Patient Registration

(Please Print)

INT-4535 rev11/16

PATIENT INFORMATION

Please present your insurance card at each visit.

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City, State) (Zip Code)

(Phone Number) (Cell Phone Number)

(E-mail Address) (Date of Birth)

(Sex) (Marital Status) (Social Security Number)

(Employer Name)

(Employer Address)

(Employer City, State) (Zip Code)

(Employer Phone Number)

(Primary Physician)

(Emergency Contact Name)

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black, African American ☐ Native Hawaiian, Other Pacific Islander ☐ White ☐ Unknown ☐ Declined

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Declined

LANGUAGE: ☐ English ☐ Spanish ☐ French ☐ German ☐ Chinese ☐ Other_____

(Patient's Occupation)

(Emergency Phone Number) (Relationship to Patient)

GUARANTOR INFORMATION (If guarantor is the same as patient, omit this section.)

(First Name) (Middle Initial) (Last Name)

(Street Address)

(City, State) (Zip Code)

(Phone Number) (Marital Status)

(Social Security Number) (Date of Birth)

(Employer Name)

(Employer Address)

(Employer City, State) (Zip Code)

(Employer Phone Number)

(Cell Phone Number)

INSURANCE INFORMATION (SUBSCRIBER)

PRIMARY INSURANCE_____

Address_____ City/State_____ Zip_____

Who holds insurance _____ Birthdate_____

Relationship to Patient_____ Policy # _____ Group # _____

Employer_____ SS#_____ Work Phone_____

SECONDARY INSURANCE_____

Address_____ City/State_____ Zip_____

Who holds insurance _____ Birthdate_____

Relationship to Patient_____ Policy # _____ Group # _____

Employer_____ SS#_____ Work Phone_____

HOW WERE YOU REFERRED TO US?

(Please check how you were referred to our clinic.)

☐ Insurance ☐ Radio ☐ Print Ad (newspaper, magazine)
☐ Family/Friend ☐ TV ☐ Physician_____
☐ Billboard ☐ Internet ☐ Other_____

ADVANCED DIRECTIVE / LIVING

Would you like information regarding Advanced Directives?

☐ Yes ☐ No

Please be advised that we will initiate CPR and dial 911 when a patient is in distress.

Signature _____ **Date** _____

What is the best phone number to contact you? _____

INTEGRIS
Pain Management

New Patient Information Sheet (Please Print)

Last Name: _____ First Name: _____ Date of Birth: _____

New Patient Medical History

Height: _____ Weight: _____

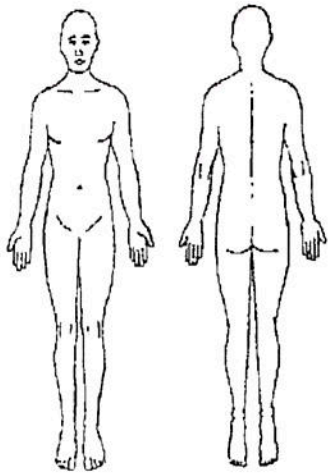
What is your main problem for which you are seeking treatment? _____

When did pain start? _____ Year/Month

Onset of Pain: [ ] Injury at work [ ] Injury not at work [ ] Motor vehicle accident [ ] Illness, non-injury

[ ] Other _____

Where is pain located:



What is your pain score:

Pain typically at (0-10): _____

Pain at best (0-10): _____

Pain at worst (0-10): _____

Is your pain [ ] Constant or [ ] Intermittent

Quality of pain:

Burning	[ ] Yes	[ ] No		Numbing	[ ] Yes	[ ] No	
Tingling	[ ] Yes	[ ] No		Aching	[ ] Yes	[ ] No	
Tender	[ ] Yes	[ ] No		Cool	[ ] Yes	[ ] No	
Throbbing	[ ] Yes	[ ] No		Other: _____			
				Stinging	[ ] Yes	[ ] No	
				Spasm	[ ] Yes	[ ] No	
				Stabbing	[ ] Yes	[ ] No	

I have weakness in my: [ ] None

[ ] Upper extremities [ ] Lower extremities [ ] Dropping objects [ ] Falling

[ ] Others _____

Factors that increase pain:

[ ] Lying down [ ] Sitting

[ ] Lifting [ ] Walking

[ ] Standing [ ] Position of limb

[ ] Coughing/Sneezing [ ] Cold

[ ] Others _____

Factors that decrease pain:

[ ] Analgesics [ ] Physical Therapy

[ ] Heat [ ] Position change

[ ] Elevation of limb

[ ] Rest [ ] Massage

[ ] Others _____

Are there associated swelling or color changes? [ ] Yes [ ] No

If yes, explain: _____

Is there bowel dysfunction [ ] Yes [ ] No Is there bladder dysfunction [ ] Yes [ ] No

If yes, explain: _____

INTEGRIS
Pain Management

New Patient Information Sheet (Please Print)

Last Name: _____ First Name: _____ Date of Birth: _____

What is your goal of treatment?

[ ] Go to work full time
[ ] Go to work part time
[ ] Perform household chores
[ ] Do yard work or shopping
[ ] Socialize with friends
[ ] Exercise
[ ] Participate in recreational activities
[ ] Others _____

Do you have a durable power of attorney or living will? [ ] Yes [ ] No [ ] If yes, has it been activated? [ ] Yes [ ] No
Explain: _____

Do you walk? [ ] Steady [ ] Smooth [ ] by Cane
[ ] by Walker [ ] by Wheelchair [ ] Others _____

Previous Pain Treatment:

Treatments	For how long Was the Treatment	No Relief	Moderate Relief (lasted for?)	Excellent Relief (lasted for?)
Physical Therapy				
Massage				
Chiropractor				
Acupuncture				
Injections/Nerve Blocks (what kind, when)				
TENs				
Surgeries (what kind, when)				
Others				

Do you have sleep difficulty [ ] Yes [ ] No
Have you been diagnosed with Cancer? [ ] Yes [ ] No

NEW PATIENT PAST MEDICAL HISTORY:

Seizure Disorders: [ ] Yes [ ] No _____
Stroke: [ ] Yes [ ] No _____
Bleeding Disorders: [ ] Yes [ ] No _____
GI Disorder/Peptic Ulcer: [ ] Yes [ ] No _____
High Blood Pressure: [ ] Yes [ ] No _____
Heart Disease: [ ] Yes [ ] No _____
Lung Disease: [ ] Yes [ ] No _____
Liver Disease: [ ] Yes [ ] No _____
Bladder/Kidney Problems: [ ] Yes [ ] No _____
Glaucoma: [ ] Yes [ ] No _____
Diabetes: [ ] Yes [ ] No _____
Arthritis: [ ] Yes [ ] No _____
Asthma: [ ] Yes [ ] No _____
Drug Allergies: [ ] Yes [ ] No If yes, what are they and explain:

Anxiety: [ ] Yes [ ] No _____
Depression: [ ] Yes [ ] No _____
Osteoporosis: [ ] Yes [ ] No _____
Infectious Disease: (HIV, AIDS, HEP A, HEP B, HEP C, TB)
[ ] Yes [ ] No _____
Prostate/Gynecological Problems:
[ ] Yes [ ] No _____
Sexual Dysfunction: [ ] Yes [ ] No _____
Pregnant or Planning Pregnancy:
[ ] Yes [ ] No _____
Cancer: [ ] Yes [ ] No _____
Thyroid Disease: [ ] Yes [ ] No _____
Others: _____

Name of drug: _____ Associated side effect: _____

Name of drug: _____ Associated side effect: _____

Name of drug: _____ Associated side effect: _____

Name of drug: _____ Associated side effect: _____

INTEGRIS
Pain Management

New Patient Information Sheet (Please Print)

Last Name:_____ First Name:_____ Date of Birth:_____

Medications You Have Taken In the Past for Pain

Prior Pain Medications (Please check the ones you took in the past for pain treatment):

[ ] Codeine
[ ] Aspirin
[ ] Demerol
[ ] Celebrex
[ ] Darvocet/Propoxyphene
[ ] Motrin
[ ] Tramadol/Ultracet
[ ] Naproxen
[ ] Dilaudid (Hydromorphine)
[ ] Mobic
[ ] Fentanyl (Duragesic)
[ ] Diclofenac
[ ] Hydrocodone (Vicodin, Norco)
[ ] Toradol
[ ] Levorphanol
[ ] Tylenol
[ ] Methadone
[ ] Baclofen
[ ] Morphine/MS Contin/Avinza/Kadian
[ ] Flexeril
[ ] Oxycodone (Percocet)
[ ] Robaxin
[ ] Soma
[ ] Others _____
_____
_____

Antidepressants/Anticonvulsants/Sedatives (Please check the ones you took in the past):

[ ] Lexapro
[ ] Klonopin/Clonazepam
[ ] Paxil
[ ] Valium/Diazepam
[ ] Prozac
[ ] Restoril/Temazepam
[ ] Zoloft
[ ] Ativan/Lorazepam
[ ] Cymbalta
[ ] Xanax/Alprazolam
[ ] Lyrica
[ ] Neurontin/Gabapentin
[ ] Others _____
_____

Medications You Are Currently Taking

(Please Include All Medications:)

Name of Medications	Dose (Mg)	Frequency (per day)	Route	Start Date
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	
		1 2 3 4	PO Patch Nasal	

INTEGRIS

Authorization to Use or Share Protected Health Information (PHI)

*Patient Name: _____ Medical Record #:_____

Patient Address: _____ Social Security #:_____

*Date of Birth: _____ Patient Phone #:_____

*I hereby authorize_____
Name of Person/Organization Disclosing PHI

To release the following information to Person/Organization Receiving PHI:

*Name, Address, Phone, and Fax	*Relationship	*Purpose

***Information to be shared:**

__ Records for dates of service between _____ and _____
__ Psychotherapy Notes (if checking this box, no other boxes may be checked)
__ Entire Medical Record (includes all records except Psychotherapy Notes)
__ Pertinent Information
__ Mental Health Records
__ STD Records
__ HIV Records
__ Substance Abuse Records
__ Billing Information

Other: _____

The information may be disclosed for the following purposes(s) only:
__ Insurance __ Continued Treatment __ Legal __ At my or my representative's request

Other:_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.

- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:

_____

* _____
Signature of Patient or Legal Representative

* _____
Date

* _____
Print Patient or Legal Representative

* _____
Expiration date (if longer than one year from date of signature or no event is indicated)

* _____
Description of Legal Representative's Authority

**Required field*

(INTERNAL USE ONLY)

1) Number of pages released: _____

2) If releasing records other than what is requested on the authorization, please specify reason below:

_____

_____

Specific documentation released:

a. Pertinent Only ____

b. Other _____

3) Staff initials: ____

4) Verification of authorized receiver:

a. License ____
b. Photo ID ____
c. Other _____

5) Authorized Receiver:

a. Name: _____

b. Signature: _____ Date: _____

Title

Instructions for ……..

1. Indicate patient name and date of birth.
2. OPTIONAL: Indicate Medical Record # and/or Social Security #.
3. Indicate the name of person/organization disclosing PHI.
4. Indicate the name and address of person/organization receiving PHI.

Information to be shared:

1. Check the appropriate box.
2. If the information to be shard is not listed, check the "other" box and indicate what information is to be shared in the space provided.
   a. If billing information is shared, indicate which billing information is requested. If all billing information is requested, just check the box.
   b. If psychotherapy notes are requested, no other information can be shared. A separate Authorization must be completed for additional information

Purpose for disclosing information:

1. Check the appropriate box.
2. If the purpose is not listed, check the "other" box and indicate the purpose in the space provided.

Expiration Date:

1. Unless otherwise indicated at the bottom of the form, the expiration date is one year from the date of the patient's signature or upon the occurrence **or** an event chosen by the individual.
   a. If the patient chooses an event, list the event in the space provided.
   b. If the patient chooses to make the expiration date longer than one3 year, indicate in the space provided at the bottom of the form.

Signature:

1. Obtain the signature of the patient or Legal Representative
2. If a Legal Representative signs the form, indicate the description of the Legal Representative's authority.

Date:

1. The date is the date the form is signed.

INTEGRIS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices describes how the INTEGRIS owned medical clinics, retail pharmacies, outpatient service providers and the individual members of their professional staff may use and disclose your medical information and how you can get access to this information. Please review the Notice carefully. If you have any questions about the Notice, you should call the facility where you were treated or you may contact the INTEGRIS Health Corporate Compliance and Privacy Officer at (405) 951-4887 (or toll free at 1-877-805-9681).

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: A complete copy of the Facility's Notice of Privacy Practices is posted in the Facility and individual copies are available upon request. By signing below you acknowledge that you have received a copy of the Facility's Notice of Privacy Practices.

_____ Date: _____
Signature of Patient

IF PATIENT IS A MINOR OR INCOMPETENT: I hereby acknowledge that I have received a copy of the Facility's Notice of Privacy Practices on behalf of the patient.

_____ Date: _____
Signature of Person Authorized to Consent for Patient

_____
Relationship to Patient