numbness
- □ Weakness
- □ Tingling

Psychological
- □ Known Mental Health Disorder (please list)_____
- □ Anxiety
- □ Substance Abuse

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Lake Physical Medicine – Surgical, Family and Social History

Surgical History – check all that apply

□ Unremarkable
□ Abdominal Surgery
□ Amputation
□ Ankle Surgery
□ Appendectomy
□ Breast Surgery
□ Carotid Artery Surgery
□ Carpal Tunnel Syndrome
□ Cataract Surgery
□ Colon Surgery
□ Foot Surgery
□ Gastric Bypass
□ Hand Surgery
□ Heart Surgery
□ Hip Surgery
□ Hysterectomy
□ Knee Surgery
□ Lung Surgery
□ Pacemaker
□ Prostate Surgery
□ Shoulder Surgery
□ Spine Surgery
□ Vascular Surgery
□ Other_____

Family History – check all that apply

□ Unknown
□ Unremarkable

□ Alcoholism	□ Mother □ Father □ Other_____
□ Angina	□ Mother □ Father □ Other_____
□ Bleeding Problems	□ Mother □ Father □ Other_____
□ Cancer type:	□ Mother □ Father □ Other_____
□ Stroke	□ Mother □ Father □ Other_____
□ Diabetes	□ Mother □ Father □ Other_____
□ Heart Disease	□ Mother □ Father □ Other_____
□ High Blood Pressure	□ Mother □ Father □ Other_____
□ Mental Disorder	□ Mother □ Father □ Other_____
□ Osteoporosis	□ Mother □ Father □ Other_____
□ Rheumatoid Arthritis	□ Mother □ Father □ Other_____

Social History – check all that apply

Alcohol Use: □ None □ Occasional □ Moderate □ Heavy
Recreational Drugs: □ No □ Yes
Smoke Tabaco: □ Yes (how much_____) □ No □ Former
Do you live alone: □ Yes □ No
Marital Status: □ Married □ Single □ Divorced □ Widow

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Lake Physical Medicine – Medication List

Allergies_____ Pharmacy_____

Blood Thinner _____ Prescribing Dr. _____

Medication	Dosage	How Often Taken
Example – Tylenol	**325 mg**	**1 or 2 once daily**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Opioid / Substance Abuse Questionnaire

1.) Do you have a family history of substance abuse? Please check all that apply.

___ Alcohol ___ male relative ___ female relative

___ Illegal Drugs ___male relative ___ female relative

☐ Prescription Drugs ___male relative ___ female relative

2.) Do you have a personal history of substance abuse? Check all that apply.

___ Alcohol

___ Illegal Drugs (please note type) _____

___ Prescription Drugs (please note type) _____

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Patient Prescription Responsibility Agreement for Controlled Substances

1. I am responsible for the controlled substance medications prescribed to me. If any prescription is lost, misplaced or stolen or if I "run out early", I understand that it will not be replaced.
2. REFILLS ON CONTROLLED SUBSTANCE MEDICATIONS:
   a. Will be made only during regular office hours, in person once a month, during a scheduled office visit, or on the phone two days in advance. Refills will not be made at night, on weekends, or during holidays.
   b. Prescription will not be filled if I "run out early", lose a prescription, spill or misplace my medications. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
   c. Will not be made as an "emergency" such as on Friday afternoon because I suddenly realized I will run out tomorrow. I will call 2-3 days prior to a refill.
3. I will not be rude to the office staff on the phone or in the office.
4. I agree to comply with random urine, blood or breathe testing, documenting the proper use of medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of state while taking the prescribed medications.
5. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involved obtaining controlled substance medications from another individual or the use of non (illegal) prescribed drugs, I may be reported to all my physicians and the appropriate law enforcement authorities.
6. I understand that the main treatment goal is to reduce pain, improve my ability to function and work. In consideration of this goal, I agree to help myself by following better health habits, exercise, weight control and avoidance of the use of tobacco and alcohol.
7. I agree to only receive controlled substance medications while receiving pain management intervention from Dr. Patrick Boylan and not by any other medical professional. I understand that violation of these conditions will result in immediate removal from Oaktree Clinic as a patient and that I will have no recourse against Dr. Boylan. I am solely responsible for the procurement of any tapering doses required to avoid withdrawal when discharged from the practice.
8. I agree to provide Dr. Boylan with my pharmacy's contact information at which I will fill all my prescriptions from Dr. Boylan. If I require changing pharmacies, I agree to notify Dr. Boylan.

PATIENTS SIGNATURE:_____DATE:_____

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Patrick T. Boylan MD Inc
Financial Policy

Date:_____

Patient Name:_____ D.O.B._____

1.) **All co-pays are due at the time of service or you will not be able to see the physician.**

2.) **All balances are due at the time of service or arrangements can be made with our financial office before being seen by the physician.**

Please remember that your co-pay and deductible is dictated by your insurance company and agreed to by you.

Patient Signature: _____

Witness Signature: _____

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