NEW ADULT PATIENT HISTORY INTAKE

Welcome to VERMONT PAIN MANAGEMENT, P.C (Evan Musman, D.O.). To help us establish you with our practice, please provide us with your complete health history.

Name: _____ Date:_____

Date of Birth___/____/_____ Age_____ **RIGHT** or **LEFT** handed?_____ Height: _____ Weight: _____

ALLERGIES (Medications, food, etc.):

_____

_____

Are you allergic to iodine or shellfish? _____ If Yes, what was the reaction? _____

MAIN PAIN COMPLAINTS: (if possible, rank in terms of importance to you)

_____

_____

_____

(Note: we may not be able to address every problem during the course of one visit.)

PRIMARY CARE PHYSICIAN: _____ PHARMACY: _____

CURRENT MEDICATIONS ***LIST ALL*** **PAST MEDICAL, SURGICAL AND TRAUMA HISTORIES**

Medication	Dose	Frequency	Event or Procedure	Date

(if necessary, please attach additional information)

SOCIAL HISTORY

Do you smoke cigarettes? ☐ YES ☐ NO If yes, #_____yrs. #_____ packs per day

Do you use street drugs? ☐ YES ☐ NO If yes, what kind? _____

Do you drink alcohol? ☐ YES ☐ NO If yes, how much? Type_____ &_____ drinks per week

Do you drink caffeinated beverages? ☐ YES ☐ NO If yes, type / how much?_____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Other		Yourself	Mother	Father	Other
Alcoholism					Glaucoma				
Alzheimer's					Heart Attack				
Elevated Cholesterol					Heart Disease				
Arthritis					High Blood Pressure				
Asthma					Irritable Bowel Syndrome				
Bleeding Disorder					Kidney Disease				
Breast Cancer					Liver Disease/Hepatitis				
Prostate Cancer					Migraines				
Colon Cancer					Pneumonia				
COPD / Emphysema					Other Cancer: _____				
Depression					Stroke				
Diabetes					Suicide				
Drug Abuse					Thyroid Disease				
Epilepsy					Other				

Have you had or do you have?

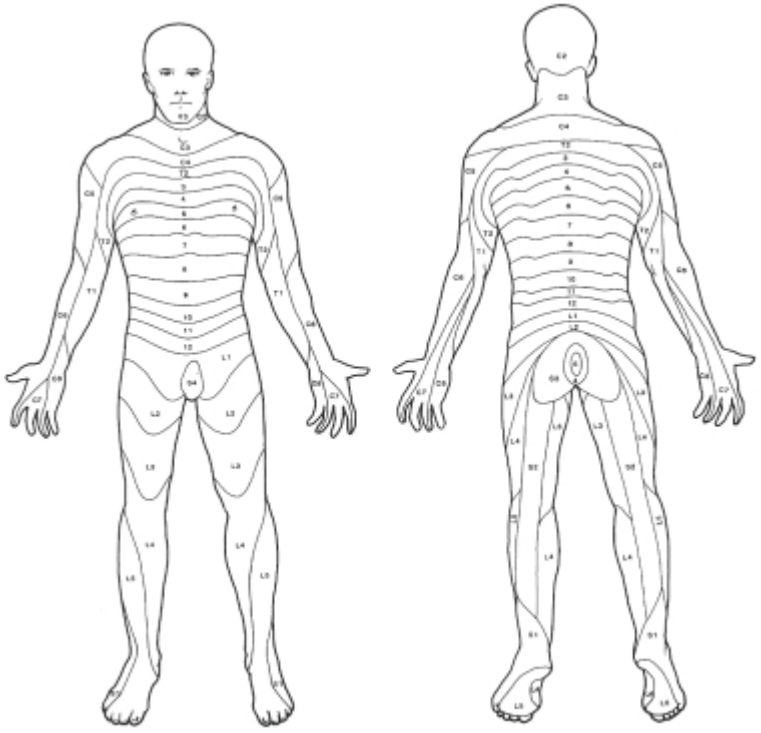
Y	N		Y	N	
___	___	Fatigue/ Feeling tired	___	___	Arthritis: Rheumatoid / Degenerative
___	___	Fever/ Chills	___	___	Swelling in hands or feet
___	___	Unexplained weight-loss	___	___	Stroke or Mini-stroke
___	___	Eye problems (besides glasses)	___	___	Lightheadedness / Dizziness / Headache
___	___	Hearing problems	___	___	Weakness in arms or legs
___	___	Frequent sinus problems	___	___	Skin problems / Rashes
___	___	Chest pain	___	___	Depression / Anxiety / Bipolar
___	___	Shortness of breath	___	___	Infections: HIV / Hepatitis / Urinary
___	___	GERD or Heartburn	___	___	Cancer
___	___	Stomach ulcer	___	___	Do you use a walker or cane?
___	___	Nausea / Vomiting	___	___	Do you use a walker or cane?
___	___	Constipation / Urinary retention			
___	___	Loss of control of bowel or bladder			
___	___	Diabetes / Thyroid problems			
___	___	Kidney problems			
___	___	Bleeding / Bruising problems			

_____

_____

_____

PLEASE NOTE YOUR AREA(s) of PAIN



This history record has been designed to facilitate our patients' continuity of care. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

_____

Patient / Guardian signature Date

VERMONT PAIN MANAGEMENT

Workers Comp _____
MVA _____
Insurance _____
Cash Pay _____

Date _____

PATIENT INFORMATION

Name _____ Title: Mr. / Miss / Mrs. / Ms.

Nickname: _____ Date of Birth _____Age _____

Street Address _____ Telephone _____

City/State/Zip _____ Cell Phone _____

Race_____ Ethnicity_____ Language_____ e-mail_____

Gender: M / F Marital Status: S / M / D / W Social Security #: _____

Employer _____ Work Phone _____ Ext _____

Address/City/State/Zip _____

Occupation _____

Emergency Contact Person _____ Relationship _____

Home Phone _____ Day Time Phone _____ Cell Phone _____

Referred By _____

Primary Care Provider _____

Address (if known) _____ Telephone _____

Fax # _____

How are you paying today: M/C / VISA CASH OR CHECK

HEALTH INSURANCE INFORMATION

Primary Insurance _____

Policy Holder (Subscriber) Name _____ Relationship _____

Policy Holder (Subscriber) ID _____ Group # _____

Office Co-Pay (If Applicable) _____ Deductible _____ Policy Effective Date _____

Does your insurance require a referral? Y / N (Have you obtained a referral from your PCP?)

Secondary Insurance _____

Policy Holder (Subscriber) Name _____ Relationship _____

Policy Holder (Subscriber) ID _____ Group # _____

Policy Effective Date _____

AUTHORIZATION:

I certify that the above information is correct and I consent to any medical treatment or procedures under the general or special instructions of Vermont Pain Management, PC. I also accept responsibility for all charges related to this treatment. I authorize release of any medical information necessary to process an insurance claim.

Signature _____ Date _____

PATIENT NOTICE OF PRIVACY PRACTICES CONSENT FORM

I have read and fully understand this Notice of Privacy Practices. I understand that Vermont Pain Management, PC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Vermont Pain Management will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Vermont Pain Management's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature Date

VERMONT PAIN MANAGEMENT, PC

PAYMENT POLICY FOR SERVICES RENDERED

- **If you Have Insurance**: Please **Initia**l the Line Next to Your Insurance in **Section 1, 2, or 3**.
- **If You Have No Insurance**: Please Read **Section 4**.
- **Everyone**: Read and Sign **Section 5** and give your card to the Receptionist so we may make a copy for our file.

1. *IF YOU HAVE INSURANCE WITH ONE OF THE FOLLOWING INSURANCE COMPANIES*, please initial the appropriate line. We have contracts with these companies and will bill them directly and follow up with them on outstanding balances. You will be responsible for payment of your designated co-pay at each visit to the office BEFORE you see the doctor. You are responsible to present updated referral authorizations from your insurance carrier or primary care physician, where required.

_____BCBS	_____MVP
_____Medicare	_____CIGNA
_____Medicaid	_____Aetna
_____CBA	_____

2. *IF YOU HAVE WORKERS COMPENSATION COVERAGE*, we must have information approving the claim from your employer and/or insurance carrier and accurate billing address information to process the claim. Without this, we will consider payment for this visit to be your responsibility. Vermont Pain Management, PLC follows the Vermont Workers Compensation fee schedule and is not a member of any Worker's Comp PPO's

   Name of Insurance Company: _____Adjuster:_____
   Address:_____Phone:_____
   Claim Number_____Date of injury:_____Fax:_____

3. *IF YOU HAVE COVERAGE WITH ANOTHER INSURANCE COMPANY, WE DO NOT HAVE A CONTRACT WITH THEM*. With a copy of your card, we will submit a claim directly to your insurance company for reimbursement. Please review the following procedure and sign.

   "I understand that my services are being billed directly to my insurance carrier for me the insurance company should send payment directly to the office for payment. If the payment is sent to me, I will forward this payment to the office immediately. If payment is not received by the office within 45 days, a statement will be sent to me. I understand that it is my responsibility to follow up with my insurance company. I understand that this entire balance is at all times my responsibility."

   Insurance Co Name_____Signed:_____Date_____

4. *IF YOU HAVE NO INSURANCE*, you are responsible for payment of your bill, in total, at the time of your visit. We accept personal checks, credit cards, and cash.

5. **"I understand and agree that regardless of my insurance, I am in the end responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and Vermont Pain Management incurs any collection charges, they will be my responsibility. Late cancellations (less than 24 hour notice) and no-shows for your appointment will be charged to your account and will be due by you."**

_____ _____
Patient or Guardian Signature Date