Mt Baker Pain Clinic
Spine & Pain Specialists

Mt Baker Pain Clinic New Patient Registration Form

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth ____/____/_____ Gender _____ Soc. Sec. # _____-_____-_____

Marital Status *(circle one):* Divorced / Married / Separated / Single / Widowed

Home Phone ( )_____ Work ( )_____ Cell ( )_____

Address _____ City _____ State _____ ZIP _____

E-mail _____ Employer _____

Work Status *(circle one):* Full-time / Part-time / Not employed / On active military duty / Student / Retired / Self employed

GUARANTOR'S INFORMATION *SAME AS ABOVE* ☐

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth ____/____/_____ Gender _____ Relationship to patient _____

Home Phone ( )_____ Work ( )_____ Cell ( )_____

Address _____ City _____ State _____ ZIP _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy # _____

Insurance Co. Phone ( ) _____ Group # _____

Subscriber's Name _____ DOB ____/____/____ Relationship _____

Secondary Insurance Co. *(if applicable)* _____ Policy # _____

Insurance Co. Phone ( ) _____ Group # _____

Subscriber's Name _____ DOB ____/____/____ Relationship _____

Work Related? Yes ☐ No ☐ Employer _____ ***Automobile Accident***? Yes ☐ No ☐

Claim Manager Name _____ Date of Injury_____/_____/_____

Claim Manager Phone ( )_____ Extension _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Phone ( )_____ Phone ( ) _____

PHYSICIAN / PHARMACY INFORMATION

Referring Physician _____ Phone ( )_____

Primary Care Physician _____ Phone ( )_____

Pharmacy _____ Phone ( )_____

As far as I know, the information I have provided above is correct.

PATIENT / GUARDIAN SIGNATURE_____ **DATE** _____

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ETHNIC BACKGROUND

RACE: □ *American Indian/Alaska Native* □ *Asian* □ *Black/African American*
□ *White/Caucasian* □ *Native Hawaiian or Other Pacific Island* □ *Other Race* □ *Decline*

ETHNIC GROUP: □ *Hispanic/Latino* □ *Latin American* □ *Mexican* □ *Mexican/American*
□ *Mexican/American Indian* □ *Not Hispanic/Latino* □ *Decline*
PREFERRED LANGUAGE: □ *English* □ *Spanish* □ *Other* _____

****

ASSIGNMENT OF MEDICAL BENEFITS

I, (Printed legal name of primary Insurance holder), _____

assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan to: Mt Baker Pain Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. This may include related drug and/or alcohol abuse treatment, AIDS/HIV, or psychiatric information; including records protected by federal regulations (42 CRF Part 2) as required to qualify for health benefit payment.

I understand that I am financially responsible for all charges incurred from medical treatment at this facility, whether they are paid by my insurance carrier or not, (public assistance recipients exempt). I also understand that all charges are due upon receipt of statement from this facility unless other arrangements are made with the bookkeeping department. If, for any reason, it becomes necessary for this office to engage an attorney or collection agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees and/or collection costs.

IF YOUR INSURANCE COMPANY SENDS PAYMENT TO YOU, AND YOU HAVE A BALANCE DUE AT THIS OFFICE, PLEASE ENDORSE THE CHECK AND FORWARD IT ALONG WITH THE EXPLANATION OF BENEFITS WHEN RECEIVED.

Signed: _____ Date: _____
(Patient or Parent/Guardian)

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HIPAA PRIVACY VERBAL AUTHORIZATION FORM

I hereby give authorization for verbal release of protected health information.

Last: _____ First: _____ Middle: _____

Other names used: _____ Date of Birth: _____ SSN: ___ - ___ - ___

Address: _____

Home Phone: (___) _____ Work: (___) _____ Cell(___) _____

I _____ give my permission to Mt Baker Pain Clinic
Your name

to release information in regards to appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number(s), test results, health care information and treatment to the following participants:

Name of person: _____ Name of person: _____

Relationship to Patient: _____ Relationship to Patient: _____

Exceptions: _____ Exceptions: _____

I understand that:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature (unless otherwise indicated.)
- Unless the purpose of this authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this authorization.
- The information authorized for release may include information which may indicate the presence of a communicable disease or a noncommunicable disease.
- The information authorized for verbal release also may include protected health information related to mental health (RCW 71.05.620)
- The information authorized for verbal release also may include drug/alcohol abuse treatment records (42 CFR Part 2). By signing below, I authorize any such records included in my health information to be release.

_____

Signature of patient / guardian Date

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Patient Payment Policy

Thank you for choosing Mt Baker Pain Clinic as your pain specialist. We are committed to providing you with the highest quality of health care and strive to keep healthcare affordable in our office. As such, we provide this document to ensure your understanding of the payment policies. Please read the following office payment policy carefully and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Payment Policy

- At the time of service, you are required to pay any applicable copay. A $10.00 fee will be assessed to your account for a copay not paid in full at time of service. This fee will be required to be paid prior to your next visit. After your insurance is billed, you are responsible for any remaining balance.
- Payment for service is due in full at the time of service provided you have no insurance.
- We accept cash, check, Visa, and MasterCard. Any returned check is subject to a $35.00 return check fee that will be required to be paid prior to your next visit.
- Unless canceled at least 24 hours in advance, your account will be charged $25.00 for a missed appointment. This fee will be required to be paid prior to your next visit. Two no show or three canceled appointments will result in a discharge from the facility.
- Please note that your insurance company will not cover any of the additional fees listed above.
- Prior to procedures, you must pay a pre-procedure deposit, predetermined by your insurance.
- If you are in need of a payment plan, you can discuss options with the office staff.
- If your account is overdue for longer than 90 days, it may be referred to a collection agency. Payments over 30 days past due from the date of the invoice will include a 10% APR billing fee.

Insurance

As a courtesy, we file your insurance claims. It is your responsibility to notify us of any changes to your insurance coverage. It is your insurance policy. It is your responsibility to know your policy in regards to benefits, maximums, waiting periods, benefit year, and patient responsibility. We will provide information required by your insurance company regarding the treatment provided by us. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays.

_____ _____

Patient name (PRINTED) Date

_____

Patient/Guarantor Signature

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HISTORY AND PHYSICAL (CURRENT AND PAST MEDICAL HISTORY)

NAME: _____ **DATE** _____

DATE OF BIRTH_____**HT**_____**WT**_____**AGE**_____

DRUG ALLERGIES: ( ) NONE

( ) Latex ( ) Iodine

( ) X-ray Contrast
( ) Benadryl

_____
_____
_____
_____
_____

CURRENT MEDICATIONS*: ( ) NONE** ***[Use additional sheet if needed]

( ) Coumadin ( ) Warfarin ( ) Plavix ( ) Lovenox ***List dosage below***

MEDICATION NAME	PRESCRIBING PHYSICIAN	DOSAGE (i.e., mg)	HOW OFTEN

PLEASE INDICATE IF YOU CURRENTLY HAVE OR HAD IN YOUR PAST ANY OF THE FOLLOWING MEDICAL CONDITIONS:

Patient Signature _____ Date_____

CARDIAC
( )Coronary Artery Disease
( )Heart Murmur
( )High Blood Pressure
( )High Cholesterol
( )Congestive Heart Failure
( )Deep Vein Thrombosis
( )Heart Attack
( )Arrhythmia

ENDOCRINE
( )Diabetes Type 1
( )Diabetes 2
( )Hypothyroidism
( )Hyperthyroidism

PULMONARY
( )Asthma
( )Bronchitis
( )COPD
( )Pulm Emboli
( )Pneumonia
( )Sleep Apnea
( )TB

NEUROLOGICAL
( )MS
( )Stroke
( )Migraine Headaches
( )Tension Headaches
( )Seizures

GASTROINTESTINAL
( ) GERD
( ) Irritable Bowel Syndrome
( ) Gall Bladder Disease
( ) Hepatitis A/B/C
( ) Ulcers
( ) Crohn's Disease
( ) Cirrhosis

MENTAL HEALTH HISTORY
( ) Depression
( ) Anxiety
( ) Bipolar

RENAL
( )Renal Failure
( )Kidney Stones
( )UTI's
( )Incontinence

ENT
( )Hay fever
( )Sinus Infections
( )Ear Infections

MUSCULOSKELETAL
( )Fibromyalgia
( )Chronic Fatigue
( )Osteoarthritis
( )Rheumatoid Arthritis
( )Lupus
( )Osteoporosis

HEMATOLOGIC
( )Iron Anemia
( )Taking Blood Thinners

CANCER HISTORY ( ) NONE _____
_____

PRIOR SURGERIES ( ) NONE
_____
_____
_____

OTHER_____
_____

***FAMILY HISTORY / please specify who*:** ( ) High Blood Pressure _____ ( ) Heart Disease_____( )Fibromyalgia_____

( )Heart attack_____ ( )Stroke_____ ( ) Cancer/ what kind? _____ ( )Depression/Anxiety_____

( ) Diabetes/Type 1 or 2_____( ) Bleeding Disorder_____ ( ) Asthma_____ ( ) Thyroid disease_____ ( ) Migraines_____

SOCIAL HISTORY ( ) MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOWED ( ) CHILDREN #_____ **Do you work?** Y / N retired / disabled

TOBACCO Cigarettes / Cigars / Smokeless How many per day? _____ Current Use / Past Use / Never

ALCOHOL Rare / Occasional / Daily / Current Alcoholic / Past Alcoholic / Never

( ) **MARIJUANA** ( ) **COCAINE** ( ) **METH** ( ) **HEROIN** ( ) **CRACK** ( ) **NONE** Current Use / Past Use / Experimented with?

List any COMMUNICABLE DISEASE (ie: Hepatitis, Venereal disease or TB) _____ Current / Past / None

Do you have a **pacemaker**? ☐ NO ☐ YES

Rate your current pain level with 0 being no pain and 10 being the worst possible pain.

1 2 3 4 5 6 7 8 9 10

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Patient Name _____ DOB _____

Date _____

PART A.

Family History of Substance Abuse (parents and siblings):

Alcohol abuse	[ ] NO	[ ] YES
Illegal drug use	[ ] NO	[ ] YES
Prescription drug abuse	[ ] NO	[ ] YES

Personal History of Substance Abuse:

Alcohol abuse	[ ] NO	[ ] YES
Illegal drug use	[ ] NO	[ ] YES
Prescription drug abuse	[ ] NO	[ ] YES

Psychological Disease:

Diagnosis of Attention Deficit Disorder Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ] NO	[ ] YES
Diagnosis of Depression	[ ] NO	[ ] YES

For Office Use Only
TOTAL ____ L / M / H

Other:

Are you age 16-45 years?	[ ] NO	[ ] YES
History of pre-adolescent sexual abuse?	[ ] NO	[ ] YES

PART B. *Choose the ONE description for each item that best describes how many days you have been bothered by each of the following over the past 2 weeks.*

	NONE	SEVERAL	7 OR MORE	NEARLY EVERY DAY
Feeling nervous, anxious, or on edge				
Unable to stop worrying				
Worrying too much about different things				
Problems relaxing				
Feeling restless or unable to sit still				
Feeling irritable or easily annoyed				
Being afraid that something awful might happen				

Patient Signature _____

For Office Use Only
TOTAL ____ L / M / H

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PAIN ASSESSMENT FORM

NAME_____ DATE _____

HISTORY OF PAIN SYMPTOMS:

1. Please check the following symptoms that you have:

   ( ) back pain ( ) leg pain ( ) tingling/numbness in leg ( ) other _____

   ( ) neck pain ( ) arm pain ( ) tingling/numbness in arm ( ) pain radiates - where? _____

2. When did your symptoms begin? _____

3. Are you experiencing any problems controlling your bladder or bowel?

   Bowel: ( ) Yes ( ) No

   Bladder: ( ) Yes ( ) No

4. Is your sleep affected by your pain? ( ) Yes ( ) No

5. What makes your pain better?

   ( ) lying down ( ) sitting ( ) walking ( ) standing ( ) bending ( ) stretching ( ) other_____

6. What makes your pain worse?

   ( ) lying down ( ) sitting ( ) walking ( ) standing ( ) bending ( ) coughing ( )sneezing ( ) twisting--*which direction*? Right / Left / Both
   Other: _____

7. Are you currently working?

   ( ) yes ( ) no, due to pain ( ) retired ( ) disabled

PAST TREATMENT HISTORY:

1. Have you ever had back or neck pain before?

   ( ) yes ( ) no, if so when? _____

2. Have you had back or neck surgery?

   ( ) yes ( ) no, if so when? _____

3. What diagnostic tests have you had related to your current pain?

   ( ) CT Scan ( ) MRI ( ) X-Ray ( ) EMG/NCS

4. Have you had any previous treatments for your pain?

   Injections: ( ) yes ( ) no Were they helpful? ( ) yes ( ) no What kind and When? _____

   Physical Therapy: ( ) yes ( ) no Was it helpful? ( ) yes ( ) no When and By Whom? _____

   What did it consist of? _____

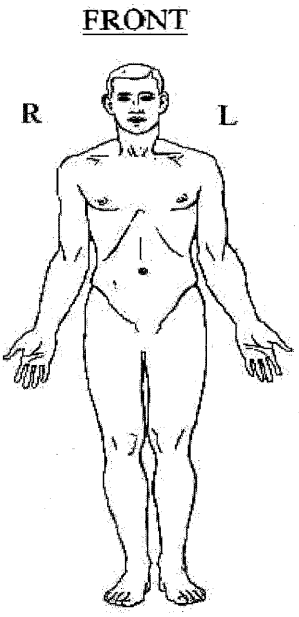
   Chiropractor: ( ) yes ( ) no Was it helpful? ( ) yes ( ) no

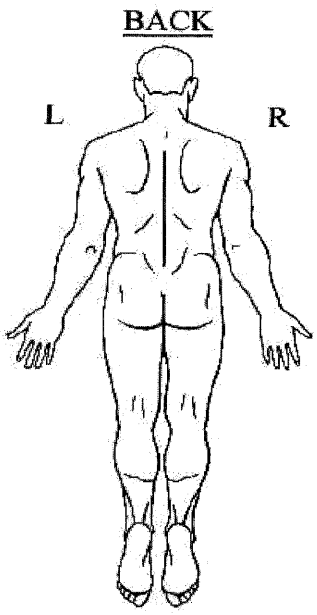
Next Page Please

Acupuncture:	( ) yes ( ) no	Was it helpful?	( ) yes ( ) no
Massage:	( ) yes ( ) no	Was it helpful?	( ) yes ( )
Acetaminophen	( ) yes ( ) no	Was it helpful?	( ) yes ( )
Anti-inflammatory	( ) yes ( ) no	Was it helpful?	( ) yes ( )

Other _____

5. Mark these drawings according to where you hurt.





Please use the scale below to indicate which sensation you are feeling.

/// Stabbing
XXX Burning
+++ Aching
=== Numbness
000 Pins & Needles

Average pain this week _____ / 10
Worst pain this week _____ / 10

Patient Signature _____

Date

_____

Please bring this completed form with you to your appointment. Thanks.

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