New Patient Registration Form

Thank you for choosing our practice. We welcome you as a new patient to our practice. Please complete this packet in its entirety to ensure that we have all the necessary information to treat you effectively.

PATIENT INFORMATION		
Patient Name: (Last)	(First)	(Middle Initial):
Gender: ☐ Male ☐ Female ☐Prefer not to answer ☐Non-Binary	SSN:	DOB:
Marital status (circle): M S D W	Driver's License Number/State:	
Address:		Apt:
City:	State:	Zip:
Primary Phone Number:		

DEMOGRAPHIC INFORMATION
Ethnicity: Central American – Cuban – Dominican – Hispanic or Latino/Spanish – Latin American/Latin – Latino – Mexican – Not Hispanic or Latino – Puerto Rican – South American – Spaniard
Race: American Indian – Asian – Asian Indian – Black or African American – European – Filipino – Japanese – Korean – Native Hawaiian or Other Pacific Islander – White – Other
Language: English – Spanish – Other:

EMERGENCY CONTACT INFORMATION		
In case of emergency, please list someone who can be contacted.		
(1) ( )	Relation:	home/work/cell/other
(2) ( )	Relation:	home/work/cell/other
(3) ( )	Relation:	home/work/cell/other

PREFERRED PHARMACY INFORMATION		
More information regarding pharmacy preference in the Opioid Agreement (presented at consultation visit)		
Name:	Phone:	Fax:
Address:		

PREFERRED CLINIC LOCATION
(1) 2315 W Ben White Blvd Austin, TX 78704
(2) 12414 Alderbrook Drive Suite 201 Austin, Tx 78727
(3) 3101 Hwy 71 E Suite 100 Bastrop, TX 78602
(4) 1301 Wonder World Drive Suite 306 San Marcos, TX 78666

Terms and Policies

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health/medical plans, to issue payment check(s) directly to Pain Management for medical services rendered to myself and/or my dependents regardless of my insurance. In the event that I receive the insurance payment directly, I realize that I will be billed personally until this balance is paid in full.

Authorization to Release Information

I hereby authorize Pain Management to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) allow a photocopy of my signature to be used to process insurance claims. I further understand that my insurance and/or third-party payer may require a copayment or coinsurance that is to be paid on the date that services are rendered. I agree to pay all such charges incurred immediately upon presentation of a financial statement. A photocopy of this assignment is to be considered as valid as the original. This order will remain in effect until revoked in writing.

I have requested medical services from Pain Management on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

Consent to Treat

I consent to treatment at Pain Management and understand that I am responsible for all charges incurred by me and all charges not allowed by my insurance company. I authorize release of any medical information to process my claims. I authorize payment of any assigned benefits to Pain Management, Anand Joshi, MD, Bennjamin Fronk, MD, Jason Carroll, DO, and associates.

Financial Policy

I have read, understand, and have received the Patient Financial Policy of Pain Management.

Notice of Privacy Practices

I have read, understand, and have received the Notice of Privacy Practices of Pain Management.

Patient Signature: ____

Patient Name (printed):____ Date: ______________

MEDICAL HISTORY
Referring Physician (name and phone number):
Primary Care Physician:
What is your main reason causing you to be referred for treatment?
Describe your symptoms in detail:
When and how your symptoms begin? Please describe in detail all the treatments you have had for this condition. Please write as much as possible in this space and attach additional pages if necessary.

Patient Initials: Staff Initials: Provider Initials:

HEALTH SUMMARY

Are you allergic to shellfish? ☐ Yes ☐ No

List your medication allergies: ☐ No Known Allergies

List your non-medication allergies: ☐ No Known Allergies

Are you allergic to anesthesia or anesthetics? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

If you answered yes, what was your reaction?

Current Medications: Please list all medications that you have taken in the last 12 months.

Also list vitamins and supplements

Name:	Dose/Strength:	Frequency:	Last Taken:

Patient Initials: Staff Initials: Provider Initials:

PAST MEDICAL HISTORY	
Please list major medical history in the following areas:	
Cardiovascular (i.e. high cholesterol, high blood pressure)	☐ None
Pulmonary (i.e. asthma, sleep apnea.)	☐ None
Gastrointestinal (i.e. acid reflux, IBS.)	☐ None
Renal/Genitourinary (i.e. renal stones, urinary tract infections.)	☐ None
Musculoskeletal/Connective Tissue (i.e. fractures, rheumatoid arthritis.)	☐ None
Endocrine (i.e diabetes, thyroid.)	☐ None
Neurological/Genetic (i.e. migraine headaches, seizures.)	☐ None
Hematologic (i.e. iron deficiency, blood disorders.)	☐ None
Immunology/Dermatology (i.e. chicken pox, sinusitis.)	☐ None
Cancers	☐ None
Psychiatric	☐ None
FEMALE PATIENTS ONLY ☐ Please indicate if you are currently or planning to become pregnant.	

Patient Initials: Staff Initials: Provider Initials:

SURGICAL HISTORY

Spine Surgery: Have you had spine surgery? ☐ Yes ☐ No

If yes, please list.

Other Surgeries: Please list any surgeries that you have had. (i.e. appendix, tonsils.)

PAST TREATMENT HISTORY- SPECIALISTS

List all previous pain management, chiropractor, physical therapists, neurosurgeon, orthopedic doctors you have seen in the last 5 years (name and phone number):

FAMILY HISTORY

Please list any and all major-medical history and disorders present in your family. Please list the medical condition and your relation to the person. Including anesthesia/anesthetic problems.

Condition	Relation

SOCIAL HISTORY

Alcohol:

☐ Never
☐ Would rather discuss with provider
☐ Current or past history of:

Type of alcohol:

Quantity and frequency:

Tobacco:

☐ Never
☐ Would rather discuss with provider
☐ Current or past history of:

Type of tobacco:

Quantity and frequency:

Substance Abuse: (Including marijuana) ☐ Never ☐ Would rather discuss with provider

☐ Current or past history of:

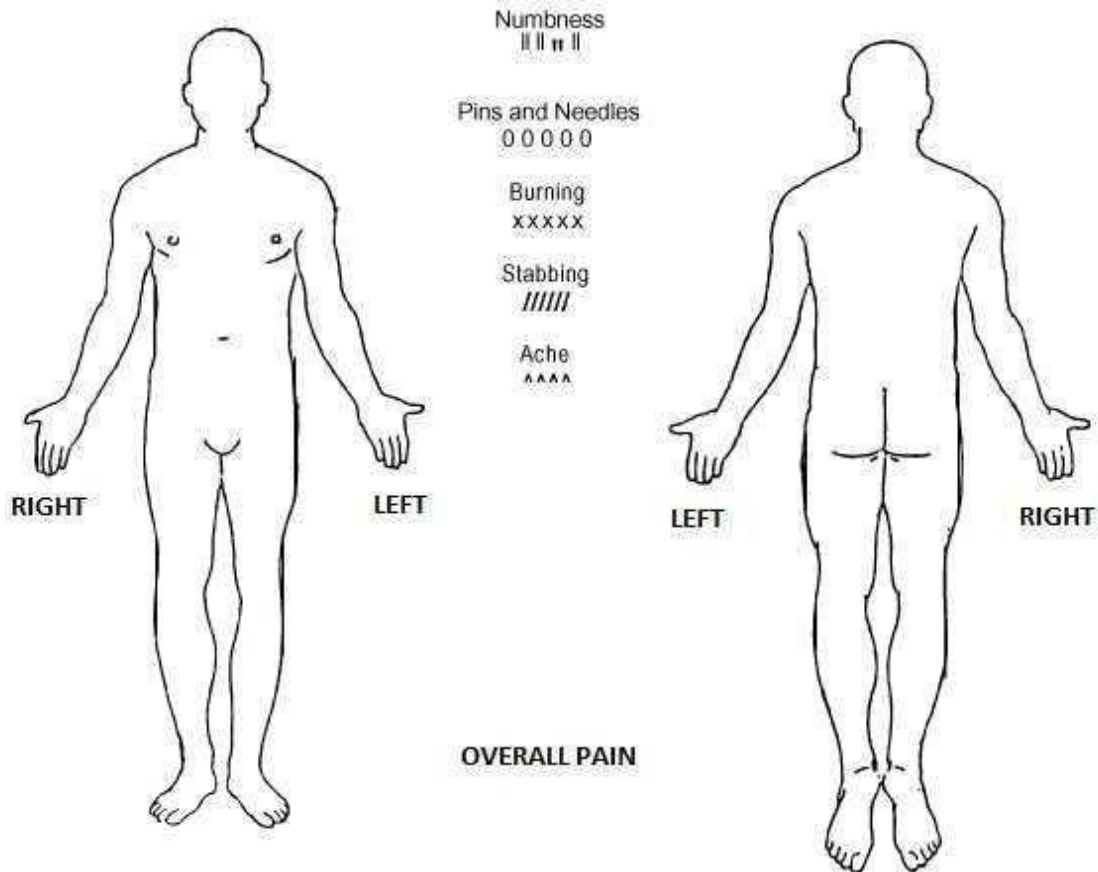
Type of substances:

Quantity and frequency:

Patient Initials: Staff Initials: Provider Initials:

Pain Diagram

Pain Diagram Instructions: Mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc.). If you feel any of the following sensations, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.



WITH PAIN MEDICATION

(NO PAIN) 1-------2-------3-------4-------5-------6-------7-------8-------9 ----- 10 (MOST PAIN)

WITHOUT PAIN MEDICATION

(NO PAIN) 1-------2-------3-------4-------5-------6-------7-------8-------9 ----- 10 (MOST PAIN)

Current treatments or therapies: Please describe current treatments or therapies (include any exercise habits you may have, type, and frequency).
Please describe the character of any pain symptoms:
Please circle each word that applies to your symptoms: Unable to describe Constant – Intermittent Mild – Moderate – Severe Aching – Stabbing – Burning – Sharp – Cramping – Dull – Tearing – Throbbing – Electrical Tingling – Stiffness – Numbness – Weakness – Skin Sensitivity – Spasms

Patient Initials: Staff Initials: Provider Initials:

Contact Numbers

Patient Name: ___________________________________

DOB_____/_____/______

When necessary for us to contact you regarding health information, please indicate (in order of preference) the phone numbers we may use. Please check yes or no if we can leave a detailed voicemail with medical information.

1. ______________________ home/work/cell Voicemail? ☐ Yes ☐ No
2. ______________________ home/work/cell Voicemail? ☐ Yes ☐ No
3. ______________________ home/work/cell Voicemail? ☐ Yes ☐ No

HIPAA Privacy Authorization Form

I, hereby authorize Pain Management to release any and all medical information and test results that pertain to me, to the following individuals.

Name:______________________________Phone #:_________________Relation:___________

Name:______________________________Phone #:_________________Relation:___________

Name:______________________________Phone #:_________________Relation:___________

I authorize Pain Management to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Pain Management in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

____ ________________________

Signature Date

Pain Management

Release of Medical Information

Please release and forward the following information to Pain Management
2315 W Ben White Blvd Austin, TX 78704 | P (512) 326-5440 | F (512) 326-8660 | Text (512) 256-9468

Patient Name:____DOB: ______________________

(Custodian of Medical Records)

____________________________ ______________________________ __________________________
____________________________ ______________________________ __________________________
____________________________ ______________________________ __________________________
____________________________ ______________________________ __________________________
____________________________ ______________________________ __________________________
____________________________ ______________________________ __________________________
____________________________ ______________________________ __________________________

I hereby authorize the above-mentioned party to provide and obtain a copy, summary, or narrative of my medical records and release the following confidential information including HIV, psychiatric, and drug rehabilitation if applicable:

☐ Complete Record
☐ Information on the following dates:
_________________to _________________
☐ Other:______________________________
☐ Records concerning the following condition:
____

Reason for this request:

☐ Continuing Medical Care
☐ Changing Doctor Care
☐ Other:______________________________

I, as the undersigned patient, understand that the requested medical facility will provide this information within 15 business days from the receipt of this request and that a fee for preparing and furnishing this information may be charged to the patient according to rulings set forth by the Texas State Board of Medical Examiners.

This release will stay in effect until it has been revoked inwriting.

Patient Signature:_____________________________________ Date: _____________________