

New Patient Paperwork

Dear Patients,

In order for our staff to better serve you. We ask that you please fill out our new patient paperwork packet completely. The more information you provide us the better we can assist your needs. Once completed please return this packet to one of our offices with any **paper** MRI, CT, X-Ray reports. **Do not** bring any CDs because we can't read them. If you do not have any reports available to you, please inform our office where you had the test done so we can request them and have them here for you first initial visit. Once packet is turned into our office then we can provide you with appointment. Feel free to fax or mail your packet in. We look forward in taking care of your healthcare needs.

-The Staff of Dr. Amy Pearson

2701 Highway 17 South, Suite 1B
Richmond Hill, Ga 31324
Phone 912.756.3004
Fax 912.756.5921

Coastal Anesthesia and Pain Relief Specialists, PC
Registration (Please print clearly)

Date Home phone number

Patient name

Responsible party (if a minor)

Street address City State Zip

Sex M F Marital Status: single married separated divorced

Age Birth date

Patient employed by Occupation

Spouse (or responsible party) name Birth date

Spouse's occupation Business phone

Spouse's business name and address

Who is responsible for this account? Relationship to patient

Social Security number Spouse's SSN

Do you have medical insurance? yes no If yes.....

Primary insurer name Contract # Group # Subscriber #

Secondary insurer (if any) Contract # Group # Subscriber #

Do you have Medicare Medicaid If yes..... Claim ID#

In case of an emergency, who should be notified? Phone #

Whom may we thank for your referral to our practice?

I, the undersigned, have insurance coverage with (insurance company name) and assign directly to Coastal Anesthesia & Pain Relief Specialists, PC all medical benefits, if any, otherwise payable to me for services rendered. 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 payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coastal Anesthesia and Pain Relief Specialists, PC for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HDFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date

Name _____ Date _____

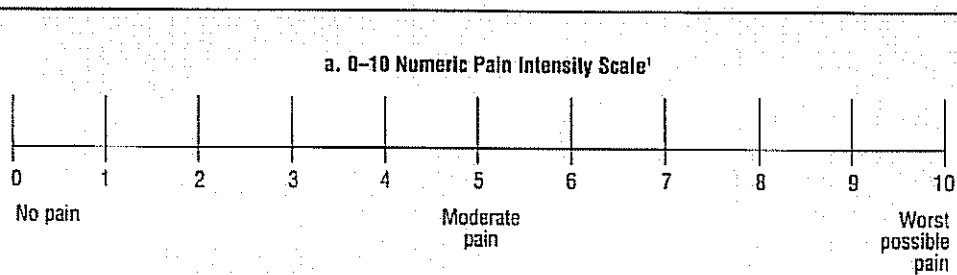
Chief Complaints

- Where is the main location of your *worst* pain?

- What date did your pain begin? _____

- Does your pain *travel* to another part of your body? Yes No If so, where?

- Please indicate your current level of pain *today*, on a 0-10 scale, where 0 is no pain at all, and 10 is the worst pain you can imagine:



- Please check off each line for a description of you chronic pain problem:

<i>Do you have any..</i>	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				

Splitting				
Tiring/Exhausting				
Sickening				
Fearful				
Punishing/Cruel				

• What other symptoms accompany your pain? None weakness (where _____)
numbness (where _____) weight loss problem with bladder function problems with
bowel function trouble sleeping other _____

• If your pain began with an injury, please describe:

• If pain began at work, please describe:

Place of employment when pain began _____

• What makes your pain better? Nothing at all ice weather heat physical activity
distraction medications walking sitting bending forward bending backwards
position (if so, which one? _____) other _____

• What makes your pain worse, or what triggers your pain?

Nothing at all ice weather heat physical activity standing medications walking
bending forward bending backwards sitting stress
position (if so, which one? _____) other _____

• Are you frequently awakened by pain at night? Yes No

If so, how often? 1-2 times 3-4 times 5-6 times more than 6 times

• On average, how many hours of sleep do you get at night?

1-2 2-4 4-6 6-8 more than 8 hours

• Are you presently involved in a lawsuit because of your pain? Yes No

If yes, please explain: _____

Were you treated in a *Pain Clinic* before? Yes No

If so, when and where:

• Please indicate if you have had previous treatments for your pain:

- physical therapy (when? _____) TENS unit surgical intervention/type _____
 psychological Techniques (if so, which ones) relaxation training biofeedback
 imagery distraction therapy
 injections(s): into muscles into a joint epidural steroid nerve block
 other _____

Alternative Medical Treatments

- chiropractor acupuncture homeopathy hypnotism
 herbal remedies(which ones? _____)

- other _____

Past Medical History

Neurological

- seizure disorder
 stroke
 other _____

Cardiac

- heart attack
 high blood pressure
 heart failure
 pacemaker
 rheumatic fever
 other _____

General

- diabetes
 blood disease
 easy bleeding
 glaucoma
 eye problems
 bladder infections
 kidney infections
 thyroid disease
 hepatitis
 kidney problems
 cancer _____
 arthritis
 other _____

Pulmonary

- chronic bronchitis
 asthma
 emphysema
 other _____

Gastrointestinal

- stomach ulcers
 colitis
 irritable bowel
 hiatal hernia
 other _____

• If you are a female, is there a chance that you are currently pregnant? Yes No

• Are you currently using blood thinner medication? Yes No

Past Surgical History

<i>Type of Surgery</i>	<i>Date of Surgery</i>	<i>Location of Surgery</i>	<i>Who Performed it?</i>
<input type="checkbox"/> Back Surgery			
<input type="checkbox"/> Neck Surgery			
<input type="checkbox"/> Appendectomy			
<input type="checkbox"/> Gall Bladder			
<input type="checkbox"/> Hysterectomy			
<input type="checkbox"/> Other			

Past Social History

•Do you currently smoke or have you ever smoked? Yes No

If so, how many packs a day? _____ For how long? _____ When did you quit? _____

•Do you drink alcohol? Yes No If so, what type and how much? _____

•Do you or have you ever used recreational drugs? Yes No

If you no longer use recreational drugs, when did you quit? _____ days/months/years (circle one)

Marital Status

married never married divorced/separated widowed

• What previous tests were done for your pain problem?

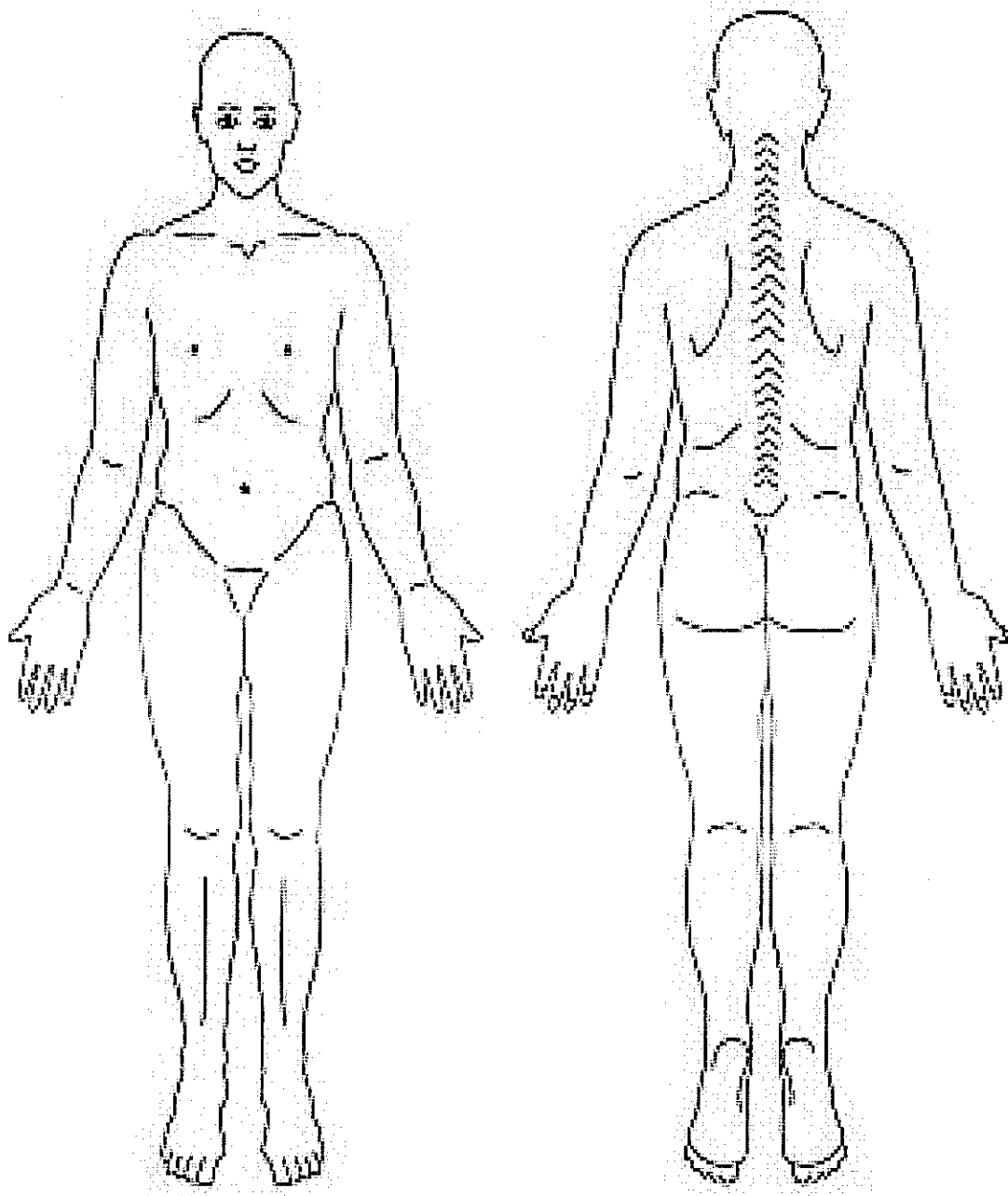
Test	When	Where	Who Ordered It	Results(if known)
X-ray				
Cat Scan				
Bone Scan				
MRI				
EMG				
Other				

If you have taken pain medications in the past, please indicate:

- Relafen Daypro Motrin/Advil Aleve/Naprosyn Celebrex/Vioxx Lodine
- Elavil Desyrel Prozac Ultram Paxil/Zoloft Darvocet
- Lortab Vicodin Demerol Dilaudid Morphine Soma
- Neurontin Flexeril OxyContin Methadone Duragesic Klonopin
- Zanaflex Ms Contin

Other:

- Please shade in your area(s) of pain on the diagrams below:



- Which statement best describes you pain?
 - always present, always the same intensity
 - always present, intensity varies
 - usually present, but have short intervals without pain
 - often present, but have pain free periods lasting one to several hours
 - often present, but I am pain free most of the day
 - occasionally present—have brief pain 1 to several times a day, lasting a few minutes to an hour
 - occasionally present for brief periods, a few seconds to a few minutes
 - rarely present, have pain every few days of weeks

Please check any symptoms you are experiencing:

General

- usual weight _____ lbs
- recent weight change
- generalized weakness
- fatigue
- fever

Skin

- rashes lumps
- itching dryness
- changes in hair
- changes in nails

Head

- headaches
- previous head injury

Eyes

- glaucoma cataracts
- eye pain redness
- visual changes
- glasses/contacts
- excessive tearing
- double vision

Ears

- hearing loss
- ringing in ears
- earaches vertigo
- infections discharge

Nose/Sinuses

- frequent colds
- nasal stuffiness
- sinus problems
- hay fever nosebleeds

Mouth/Throat

- hoarseness sore tongue
- bleeding gums
- frequent sore throats
- poor condition of teeth

Neck

- goiter lumps in neck
- swollen glands

Breasts

- lumps pain
- discharge

Respiratory

- tuberculosis pneumonia
- emphysema bronchitis
- short of breath asthma
- chronic cough
- blood in sputum
- pain on breathing

Cardiac

- heart murmur heart trouble
- rheumatic fever angina
- high blood pressure
- irregular heart beats
- previous heart attacks

Gastrointestinal

- nausea vomiting
- diarrhea constipation
- hepatitis liver problems
- trouble swallowing
- abdominal pain
- heartburn/indigestion
- vomiting blood hemorrhoids
- bleeding from rectum
- change in bowel habits
- food intolerance
- excessive belching
- excessive passing of gas
- gallbladder trouble

Urinary

- urgency hesitancy
- increased frequency
- burning on urination
- blood in urine kidney stones
- frequent urinary tract infections
- trouble "holding your water"

Genito-Reproductive Male

- hernias testicular pain
- decreased sex drive
- problems with erection

Female

- currently pregnant
- abnormal periods
- vaginal discharge
- vaginal pain
- decreased sex

Musculoskeletal

- joint pains gout
- arthritis
- joint stiffness
- muscle aches/pains
- backache

Neurologic

- fainting spells
- seizure disorder
- memory loss
- tremors

Psychiatric

- nervousness
- tension/stress
- mood swings
- depression

Endocrine

- thyroid trouble
- excessive sweating
- diabetes
- excessive thirst
- excessive hunger
- excessive urination

Hematologic

- anemia
- easy bruising/
bleeding
- transfusion
- reaction
- sickle cell
disease

Cancellation / No Show / Missed Appointment Policy

All patients are required to give Coastal Anesthesia & Pain Relief Specialists, PC a 24 hour notice for a cancellation of your scheduled appointment. Failure to do so will result in a charge added to your account that must be paid before we can schedule another appointment. **Your insurance will not pay for this charge.**

Charges will be as follows:

\$35.00 if you do not provide a 24 hour notice for your office visit.

\$50.00 if you do not provide a 24 hour notice for any injection / procedure (including those done in the office)

\$25 returned check

Reminder calls are a courtesy and can not always be provided. It is your responsibility to report for your appointment on the scheduled date and time. Your signature below conveys that you have read and understand our policy regarding missed appointments.

Patient Name Printed

Patient Signature or legally authorized individual signature

Date

COASTAL ANESTHESIA AND PAIN RELIEF SPECIALISTS

Amy Pearson, MD Tommy Hersch, PA-C
2701 Highway 17 Suite 1B
Richmond Hill, Ga 31324
(912) 756-3004

PATIENT/DOCTOR TREATMENT & MEDICATION AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you might be prescribed for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

By signing this agreement you have read, understood, and agreed to these rules:

1. If recommended, I will submit to an evaluation by an addictionologist, which may include a psychiatric evaluation.
2. If I break this agreement, my doctor may stop prescribing these pain control medicines and I may be DISCHARGED from the practice.
3. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
4. I will not use alcohol or ANY ILLEGAL controlled substances, including but not limited to: marijuana, cocaine, methamphetamines, etc.
5. I will not SHARE, SELL, or TRADE my medications with anyone.
6. I will not attempt to obtain any controlled medications, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctors or practice.
7. I will SAFEGUARD my pain medicine from loss or theft. Loss or stolen medicines WILL NOT be replaced.
8. Refills of any prescriptions for pain medicine will be made only during regular office hours. All refill requests must be made FIVE business days in advance. NO REFILLS WILL BE AVAILABLE DURING EVENING, WEEKENDS, OR HOLIDAYS.
9. I understand that I MUST BE SEEN IN THE OFFICE AT LEAST EVERY NINETY DAYS or more often if recommended to request a refill or my refill will be denied until I am seen.
10. I will submit to random urine testing as requested by my doctor to determine compliance with my program of pain control medicine.
11. I will use my medicine at a **rate no greater than the prescribed rate** use of my medicine at a greater rate will result in my being without medicine for a period of time.
12. If at any time I break the law with regards to my pain medicine, I am aware that the appropriate law enforcement department may be notified and my records could be released to them. It is illegal to sell, trade, or share prescription medication. It is illegal to obtain controlled substances from more than one doctor without telling the other doctor. It is illegal to alter or fabricate prescriptions.

13. I understand there is a small risk that opioid addiction could occur. This means I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.
14. I understand that if I am pregnant or become pregnant while taking opioid medications, my child could become physically dependant on opioid medications, and withdrawals can be life-threatening for a baby.
15. **While interacting with the staff of Coastal Pain Relief Specialists, my behavior will be becoming of a rationale, reasonable, and well mannered person. The staff is expected to respond in an equally courteous and respectful way. If the interactions between the staff and myself are deemed to be repeatedly rude or confrontational, Dr. Pearson will request for me to seek treatment at another facility. Please initial _____**
16. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment and medications have been adequately answered. A copy of the Agreement has been given to me.

This Agreement has been reviewed and signed on this _____ day of _____ in the year of _____.

Patient Name: _____ Patient Signature: _____

Witnessed by: _____ Doctor Signature: _____

Patient Consent for Use/Disclosure of Health Care Information

Patient's name: _____ Date of Birth: _____

SSN: _____ Previous name: _____

I understand that the patient's health information is private and confidential. I understand that **Coastal Anesthesia and Pain Relief Specialists** (further referred in this document as **CAPRS**) work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that **CAPRS** may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

CAPRS has a detailed document called "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

CAPRS may update this "Notice of Privacy Practices". If I ask, **CAPRS** will provide me with the most current "Notice".

Under the terms of this consent, I can ask **CAPRS** to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations, I understand that **CAPRS** does not have to agree to my request. If **CAPRS** does agree to my request, I understand that **CAPRS** would follow the agreed limits.

I may cancel this consent in writing at any time by doing the following:

Writing, signing, and, dating a letter to **CAPRS**. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care options.

If I revoke this consent, **CAPRS** does not have to provide any further health care to the patient.

My signature below indicates that I have been given the chance to review a current copy of **CAPRS's** "Notice of Privacy Practices". My signature means that I agree to allow **CAPRS** to use and disclose the patient's health information to carry out treatment, payment, and health care options.

Patient or legally authorized individual signature

Date

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc)

Witness