

Pain Management



206 E. Jericho Turnpike, Huntington Station, NY 11746

Attention:

If you are a new patient,
(your first time here)
please fill out the next 3
pages. If you are a returning
patient, please go to page 4.

Thank you



206 E. Jericho Turnpike, Huntington Station, NY 11746

Patient Personal Information

Date:

Marital Status: Single Married Widowed

Sex: Male Female

Name: _____

Home Phone: _____

Address: _____

Work Phone: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Email Address: _____

Pharmacy: _____

Employer: _____

SS #: _____

Address: _____

Primary Care Physician: _____

Phone: _____

Address/Phone: _____

Referring Doctor: _____

Primary Insurance Company:

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Date of Birth: _____ SSN#: _____

Identification #: _____ Group ID: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance Company:

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Date of Birth: _____ SSN#: _____

Identification #: _____ Group ID: _____

Relationship to Patient: _____ Employer: _____

Accident Information:

Is condition due to an accident? Yes No Date: _____

Type of Accident: Auto Work Home Other: _____

Assignment and Release:

I hereby authorize the physician(s) of Orthopedic Spine Care of Long Island, PC, to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependent for purposes of review, investigation or evaluation of claims.

I authorize payment of medical benefits to the physician(s).

Patient or Authorized Signature: _____

Physician's Signature: _____

In case of denial or termination of benefits, I the undersigned, understand that I am responsible for payment in full for services rendered.

Patient or Authorized Signature: _____ **Date:** _____

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa, Mastercard, Discover and American Express
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim. If we later receive a check from your insurer, and your account is paid in full, we will refund any overpayment to you.
3. We have made prior arrangements with some insurance companies and other health plans to accept an assignment of benefits. We will bill them directly, but you are required to pay your co-insurance and deductible at the time of your visit.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. When you receive that payment you will be responsible to forward to us the difference between what was paid by you at the time the service was rendered and what was billed to your insurance carrier.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance.
7. If you miss an appointment without calling 24 hours in advance to cancel that appointment, you will be charged \$100, barring any unusual circumstances. This charge is allowed by your insurance carrier and will not be billed to them.

I have read and understand the practice’s financial policy and I agree to be bound by these terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party, if minor)

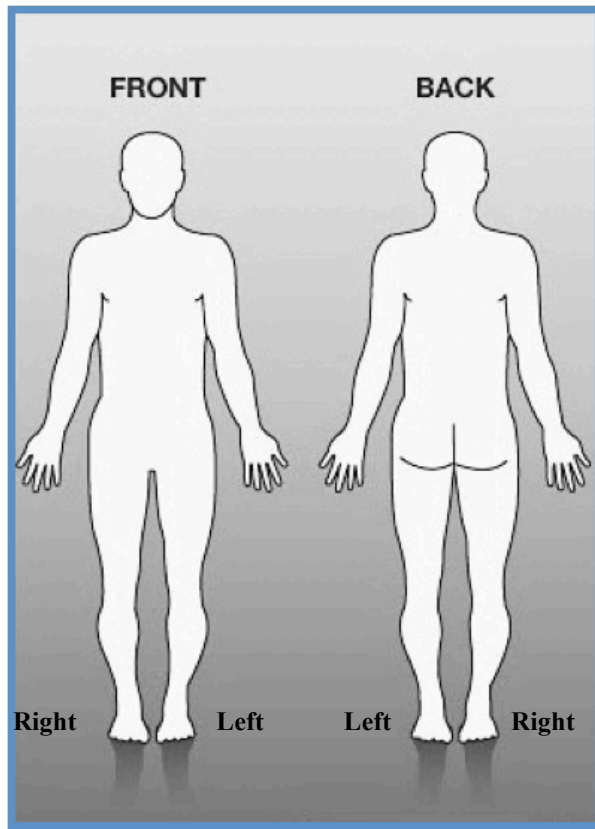
Date

Please print the name of the patient

Name _____ DOB _____ Age _____ Sex _____
 Weight _____ Height _____
 Referred by _____
 CC: _____

About Your Pain

On the drawings, please mark the areas of your body where you feel the pain.



Please mark an "X" on your body where you feel the pain at its worst.

For what reason are you referring to our office?

HPI:

1. When did the pain start? _____
2. Did your pain develop: Suddenly or Gradually?
3. Since your problem has begun, is the pain: Increasing Decreasing Not Changed

4. Were there any events that incited your pain?

- Lifting Twisting Fall Bending Pulling
- No apparent cause Work injury Sport injury
- Other _____

5. Please describe your pain. Place a circle in the column that represents the degree to which you feel that type of pain.

None = 0, Mild = 1, Moderate = 2, Severe = 3

Throbbing	0	1	2	3
Shooting	0	1	2	3
Stabbing	0	1	2	3
Sharp	0	1	2	3
Cramping	0	1	2	3
Gnawing	0	1	2	3
Hot-Burning	0	1	2	3
Aching	0	1	2	3
Heavy	0	1	2	3
Tender	0	1	2	3
Splitting	0	1	2	3
Tiring-Exhausting	0	1	2	3
Sickening	0	1	2	3
Fearful	0	1	2	3
Punishing-Cruel	0	1	2	3

6. Please mark below, how bad your pain in NOW



7. Please, evaluate the intensity of your total pain experience. Please a circle corresponding to your pain.

- 0 No Pain 1 Mild 2 Discomforting 3 Distressing 4 Horrible 5 Excruciating

- 8. Does your pain awaken you from sleep? YES NO
- 9. Does the area of your pain ever change color? YES NO
- 10. Is there area of your pain sensitive to soft touch or clothing? YES NO
- 11. Have you ever been hospitalized for your pain problem? YES NO
- 12. Have you ever had surgery for this problem? YES NO

If yes, please describe:

Medications you have tried before for pain:

13. Do you experience weakness?

If yes, where?

- 14. How often is the pain present?** Constant Frequent Occasional Rare

15. What makes the pain increase (+) or decrease (-)?

Standing____ Walking____ Sitting____ Manipulations____
 Traction____ Bending forward____ Bending backward____ Physical Therapy____
 Heat____ Cold____ Weather changes____ Bed rest____
 Injections____ Stimulation/Trials____ Acupuncture/Tens Units____
 Other, please explain

16. Circle the numbers below that best describe how pain has interfered with your daily functioning:

	Does Not Interfere ----- Completely Interferes				
General Activity	1	2	3	4	5
Mood	1	2	3	4	5
Walking Ability	1	2	3	4	5
Normal Work Routine	1	2	3	4	5
Relations With Other People	1	2	3	4	5
Sleep	1	2	3	4	5
Enjoyment of Life	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Appetite	1	2	3	4	5

17. Have you had any of these to help with your pain?

Procedure	Yes	No	When?
X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	
CT-Scan	<input type="checkbox"/>	<input type="checkbox"/>	
MRI	<input type="checkbox"/>	<input type="checkbox"/>	
EMG	<input type="checkbox"/>	<input type="checkbox"/>	
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	
Discogram	<input type="checkbox"/>	<input type="checkbox"/>	

18. What types of other doctors have you seen for this condition?

19. Do you have any additional information that would be helpful in understanding your problem?

About your health

1. Please check if you experience any of the following symptoms:

Symptom	Yes	No	Comments
Recent significant weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Recent significant weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	
Increased fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulties hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
History of heart attack	<input type="checkbox"/>	<input type="checkbox"/>	

Irregular heart beat/palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
High level of stress/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
History of tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea/bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach pain/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty voiding/bladder incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	
Joint pains or swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	
Are you pregnant or do you think you might be?	<input type="checkbox"/>	<input type="checkbox"/>	

2. Please circle any of the following medical conditions that you have.

Diabetes	Angina	Heart Attack	Thyroid Disease	Pacemaker	High Blood Pressure	Stroke
Asthma	Sleep Apnea	Artificial Joints	Bronchitis	Cancer	Emphysema	Arthritis
Kidney Disease	Liver Disease	Seizure Disorder	Stomach Ulcers	Anemia	Hiatal Hernia	

Please list here if you have other medical problems.

3. Have you had any recent infections or hospitalizations? Yes No

If yes, please describe and list dates.

4. List surgeries you have had including approximate years.

5. Have you had general anesthesia before? Yes No

If yes, were there any problems from it? _____

6. List medications you currently take (include herbal remedies and blood thinners).

Name	Dosage	Name	Dosage

7. Are you allergic to or had any bad reactions from the following?

Medication	Yes	No
Local anesthetics (novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Other:		

8. Are there any medical problems running in your family? Please indicate mother or father side.

9. About your social history. Please mark all which apply.

<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Married	<input type="checkbox"/> Student
<input type="checkbox"/> Employed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired	<input type="checkbox"/> Disability/Work Comp	

Occupation _____

Do you have any lawsuits pending regarding your pain? Yes No

Who do you live with? _____

Do you have any children? (how many) _____

Do you exercise? Daily Weekly Monthly Never

What type of exercise do you do? _____

Do you have a history of substance abuse? Yes No

If yes, what _____

Do you currently smoke? No Yes _____ packs per day for _____ years

Did you quit smoking? <1 year >1 year <5 years <10 years

Do you drink alcohol? No Yes Daily 1-2x per week 1-2x per month

PATIENT SIGNATURE _____ DATE _____

REVIEWED BY _____ MD, DATE _____

Patient Contract for Using Opioid Pain Medication in Pain

This is an agreement between _____ (the patient) and Orthopedic Spine Care of Long Island (OSCLI) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of pain.

Opioid and Controlled Substances Agreement and Informed Consent:

Opioid medications are used judiciously in the treatment of benign or malignant pain conditions. The following is an agreement and explanation of issues related to treatment of painful disorders through the use of opioid medications and/or other controlled substances. These medications include but are not limited to morphine (e.g. MS Contin, Kadian, MS IR), oxycodone (e.g. Percocet, Oxycontin, Roxicodone), Hydromorphone (dilaudid), Hydrocodone (e.g. Vicodin, Lortab, Norco), propoxyphene (e.g. Darvocet), fentanyl (e.g. Duragesic patch, Actiq), methadone, codeine (e.g. Tylenol No. 3), benzodiazepines (e.g. Valium, Xanax), stimulants (e.g. Adderall, Ritalin), Barbiturates (e.g. Fioricet, Fiorinel), etc.

Side Effects & Risks:

Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include but are not limited to allergic reactions, sedation, somnolence, respiratory depression (i.e. slow breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, physical dependence, tolerance, addiction, or death.

Caution:

Opioid medications may cause drowsiness. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval of your pain physician while taking these medications. Driving a car or operating dangerous machinery may not be allowed initially until a stable dose of these medications are obtained. Usually, most side effects of opioid use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated if necessary. If decision is made to terminate opioid therapy, a weaning manner rather than abrupt discontinuation of treatment should be exercise to prevent withdrawal symptoms (e.g. increased pain, agitation, nausea, diarrhea...)

The following conditions must be followed and agreed upon as long as the patient is receiving treatment at OSCLI. Noncompliance with any one of these conditions may result in discharge from the practice.

1. OSCLI must be the only source for the medications that were reviewed above. The patient may not obtain these medicines from any other source or physician except when it is explicitly allowed and approved by your OSCLI provider.
2. The patient understands that the treatment goal is to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine benefits of opioid therapy and adjust the dosage accordingly.
3. The patient understands that he/she must take the medications as instructed and prescribed. Any change in dosing must be approved by an OSCLI physician.

4. The patient agrees to use only one pharmacy whose contact information and address the patient would provide to the OSCLI provider. If for any reason another pharmacy is to be used (e.g. unavailability of a certain medicine), the patient should notify OSCLI.

5. **Lost or stolen prescriptions or medications will NOT be replaced.** It is the patient's responsibility to ensure that prescriptions are filled correctly at the pharmacy. If the patient realizes a medication is lost, stolen, or misplaced, a police report must be filed, and the case number should be given to OSCLI.

6. To ensure efficacy of treatment and for monitoring purposes, the patient should keep all recommended appointments.

7. **Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays. If there is a need to change any narcotic prescription a new appointment will be made.**

8. OSCLI has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances.

9. Opioid therapy usually is only part of the overall treatment plan. The patient shall comply with all other treatments as outlined by their physician at OSCLI.

10. **The patient may be asked for urine and/or blood screening tests as well as random pill count. Failure to comply with this results in immediate discharge from the practice.**

11. The patient understands that sharing of medications referred to above with anyone is absolutely forbidden and is against the law.

12. Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results.

13. **Patient agrees that any use of illicit substances (Marijuana, Cocaine, etc.) during treatment is strictly prohibited, and if identified during a urine test it will result in discharge.** The only exception is marijuana used for medicinal purposes and only when prescribed by a US licensed physician.

I, the undersigned, attest that above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with above can result in my discharge from OSCLI.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient Signature

Date

Doctor Signature

Date