Appointment: _____

PainCare OF SILICON VALLEY
www.paincareofsiliconvalley.com

2101 Forest Avenue - Suite #220A
San Jose, CA 95128

Phone 408-295-8628
Fax 408-295-8061

Patient Registration Form

Personal Information

Today's Date

Send referral to (check one): ☐ Ray Hsieh, MD ☐ Justin Lo, MD ☐ Steve Wang, MD ☐ Jonelon Tsang, MD ☐ Tanzina Khan, MD

Patient's Name:

Date of Birth:

Sex M / F

Social Security Number:

Home Phone

Alternate Phone

Address:
(Street, City, State, Zip)

Emergency Contact

Relationship

Phone Number

Employer

Employer Address

Name of Spouse

Workers Comp

Claim Number

Date of Injury

Insurance Carrier

Adjuster Name

Phone Number

FAX number

Primary Insurance

Insurance Carrier

Type of insurance PPO HMO IPO Private
(circle one)

Subscriber ID #

Address

Phone number

FAX number

Pharmacy Name and Phone Number

Referring MD / Attorney

Address

Phone Number

Secondary Insurance

PainCare
OF SILICON VALLEY
www.paincareofsiliconvalley.com

2101 Forest Avenue - Suite #220A
San Jose, CA 95128

Phone 408-295-8628
Fax 408-295-8061

Intake Questionnaire

Name *(Last)* *(First)* *(M.I.)*

Date of Birth

Referred By

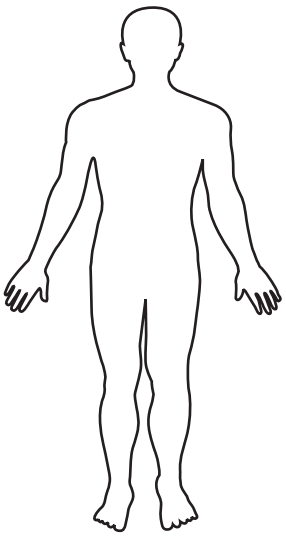
Month/Year your pain began

1. Where is your pain?

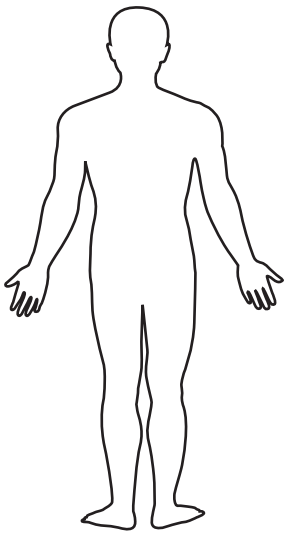
- ☐ Lower back
- ☐ Chest
- ☐ Abdomen
- ☐ Thigh (R, L)
- ☐ Buttock (R, L)
- ☐ Calf (R, L)
- ☐ Hand (R, L)
- ☐ Mid Back (R, L)
- ☐ Ankle (R, L)
- ☐ Head
- ☐ Arm (R, L)
- ☐ Groin
- ☐ Face
- ☐ Neck
- ☐ Upper Back
- ☐ Shoulder (R, L)
- ☐ Other:_____

2. Please mark the following drawing to highlight your areas of pain.

Front



Back



3. Please rate your pain level:

0=No Pain 10= worse possible pain

Maximum Pain: ☐

Least Pain: ☐

4. Is your pain related to one of the following:

Accident (Type of): _____

Illness: _____

Other: _____

5.Would you describe your pain as:

- ☐ Sharp
- ☐ Burning
- ☐ Aching
- ☐ Throbbing
- ☐ Shooting

6. Does your pain travel?

Yes

Explain_____

No

PainCare
OF SILICON VALLEY
www.paincareofsiliconvalley.com

2101 Forest Avenue - Suite #220A
San Jose, CA 95128

Phone 408-295-8628
Fax 408-295-8061

Intake Questionnaire

7. What time of day is your pain worse?

7 AM 11 AM 3 PM 7 PM 11 PM 3 AM
(circle one)

8. Does the pain wake you up at night?

☐ **Yes** ☐ **No**

9. Describe (in your own words) your pain:

_____
_____
_____
_____
_____

10. What makes your pain worse?

- ☐ Coughing
- ☐ Sneezing
- ☐ Standing
- ☐ Walking
- ☐ Sitting
- ☐ Bending
- ☐ Eating
- ☐ Sexual Intercourse

11. What makes your pain better?

- ☐ Sleeping/Resting
- ☐ Relaxation
- ☐ Away from work
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Exercise
- ☐ Alcohol
- ☐ Nothing
- ☐ Heat Application
- ☐ Cold Application
- ☐ Medicine (List):_____
  _____
- ☐ Other:_____

12. Please list all current medications:

_____
_____
_____
_____
_____

13. What treatments have helped your pain in the past?

- ☐ Medical Procedure or Surgery: (Explain)

_____
_____
_____
_____

- ☐ Medicine: (List)

_____
_____
_____
_____

- ☐ Physical Therapy
- ☐ Visual Imagery or Biofeedback
- ☐ Psychotherapy
- ☐ Other:_____

14. What other symptoms accompany your pain?

- ☐ Numbness
- ☐ Tingling with pins & needles
- ☐ Skin Changes
- ☐ Weakness
- ☐ Coldness
- ☐ Bowel Problems
- ☐ Bladder Problems
- ☐ Increased Sweating
- ☐ Muscle Spasms or tightness
- ☐ Other:_____

PainCare
OF SILICON VALLEY
www.paincareofsiliconvalley.com

2101 Forest Avenue - Suite #220A
San Jose, CA 95128

Phone 408-295-8628
Fax 408-295-8061

Intake Questionnaire

15. How does your pain affect the following:

Sleep _____
Appetite _____
Concentration _____
Physical Activity _____
Emotions _____
Family _____
Social Relationships _____
Sexual Activity _____
Work Activity _____

16. What do *you* think is causing your pain now?

_____
_____
_____

17. Since your pain began, has it:

- ☐ Decreased
- ☐ Increased
- ☐ Remained the same

18. What is your goal in regards to your pain?

_____
_____
_____

19. Have you been hospitalized for your pain?

- ☐ Yes

Explain _____
_____
_____

- ☐ No

20. Have you had any of the following tests to evaluate your pain?

- ☐ X-ray
- ☐ MRI
- ☐ CT Scan
- ☐ EMG
- ☐ Myelogram

21. What specific treatments/procedures have you had for the treatment of your present pain?

Date _____
Procedure _____
Physician _____
How long did relief last? _____

Date _____
Procedure _____
Physician _____
How long did relief last? _____

Date _____
Procedure _____
Physician _____
How long did relief last? _____

22. Do you smoke?

What? _____
How much? _____

- ☐ N/A

23. Alcohol consumption

- ☐ None
- ☐ Social Only
- ☐ 1-2 Drinks per Day
- ☐ 3 or more

24. Does your medication intake concern you?

- ☐ **Yes**
- ☐ **No**

25. Do you have legal action pending related to you pain?

Attorneys Name: _____
Phone number: _____

26. Please list the name and phone number of your insurance adjuster:

_____

Pain Care of Silicon Valley

2101 Forest Avenue #220A San Jose, CA 95128
Tel: 408-295-8628 Fax: 408-295-8061

HIPAA Privacy Rule – Written Acknowledgement of Privacy Practices Receipt
New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my heath care, the Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that information serves as:

- A basis for planning my care and treatment
- A means of communication among the may health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- Right to object to the use of my health information for a directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment call a payment, or health care operations.

Understand that the center is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance is thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164. 506 of the Code of Federal Regulation.

I further understand that the Center reserves the right to change their notice and practices and prior tom implementation, in accordance with Section 164.52 of the Code of Federal Regulations. Should the Center change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

_____ _____
Patient Signature Date

FOR CENTER USE ONLY
{ } Consent received by: _____ on _____
{ } Consent refused by patient, and treatment refused as permitted.

Contract for Controlled Substance Prescriptions:

This contract is an agreement between the patient and doctor to help better facilitate the legal distribution of controlled substances for the relief of pain. I understand the treatment goal while using controlled substances is to improve mu ability to function work and to alleviate the anguish of pain. I realize that my pain may not be totally alleviated by the use of potent controlled substances medication:

- I am responsible for my controlled substance medication (Pain Medication)
- If the prescription or medication is lost, misplaced, or stolen or if it used up sooner than the duration prescribed, I understand that the **medication will not be replaced.**
- I will keep all medication in a secure place, where no one can have access to it (especially children)
- Pain medication may cause drowsiness, especially if taken with others today sedating drugs. I will not drink alcohol while taking any medication. I will use caution when taking other sedating drugs cover including over the counter non-prescription medications (antihistamine)
- I will use caution before driving a car or using hazardous equipment
- I will take all my medication **exactly** as prescribed. I will not increase or abruptly stop medication without
- discussion with my doctor. All narcotic medication will be taken on a scheduled basis. If my pain is relieved, I may gradually take less medications.
- I must report stolen medication to the police
- I will not request nor accept controlled substance medication from any other position for the purpose of controlling pain. The only exceptions are if it is prescribed when I am admitted to a hospital or referred to another physician specifically for treatment of my pain.
- Only **one physician** is to prescribe **all** narcotic type medication at any given time. I will receive all controlled substance medication from one pharmacy if possible
- If I notice signs of any allergic reaction or withdrawal, I notify my doctor by phone and make an appointment as soon as possible.
- When my prescription for controlled substances have been written, I must review the total amounts to be dispensed and make sure I will have enough until my next follow up appointment.
- I will not stockpile medication and will dispose of any expired medication.

Refills of controlled substance medication:

- Refills will be made only during regular office hours 9:00 to 5:00 Monday through Friday, in person during a scheduled office visit.
- Refills will not be made on holidays, Friday afternoons, weekends or at night.
- Phone in refills for controlled substances will not be made.
- I will call at least 24 hours ahead if I need assistance with a medication.
- Refills will not be made in an “emergency”, such as on Friday afternoon.

I understand that if I violate any of the above conditions, that my controlled substance prescriptions and/or treatment may be terminated immediately. If the violation involves obtaining controlled substances another individual, I may also be reported to my primary physician, local medical facilities and other authorities.

I have been fully informed by my doctor about psychological dependence (addiction) potential of controlled substances. All narcotic drugs are habituating and create tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control over a time. If I am taking potent medication for several weeks, I know I will develop a tolerance. If narcotic medication is stopped abruptly, Physical symptoms of withdrawal will develop including the possibility of tremors, sweats, nausea and diarrhea. I must taper narcotic medication gradually and only under medical supervision or I may have withdrawal symptoms. Occasionally a short hospitalization maybe necessary in order to discontinue narcotic medication I agree to comply if asked to detoxify my system of narcotic medication to help in the evaluation of my pain

I have read above agreement and have had all questions answered concerning days of controlled medications in my pain treatment program.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

PainCare
OF SILICON VALLEY
www.paincareofsiliconvalley.com

Medical Records Release Authorization

Signature needed only

To: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Patient Name: _____

Date of Birth: _____ **Age:** _____ **SSN#:** _____

Records Requested:

- ☐ All Medical Records from: _____
- ☐ Recent MRI and X-ray reports
- ☐ Recent Progress notes
- ☐ Evaluation

Please provide medical records on/before: _____

I hereby authorize you, the above addressed physician, hospital or medical facility to release medical records or the information listed above to:

Justin Lo, MD
Raymond Hsieh, MD
Jonelon Tsang, MD
Tanzina Khan, MD
Steven Wang, MD

Please send or fax records to:

Pain Care of Silicon Valley
2101 Forest Avenue Suite. #220A
San Jose, CA 95128
FAX: (408) 295-8061
OFFICE: (408)295-8628

_____ _____
Patient Signature/Guardian Date

Patient/Guardian Name: _____

PainCare
OF SILICON VALLEY
www.paincareofsiliconvalley.com

2101 Forest Avenue Suite# 220A
San Jose, CA 95128

Phone: (408) 295-8628
Fax: (408) 295-8061

OBAMACARE/Covered California Insurance Responsibility

I hereby acknowledge that I am fully aware that it is my responsibility as the patient to find out whether my insurance is part of the Obamacare/Covered California insurance plan or not. I am aware that my doctor is not contracted and does not accept this insurance plans and that I will be fully responsible for all the cost incurred from office visits and treatments done by the doctor if I have Obamacare/Covered California insurance. I agree to check with my insurance as to what kind of insurance plan I have and understand that it is it is my responsibility alone to confirm my insurance plan type. If I do see the doctor despite having the Obamacare/Covered California insurance, then I know I am fully responsible for all cost incurred from office visits and treatments.

_____ _____

Patient Name (Printed) Date

_____

Patient Signature

_____

Witness Signature

PainCare
OF SILICON VALLEY
www.paincareofsiliconvalley.com

2101 Forest Avenue Suite# 220A
San Jose, CA 95128

Phone: (408) 295-8628
Fax: (408) 295-8061

NOTICE

All patients agree to a $25.00 service charge for any and all preauthorization forms, peer to peer review, phone discussions, and any other forms that are being requested for the physician to be filled out.

_____ _____

Name Date