REGISTRATION HEALTHCARE PAIN MANAGEMENT

(PLEASE PRINT)

PATIENT INFORMATION

Name____ Sex __Male__Female Soc. Sec.# ____________________
LAST NAME FIRST INITIAL

Address____City__________________State_____________Zip__________

Home Phone ____________________ Cell Phone_____________________ E-Mail__________________________________

Date of Birth ______________________ Marital Status ________________ Work Phone____________________ Ext ___________

Employer ____ Pharmacy ____

Occupation ________________________________ Work Status ____Full time_____ Part time ____ Disability ____ Unemployed

Primary Physician ______________________________________ Phone ____________________________________

Referring Doctor_______________________________________ Phone____________________________________

Emergency Contact (Name & Relationship) ____ Phone ______________________

MEDICAL INSURANCE INFORMATION

Primary Insurance__________________________________ **Name of Insured** (if different from above) ______________________

Address of insured (if different from above) _____________________ Social Sec.__________________ Date of Birth ___________

Secondary Insurance________________________________ **Name of Insured** (if different from above) ______________________

Address of insured (if different from above) _____________________ Social Sec.__________________ Date of Birth ___________

FOR AUTO ACCIDENT/ WORKMAN'S COMP. ACCIDENTS ONLY

My injury is related to ____ Employment (Work) ____ Auto accident ____ Slip and Fall Injury (involving lawsuit) _______________

Date of injury________________ Dates unable to work: from __________________________to ____________________________

Name of Accident Insurance ____

Address of Insurance ____ Phone # __________________________

Claim Adjustor _____________________Claim # ___________Lawyer's Name_________________________ Phone ____________

ASSIGNMENT AND RELEASE

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I assign directly to ***HealthCare Pain Management/ Dr. del Valle*** all insurance benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I certify that this information is true and correct.

____

Responsible Party Signature DATE

Healthcare Pain Management

Name: ____ Age: ____ Sex: ____ Height: ____ Weight: ____

Recent Blood Pressure _____________

Pharmacy: ______________________________________ Pharmacy Phone: ____________

Medical Questionnaire

Reason for this Consultation (WHERE IS YOUR PAIN?) ____

Medical Conditions: (Pls. check those that apply to you and specify if needed)

__ Hypertension
__ Diabetes
__ Heart Attack/Chest Pain
__ Heart Failure/Other Heart Condition
__ Heart Rhythm Problems
__ Mitral Valve Prolapse
__ Use of a Pacemaker
__ Hypercholesterolemia (Cholesterol)
__ Stroke/TIA
__ Seizure Disorder
__ Bleeding Disorder
__ Enlarged Prostate
__ HIV
__ COPD
__ Asthma
__ Sleep Apnea Do you use CPAP? __ Yes __No

__ Psoriasis
__ GERD/Gastritis
__ Peptic Ulcer Disease
__ Hepatitis/Liver Disease
__ Diverticulitis
__ Kidney Problems/Dialysis
__ Bladder/Bowel Incontinence
__ Hearing Problems
__ Anxiety/Panic Attacks
__ Depression
__ Migraine
__ Thyroid Condition (Hyperthyroidism)
__ Thyroid Condition (Hypothyroidism)
__ Are You Pregnant?
__ Cancer (what kind) _______________
__COVID19 (when) _____________

Other Medical Condition (specify): ____

Date of last COLONOSCOPY _________________ RESULT: NORMAL ☐ YES ☐ NO
Date of last MAMMOGRAM _________________ RESULT: NORMAL ☐ YES ☐ NO
Date of last PAP SMEAR ____________________ RESULT: NORMAL ☐ YES ☐ NO

Surgical History: List **ALL** surgeries **since you were born like Tonsillectomy, Appendectomy, Hernia, Cataract, Cosmetic surgery, etc.**)

____
____
____

Patient's NAME: ____________________________

Revised 5/2020

Medications/Dosage: (include over-the-counter medications like Vitamins, Herbal Medicine, Advil, Aleve, Aspirin, etc.)

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____
____

Allergies: List **ALL** medications/substances that you are allergic to:

____

Family History: Is your father alive? ☐ YES ☐ NO List all medical problems ____________________
Is your mother alive? ☐ YES ☐ NO List all medical problems ____________________

As best as you know, do any of your brothers/sisters/cousins/relatives/etc currently suffer from or have died from any medical/psychiatric conditions? ☐ YES ☐ NO
If YES to above, pls specify: ____

Social History:

Do you smoke? ☐ YES ☐ NO
If YES, how many packs a day ____________ How many years have you been smoking? _______
If NO, date when you quit smoking ___________ How many packs did you smoke per day? _______
For how many years did you smoke before you quit smoking? _________

Do you drink alcohol? ☐ YES ☐ NO If Yes, What kind? ☐ Beer ☐ Wine ☐ Liquor
Number of drinks: _______ ___/Day ____ /Week ___ /Month ___/Year

Any history of Substance/Drug Abuse? ☐ YES ☐ NO; if Yes, what kind ___________________

Miscellaneous:

Have you seen any other doctors/therapists/chiropractors/etc. for your current pain problem(s) before coming to this office? ☐ YES ☐ NO If yes, pls specify doctor's/therapist's names, specialties, treatments rendered and approximate dates:

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Have you ever been seen and treated by a Psychiatrist? ☐ YES ☐ NO If yes, for what condition?

____

Have you ever been injured before (car accident, slip & fall, assault, etc)? ☐ YES ☐ NO
If yes, specify condition and approximate date:

____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: ____ Date: ___________________

If translated, signature of translator: ____________________________ Date: ___________________