NEW PATIENT INFORMATION

Please fill out all fields below. If you have questions feel free to contact our office at 402-614-1999 or by email at info@omahapainphysicians.com.

IDENTIFICATION

Last Name _____ First Name _____

Gender ___Male ___Female DOB ____/____/_____ SSN _____

CONTACT INFORMATION

Address _____ Apt _____

City _____ State _____ ZIP_____

Home Phone ( ) _____-_____ Mobile Phone ( ) _____-_____

E-Mail _____

INSURANCE

Type of Insurance: **[ ]** *Private* **[ ]** *Medicare* **[ ]** *Medicaid* **[ ]** *Worker's Comp* **[ ]** *Auto Insurance*

PRIMARY

Insurance Carrier _____ Policy #_____

Primary Policy Holder Name _____ DOB _____

SECONDARY

Insurance Carrier _____ Policy #_____

Primary Policy Holder Name _____ DOB _____

ADDITIONAL INTAKE INFORMATION

Emergency contact name _____ Phone ( ) _____-_____

Primary Care Physician _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Who referred you / how did you hear about us?_____

List all **current** medications (you may attach an additional sheet if you choose) _____

_____

_____

List surgical history (you may attach an additional sheet if you choose) _____

_____

_____

Name _____

MEDICAL HISTORY

Primary Care Physician _____

Pain Physician's you have seen before _____

List allergies to any drugs/medication? _____

Topical Allergies: [ ] *Latex* [ ] *Iodine* [ ] *Tape* [ ] *IV Contrast*

Alcohol Use: [ ] *Never* [ ] *Social use* [ ] *Daily use* [ ] *Alcoholism (past)* [ ] *Alcoholism (present)*

Tobacco Use: [ ] *Never* [ ] *Former* [ ] *Current* [ ] *Packs per day?*_____ [ ] *How many years?* _____

Illegal Drug Use: [ ] *Never* [ ] *Former* [ ] *Current*

Have you ever abused narcotic or presecription medications?: [ ] *Yes* [ ] *No*

DIAGNOSTIC TESTS & IMAGING

Please let us know if you have had any of the following tests for your pain. If none, leave blank.

MRI of the _____ Year _____

X-Ray of the _____ Year _____

CT Scan of the _____ Year _____

EMG/NCV of the _____ Year _____

Other _____ Year _____

PAIN HISTORY

Where is your worst area of pain located? _____

Does the pain radiate? If so, where? _____

List additional areas of pain: _____

Approximately when did this pain begin? _____

Previous pain medications used for pain complaint? _____

What caused your current pain episode?

[ ] *Motor Vehicle Accident* [ ] *Personal Injury* [ ] *Other* _____

How did your current pain episode begin? [ ] *Gradually* [ ] *Suddenly*

Since your pain began, how has it changed? [ ] *Decreased* [ ] *Increased* [ ] *Stayed the same*

PAIN DESCRIPTION

Check all that describe your pain:

[ ] *Aching* [ ] *Cramping* [ ] *Dull* [ ] *Tingling/Pins & Needles* [ ] *Hot/Burning* [ ] *Numbness*

[ ] *Shock-like* [ ] *Shooting* [ ] *Spasming* [ ] *Squeezing* [ ] *Stabbing/Sharp* [ ] *Throbbing*

[ ] *Tiring/Exhausting*

Name _____

REVIEW OF SYSTEMS

Please check any of the following symptoms that you are experiencing currently.

CONSTITUTIONAL:	☐ Fever ☐ Weight Gain	☐ Chills ☐ Decreased energy	☐ Night sweats ☐ Loss of appetite	☐ Weight loss
HEENT:	☐ Runny Nose ☐ Vision changes	☐ Nose bleeds	☐ Sinus Congestion	☐ Hearing loss
SKIN:	☐ Rash	☐ Non healing skin lesions		
NEUROLOGIC:	☐ Seizure disorder	☐ Tremors	☐ Dizziness/Fainting	☐ Weakness in extremity
CARDIAC:	☐ Chest pain/ Angina	☐ Heart Palpitations	☐ Rapid Heart Rate	☐ Swelling in extremity
RESPIRATORY:	☐ Wheezing ☐ Dyspnea	☐ Cough	☐ Sleep apnea	☐ Blood stained sputum
GASTROINTESTINAL:	☐ Abdominal pain ☐ Diarrhea	☐ Vomiting ☐ Bloody Stools	☐ Heartburn ☐ Hepatitis	☐ Constipation
GU/NEPHRO:	☐ Dysuria	☐ Hematuria	☐ Chronic renal failure	
ENDOCRINE:	☐ Diabetes	☐ Heat intolerance	☐ Cold intolerance	☐ Thyroid problems
HEMATOLOGIC:	☐ Abnormal bruising/bleeding	☐ Swollen lymphnodes		
MUSCULOSKELETAL:	☐ Joint pain ☐ Joint restrictions	☐ Back pain	☐ Neck pain	☐ Muscle pain
PSYCHIATRIC:	☐ Depression	☐ Anxiety	☐ Drug abuse	
IMMUNOLOGIC:	☐ HIV/AIDS			

MARK THE FOLLOWING YOU HAVE BEEN TREATED FOR IN THE PAST:

GENERAL [ ] *Cancer - Type*_____ [ ] *Diabetes - Type*_____

CARDIOVASCULAR/HEMATOLOGIC [ ] *Anemia* [ ] *Heart Attack* [ ] *Coronary Artery Disease* [ ] *High Blood Pressure* [ ] *Peripheral Vascular Disease*

GASTROINTESTINA [ ] *GERD (Acid Reflux)* [ ] *Gastrointestinal Bleeding* [ ] *Stomach Ulcers* [ ] *Constipation*

UROLOGICAL [ ] *Kidney Disease* [ ] *Kidney Stones* [ ] *Uriniary Incontinence* [ ] *Dialysis*

NEUROPSYCHOLOGICAL [ ] *Multiple Sclerosis* [ ] *Peripheral Neuropathy* [ ] *Seizures* [ ] *Depression* [ ] *Anxiety* [ ] *Schizophrenia* [ ] *Bipolar Disorder*

HEAD/EARS/EYES/NOSE/THROAT [ ] *Headaches* [ ] *Migraines* [ ] *Head Injury* [ ] *Hyperthyroidism* [ ] *Hypothyroidism* [ ] *Glaucoma*

RESPIRATORY [ ] *Asthma* [ ] *Bronchitis/Pneumonia* [ ] *Emphysema/COPD*

MUSCULOSKELETAL/RHEUMATOLOGIC [ ] *Bursitis* [ ] *Carpal Tunnel Syndrome* [ ] *Fibromyalgia* [ ] *Osteoarthritis* [ ] *Osteoporosis* [ ] *Rheumatoid Arthritis* [ ] *Chronic Joint Pain*

DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, HEALTHCARE INFORMATION AND FINANCIAL

I understand I can request and review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Please list family members or other persons, if any, whom we may inform of your general medical condition and your diagnosis (including treatment, payments, and healthcare options):

NAME: _____ NAME: _____

NAME: _____

My personal medical information may/may not be left at the following:

Home/Cell Phone Number: _____

- ☐ May **only** leave providers name and number
- ☐ May leave detailed information (lab results, appointment reminders)
- ☐ May **NOT** leave message

Work Phone Number: _____

- ☐ May **only** leave providers name and number
- ☐ May leave detailed information (lab results, appointment reminders)
- ☐ May **NOT** leave message

_____ _____

Signature of Patient or Legal Representative Date

OMAHA PAIN PHYSICIANS HIPPA NOTICE OF PRIVACY

I understand that I can request and review Omaha Pain's full HIPPA Notice of Privacy policy that provides a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. By signing below I acknowledge that Omaha Pain Physicians, legal entity name Pain Centers of the Midlands may use or disclose your protected health information when needed for treatment, payment, appointment reminders, requirements by law, and other operations listed on the full HIPPA Notice. By signing below I consent.

_____ _____

Signature of Patient or Legal Representative Date

OMAHA PAIN PHYSICIANS FINANCIAL POLICY

I understand that I can request and review Omaha Pain's full financial policy that provides a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. By signing below I agree to paying for any medical treatment billed to me from Omaha Pain Physicians, legal entity name Pain Centers of the Midlands, LLC.

_____ _____

Signature of Patient or Legal Representative Date