bostonpaincare

DEMOGRAPHIC FACE SHEET

85 First Avenue, Waltham, MA 02451 (781) 647-PAIN (7246) www.bostonpaincare.com

In order for us to maintain current contact information and a complete and current medical history, it is important for you to verify that the information on this form is accurate. Please make any changes below and verify the accuracy of what we have for your electronic health record.

Full name: _____ Date of Birth: _____

Address: _____

Email Address: _____ Marital Status: _____ Sex: ____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Method of Contact: Email ☐ Home Phone ☐ Cell Phone ☐

Pharmacy Pref: _____ Phone #: _____
(include location)

How did you hear about us? _____

PCP: _____ PCP Phone #: _____

PCP Address: _____

Referring Physician: _____ Referring Phone #: _____

Referring Address: _____

Please list your insurance information:

Primary	Secondary
Group #:	Group #:
Policy #:	Policy #:

Name of Primary Insurance Policyholder: _____

Relationship to Primary Insurance Policyholder: Self ☐ Spouse ☐ Child ☐ Other: _____

Injury is: Work Related YES ☐ NO ☐ Car Accident YES ☐ NO ☐ Other: _____

Date of Injury (if it applies): _____ State in which the accident occurred: _____

Employer Name: _____ Employer Address: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I authorize the release of any previous results or images in the event it is needed to help with the diagnosis and plan of care for further treatment. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. We will bill your insurance carrier as a courtesy. In the event of a non-payment, I understand I will be responsible for any outstanding balances.

_____ _____

Patient / Legal Guardian Signature Date

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Appt. Date: _____

Name: _____ Date of Birth: _____

1. What is the Main reason you are here to see the Physician today?

2. Please circle the type of pain you've experienced (circle all that apply).

   Burning Stabbing Aching Sharp Numbness Other: _____

3. How long have you been having Pain in this location?

   _____ Hours _____ Days _____ Months _____Years

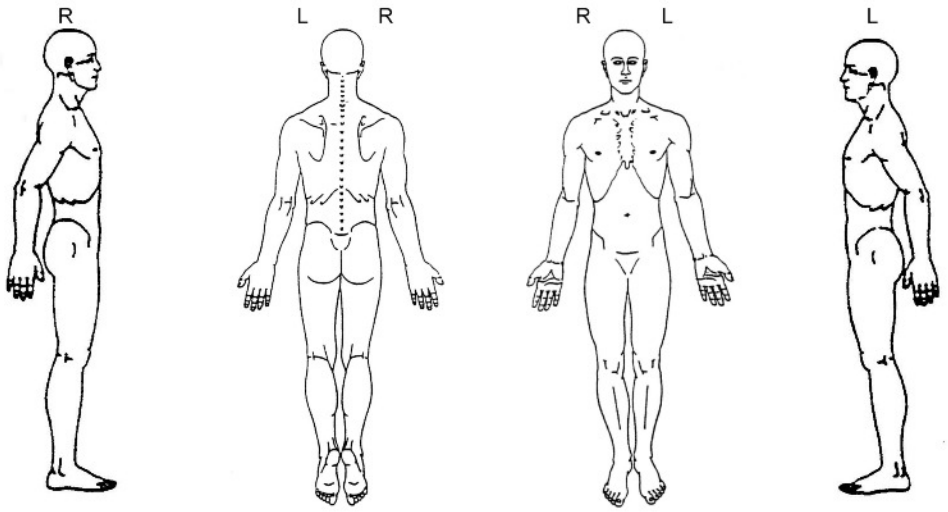
4. Is this a Worker's Comp related problem? Yes [ ] No [ ]

   If yes, when did the injury occur? _____ (Date)

5. On a scale of 1 - 10 with 10 being the worst pain you ever experienced, what would you rate your pain today?

   0 1 2 3 4 5 6 7 8 9 10
   no pain most severe

   Please mark on the body below in the location you are having pain.



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MEDICATIONS AND ALLERGIES

Date: _____

Name: _____ Date of Birth: _____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

CURRENT MEDICATIONS: Are you taking ANY kind of medication now? Yes [ ] No [ ]
(This includes prescription, over-the-counter, or herbal medications). If yes, please list below.

Medication Name	**Dosage**	**Frequency** (how many times a day)

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes [ ] No [ ]
if yes, please list below.

Are you allergic to: [ ] Latex [ ] Contrast Dye [ ] Adhesive Tape

Medications Name(s)	**Reactions**

Patient Signature: _____ _____
Date

Nurse Signature: _____ _____
Date

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PAST MEDICAL HISTORY

Date: _____

Name: _____ Date of Birth: _____

Have you ever been diagnosed with any of the following?

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Cancer	[ ]	[ ]	Arthritis	[ ]	[ ]	Anemia
Type:		_____	[ ]	[ ]	Osteoporosis	[ ]	[ ]	VonWillebrand
[ ]	[ ]	Migraine Headache	[ ]	[ ]	Lyme Disease	[ ]	[ ]	Hemophilia
[ ]	[ ]	Chronic Sinusitis	[ ]	[ ]	Ehler Danlos	[ ]	[ ]	Other Bleeding Disorder: _____
[ ]	[ ]	Angina	[ ]	[ ]	Epilepsy	[ ]	[ ]	Rheumatoid Arthritis
[ ]	[ ]	Atrial Fibrillation	[ ]	[ ]	Multiple Sclerosis	[ ]	[ ]	Lupus
[ ]	[ ]	Arrhythmia	[ ]	[ ]	Parkinson's Disease	[ ]	[ ]	Scleroderma
[ ]	[ ]	Heart Attack	[ ]	[ ]	Seizure Disorder	[ ]	[ ]	Psoriasis
[ ]	[ ]	High Cholesterol	[ ]	[ ]	Neuropathy	[ ]	[ ]	Polymyalgia Rheumatica
[ ]	[ ]	High Blood Pressure				[ ]	[ ]	Other Autoimmune Disorder: _____
[ ]	[ ]	Stroke (CVA)	[ ]	[ ]	Insulin Dependent Diabetes			
[ ]	[ ]	CHF	[ ]	[ ]	Diabetes w/Oral Medication			
[ ]	[ ]	Edema	[ ]	[ ]	Diet Controlled Diabetes	[ ]	[ ]	Herniated Disc
						[ ]	[ ]	Spinal Stenosis
[ ]	[ ]	Chronic Bronchitis	[ ]	[ ]	Thyroid Dysfunction			
[ ]	[ ]	Asthma	[ ]	[ ]	Other Endocrine Disorder: _____			
[ ]	[ ]	COPD / Emphysema						
[ ]	[ ]	Sleep Apnea	[ ]	[ ]	Depression	[ ]	[ ]	Kidney Disease
[ ]	[ ]	Ulcerative Colitis	[ ]	[ ]	Anxiety	[ ]	[ ]	Kidney Stones
[ ]	[ ]	GI Reflux	[ ]	[ ]	Bipolar	[ ]	[ ]	Shingles
[ ]	[ ]	Hepatitis	[ ]	[ ]	PTSD	[ ]	[ ]	Are you pregnant?
[ ]	[ ]	Stomach Ulcer				[ ]	[ ]	Endometriosis
[ ]	[ ]	GI Bleed	[ ]	[ ]	AIDS	[ ]	[ ]	Prostate Enlargement
[ ]	[ ]	Crohn's Disease	[ ]	[ ]	HIV	[ ]	[ ]	Hepatitis
						[ ]	[ ]	Complex Regiional Pain Syndrome (CRSD)

Do you have any pertinent diagnoses not listed? _____

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SURGICAL HISTORY

Date: _____

Name: _____ Date of Birth: _____

Please note below any surgery you have had:

Cardiac

[ ] Angioplasty
[ ] Open Heart Surgery

Orthopedic

[ ] Carpal Tunnel
[ ] Knee Scope

Implants

[ ] Knee Replacement
[ ] Hip Replacement
[ ] Pacemaker
[ ] Defibrillator
[ ] Insulin Pump
[ ] Medication Infusion Pump
[ ] Spinal Cord Stimulator
[ ] Other Metal Implants

_____

_____

Reproductive

[ ] Hysterectomy
[ ] Breast Surgery

General

[ ] Organ Transplant
[ ] Removal of Kidney
[ ] Removal of Thyroid
[ ] Appendectomy
[ ] Gall Bladder Removed
[ ] Bowel Surgery
[ ] Laparoscopy
[ ] Gastric Bypass
[ ] Hernia Repair

Spine

[ ] Neck Surgery
[ ] Back Surgery
[ ] Other Surgeries not Listed

_____

_____

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REVIEW OF SYSTEMS

Date: _____

Name: _____ Date of Birth: _____

Do you now have or have you recently had any of the following?

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Fatigue	[ ]	[ ]	Chest Pain	[ ]	[ ]	Anxiety
[ ]	[ ]	Fever	[ ]	[ ]	Swelling of Ankles	[ ]	[ ]	Depression
[ ]	[ ]	Unintentional Weight Gain	[ ]	[ ]	Irregular Heartbeat	[ ]	[ ]	Sleeping Problems
[ ]	[ ]	Unintentional Weight Loss	_____			_____		
[ ]	[ ]	Snoring	[ ]	[ ]	Abdominal Pain	[ ]	[ ]	Change in nails
			[ ]	[ ]	Loss of bowel control	[ ]	[ ]	Change in hair
[ ]	[ ]	Hearing Loss	[ ]	[ ]	Constipation	[ ]	[ ]	Change in skin color
[ ]	[ ]	Ringing in the Ears	[ ]	[ ]	Diarrhea	[ ]	[ ]	Rash after contact with specific substance
[ ]	[ ]	Frequent nose bleeds	[ ]	[ ]	Heartburn			
[ ]	[ ]	Visual changes	[ ]	[ ]	Nausea			
[ ]	[ ]	Severe face pain	[ ]	[ ]	Vomiting			
_____			_____			_____		
[ ]	[ ]	Cough	[ ]	[ ]	Loss of bladder control	[ ]	[ ]	Dizziness
[ ]	[ ]	Shortness of breath	[ ]	[ ]	Difficulty Urinating	[ ]	[ ]	Blacking out or fainting
[ ]	[ ]	Wheezing				[ ]	[ ]	Headache
						[ ]	[ ]	Seizures
						_____		
						[ ]	[ ]	Easy bleeding
						[ ]	[ ]	Easy bruising
						[ ]	[ ]	Joint swelling
						[ ]	[ ]	Leg cramps

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Date: _____

Name: _____ Date of Birth: _____

FAMILY HISTORY

Have any family members been diagnosed with the following?

	Yes	No		Yes	No
Migraines	[ ]	[ ]	Depression	[ ]	[ ]
Heart Disease	[ ]	[ ]	Substance Abuse	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Diabetes	[ ]	[ ]
Asthma	[ ]	[ ]	Bleeding Problems	[ ]	[ ]
Stroke	[ ]	[ ]	Autoimmune Problems	[ ]	[ ]
Alcoholism	[ ]	[ ]			
Anesthesia Problems	[ ]	[ ]			

SOCIAL HISTORY

Relationship Status (circle one) Married Single Divorced Widowed

Dependents: [ ] Yes [ ] No How Many? _____

Living Environment (circle one) House Condo Apartment Other _____

Do you use tobacco? [ ] Yes [ ] No

Do you drink alcoholic beverages? [ ] Yes [ ] No

Have you ever been diagnosed or have received treatment for substance abuse?

[ ] Yes [ ] No

OCCUPATIONAL HEALTH / FUNCTIONAL STATUS

Are you right or left hand dominant? (circle one) Right Left

Do you currently work outside of your home?

[ ] Yes Profession: _____

[ ] Retired

[ ] No If no, are you capable of returning to work? [ ] Yes [ ] No

Do you work within your home? [ ] Yes _____ (occupation)

_____ _____

Patient Signature Date

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RACE, ETHNICITY and LANGUAGE

Date: _____

Name: _____ Date of Birth: _____

Please complete your Race, Ethnicity and Language classification below.

Why are we asking you this information?

With a growing disparity in healthcare, the Federal Government is requiring healthcare providers to collect patients' Race, Language and Ethnicity. The collected information will be reported to the federal government in order to meet Meaningful Use requirements.

Race
(please choose 1 or more)

[ ] Alaskan Native
[ ] American Indian or Alaska Native
[ ] Asian
[ ] Black or African American
[ ] Black / African American (Not Hispanic)
[ ] Cape Verdean
[ ] Greek
[ ] Hispanic or Latino
[ ] Indian
[ ] Native American Indian
[ ] Native Hawaiian or Other Pacific Islander
[ ] Unknown / Not Reported
[ ] White
[ ] White (Not Hispanic / Latino)
[ ] Other Race

Ethnicity

[ ] Hispanic or Latino
[ ] Not Hispanic or Latino
[ ] Unknown / Not Reported

Preferred Language
(please choose 1)

[ ] Arabic
[ ] Bulgarian
[ ] Cambodian
[ ] Central Khmer
[ ] Chinese
[ ] English
[ ] French
[ ] German
[ ] Haitian; Haitian Creole
[ ] Hebrew
[ ] Hindi
[ ] Italian
[ ] Japanese
[ ] Korean
[ ] Polish
[ ] Portuguese
[ ] Russian
[ ] Somali
[ ] Spanish
[ ] Spanish; Castilian
[ ] Swahili
[ ] Thai
[ ] Urdu
[ ] Vietnamese
[ ] Other

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CONSENT TO TREAT

Consent to Treat

1. I voluntarily give my informed consent to be treated at Boston PainCare Center (henceforth referred to as BPC). I understand that the provision of health care services may involve significant risk. I understand that the physicians and employees of BPC will fully inform me of the risks, benefits, and alternatives to specific recommended treatments so that I may give my informed consent to a specific medical procedure or treatment. I understand that I have the right to refuse any diagnostic or therapeutic treatment procedure.
2. I acknowledge that no guarantees have been made to me concerning the results or outcomes of diagnostic tests, evaluations, treatments or procedures.
3. I acknowledge that I have received notification of BPC policies on advanced directives and notice of my patient rights in advance of the day of my procedure.

Consent for Use and Disclosure of Information for Payment, Treatment, and HealthCare Operations

I understand that BPC may use a secured electronic database to access patient medication or health history. I consent to BPC's release of my medical information so that BPC may treat me, seek payment from third parties for such treatment and information to insurers and providers outside of BPC when necessary so that these providers may treat me, seek payment that treatment, and carry on their health care operations. Without limiting the foregoing, my medical information may be released to the following parties:

A. My primary care physician or any other physicians caring for me;
B. My workman's compensation carrier, if my treatment is related to an accident suffered at work;
C. Third-party payers (insurers);
D. Billing services;
E. Other entities as required by law.

Patient Responsibilities

I hereby irrevocably assign and transfer to BPC the benefits to any and all insurance polices covering myself for medical services provided to me by BPC. BPC will bill my insurance on my behalf. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to BPC any plan documents, insurance policy and/or settlement information upon attempt to verify benefits for the patient, however verification is not a guarantee of benefits and ultimately coverage and payment lies at the sole discretion of the third-party payer.

I understand that I am financially responsible for the charges associated with the provision of care at BPC. It is my responsibility to pay all copayments at the time services are rendered, and to notify BPC when a change in or loss of insurance coverage occurs. BPC may not be a plan provider for your insurance company, and this may result in your insurer forwarding you payment for services rendered at BPC. In the event of a benefits check is sent to me for services rendered at BPC, I agree to endorse the check immediately and forward to BPC by certified mail, or pay by personal check (with a copy of the explanation of benefits from my insurance carrier) within 48 hours for the value of the benefits check. I understand that charges to become due and payable immediately, and that I will be responsible for legal and collection fees if incurred. I hereby authorize BPC to appeal claims under the Employee Retirement Income Security Act (ERISA) and/or state laws when applicable as situations occur. A photo copy of this document is to be considered as valid as the original. I have read and do fully understand this agreement.

Patient / Responsible Party Signature (state relationship)	Patient's DOB	Date

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1. I understand that my medical records currently contain or will in the future contain sensitive information. Unless otherwise indicated below, I consent to the release of such information as part of my medical record to insurers billing service agents and other providers for the purpose of obtaining treatment for me, payment for the treatment provided to me, and so that these entities can carry on their health care operations.
2. I understand that Boston PainCare Center may require details regarding my health history in order to provide care to me. I specifically consent to the release of such information as listed below from the following facilities.

PCP Name: _____ Specialist Name: _____

Referring Physician: _____ Facility Name: _____

Other: _____ Other: _____

_____

_____

- History and physical exam;
- Progress notes;
- Lab reports including HIV / AIDs status;
- Information regarding treatement for substance abuse (alcohol or drug);
- Information related to mental health including psychotherapy notes, social history, and assessment;
- Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied health or human services professional;
- X-Ray reports

4. The understand that I may revoke this authorization at any time by notifying Boston PainCare Center in writing, and it will be effective on the date noted except to the extent action has already been taken in reliance upon this authorization.

Patient / Responsible Party Signature (state relationship)	Patient's DOB	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Boston PainCare Notice of Privacy Practices ("Notice"):

- It tells me how Boston PainCare will use my health information for the purposes of my treatment, payment for my treatment, and Boston PainCare health care operations.
- The Notice explains in more detail how Boston PainCare may use and share my health information for other than treatment, payment, and health care operations.
- Boston PainCare will also use and share my health information as required/permitted by law.
- Boston PainCare may also exchange my health information for treatment purposes when participating in Health Information Exchange (HIE).

I consent to Boston PainCare using and disclosing my treatment records maintained by Boston PainCare for the purposes detailed in Boston PainCare Notice of Privacy Practices.

Patient's Complete Legal Name: _____

Patient's DOB: _____ Date: _____

Signature: _____

(Patient or legal representative*)

*May be requested to show proof of representative status