NEW PATIENT INFORMATION

DATE: _____ **/** _____ **/** _____ **SOCIAL SECURITY #** _____-_____-_____

PATIENT NAME: _____ BIRTH DATE: _____/_____/_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

WORK PHONE: ( ) _____ E-MAIL: _____

AGE: _____ SEX: ☐ M ☐ F ☐ MARRIED ☐ WIDOWED ☐ SEPARATED

☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ SINGLE ☐ DIVORCED

EMPLOYER: _____ NO. OF CHILDREN _____

OCCUPATION: _____

WHO IS RESPONSIBLE FOR YOUR BILL? ☐ SELF ☐ SPOUSE ☐ WORKER'S COMP ☐ AUTO INSURANCE

☐ MEDICARE ☐ MEDICAID ☐ PERSONAL HEALTH INSURANCE ☐ OTHER _____

REFERRED TO THIS OFFICE BY: _____

NAME OF EMERGENCY CONTACT _____ **PHONE:** _____

PRIMARY PHYSICIAN'S NAME: _____

Current Health Condition

DATE OF ONSET PAIN _____ CAUSE OF PAIN _____

WAS THIS INJURY ☐ AT WORK ☐ AUTO ACCIDENT ☐ OTHER _____

IS THERE LEGAL ACTION RELATED TO YOUR INJURY? ☐ NO ☐ YES / PLEASE EXPLAIN _____

_____

_____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

IF DISABLED FROM WORK, PLEASE GIVE DATES _____

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

☐ NERVE PILLS ☐ PAIN KILLERS/MUSCLE RELAXERS ☐ INSULIN ☐ BLOOD PRESSURE MEDS

☐ OTHER(S) (Please List All Medications): _____

_____

PREVIOUS CHIROPRACTIC CARE: ☐ NONE ☐ YES / DR'S NAME AND DATE OF LAST APPOINTMENT _____

_____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐ NO ☐ YES / PLEASE EXPLAIN _____

_____

ALLERGIES: Please list any drug, Latex or Iodine allergies here:

_____

_____

Patient Name_____ Birthdate _____

New Patient Evaluation Form

INITIAL PATIENT DATA BASE: In order to help us provide the best possible care for you at Great Midwest Pain Center, we ask for your cooperation in providing the following information. Please bring this form with you to your first appointment.

General Information

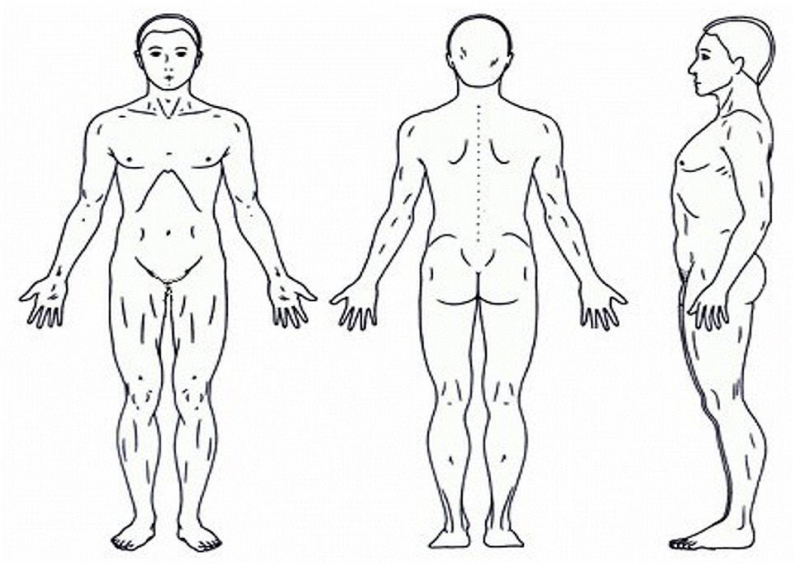
HEIGHT: _____ FT. _____ IN. WEIGHT: _____ LBS. AGE_____ BIRTHDATE_____

ON A SCALE FROM 0 TO 10, RATE YOUR PAIN AT ITS WORST _____, AT ITS BEST _____, AT THE MOMENT _____.

0 – No hurt 1-2 Hurts a little 3-4 Hurts a little more 5-6 Hurts more 7-8 Hurts a lot 9-10 At its worst

Location of Your Pain

ON THE PICTURE, COLOR IN ALL AREAS OF PAIN.



PLEASE CHECK ANY PREVIOUS TREATMENTS FOR CURRENT PAIN:

☐ BIOFEEDBACK ☐ CHIROPRACTIC VISITS

☐ COUNSELING ☐ HERBAL REMEDIES ☐ HYPNOSIS

☐ INJECTIONS ☐ PHYSICAL OR OCCUPATIONAL THERAPY

☐ TENS UNIT ☐ WORK HARDENING ☐ MEDICATIONS, LIST _____

_____

_____

LIST ANY TESTS YOU HAVE HAD DONE FOR YOUR PAIN: ☐ BLOOD TESTS ☐ BONE SCAN

Please bring any imaging studies to your appointment.

Past Medical History

PLEASE CHECK ALL THAT APPLY:

☐ ANEURYSM	☐ DIABETES	☐ HIGH CHOLESTEROL	☐ REFLUX	☐ THYROID
☐ ASTHMA	☐ FIBROMYALGIA	☐ HIV OR AIDS	☐ RESPIRATORY	☐ ULCER
☐ BLEEDING DISORDER	☐ HEART ATTACK	☐ LIVER	☐ RHEUMATOID FEVER	☐ OTHER, PLEASE LIST
☐ CANCER	☐ HEART DISEASE	☐ KIDNEY DISEASE	☐ SEIZURE DISORDER	_____
☐ CIRCULATION PROBLEM	☐ HEPATITIS	☐ MURMUR	☐ STROKE	_____
☐ DEFIBRILLATOR	☐ PACEMAKER	☐ HIGH BLOOD PRESSURE	☐ SLEEP APNEA	_____

Patient Name_____ Birthdate _____

Past Surgical / Hospitalization History

PLEASE CHECK/DESCRIBE ANY MAJOR SURGERY/OPERATIONS: ☐ APPENDECTOMY ☐ TONSILLECTOMY

☐ GALL BLADDER ☐HERNIA ☐ BROKEN BONES ☐ OTHER _____

MAJOR ACCIDENTS OR FALLS: _____

_____

LIST ALL PREVIOUS SURGERIES / HOSPITALIZATIONS

DATE	*SURGERY / HOSPITALIZATION*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Work History

Do you work? ☐ No ☐ Yes / Where? _____

Occupation_____

How long have you worked at your current job? _____

Do you like your job?	☐ No	☐ Yes	Are you on worker's compensation?	☐ No	☐ Yes
Do you have problems at work?	☐ No	☐ Yes	Is your employer contesting?	☐ No	☐ Yes
Do you get along with your co-workers?	☐ No	☐ Yes	Do you have an attorney?	☐ No	☐ Yes
When did you last work? _____			If yes, attorney's name _____		
Are you currently working?	☐ No	☐ Yes	Do you have work restrictions?	☐ No	☐ Yes
Have you missed work because of your pain?	☐ No	☐ Yes	Do you want to go back to work?	☐ No	☐ Yes
Would you return to work with restrictions?	☐ No	☐ Yes	Do you want permanent disability?	☐ No	☐ Yes

Patient Name_____ Birthdate _____

Psychosocial History

Do you have a history of alcohol abuse?	☐ No	☐ Yes
Do you have family members with a history of alcohol abuse?	☐ No	☐ Yes
Do you have a history of drug abuse?	☐ No	☐ Yes
Do you have family members with a history of drug abuse?	☐ No	☐ Yes
Have you ever been treated for depression?	☐ No	☐ Yes / When _____
Have you ever been treated for emotional /behavioral disorder?	☐ No	☐ Yes
Do you have a history of suicidal attempts?	☐ No	☐ Yes

Review the following list and check any that apply to you.

ALLERGIC/IMMUNOLOGIC
___ Environmental allergies
___ Food Allergies

CARDIOVASCULAR
___ Ankle Swelling
___ Chest Pain
___ Palpitations
___ Shortness of breath

CONSTITUTIONAL
___ Chills
___ Fatigue
___ Fever
___ Insomnia
___ Weight gain / Amount _____
___ Weight loss / Amount _____

EARS
___ Dizziness
___ Hearing loss
___ Tinnitus (ringing in the ears)
___ Vertigo (spinning sensation)

NOSE
___ Decreased smell
___ Epistaxis (nose bleeds)
___ Facial pain
___ Nasal congestion

THROAT
___ Dysphagia
___ Sore throat

EYES
___ Abnormal vision
___ Dryness
___ Pain

ENDOCRINOLOGY
___ Diaphoresis (sweating
___ Intolerance to cold
___ Intolerance to heat

GENITOURINARY
___ Dysuria (pain with urination)
___ Erectile dysfunction
___ Hematuria (blood in urine)
___ Incontinence
___ Loss of sexual drive
___ Urgency

GASTROINTESTINAL
___ Abdominal pain
___ Bloody stool
___ Constipation
___ Diarrhea
___ Dysphagia (difficulty swallowing
___ Fecal incontinence
___ Heartburn
___ Nausea
___ Vomiting

HEMATOLOGICA/LYMPHATIC
___ Easy bleeding
___ Easy bruising
___ Lymphadenopathy (swollen glands)

MUSCULOSKELETAL
___ Joint pain
___ Low back pain
___ Mid back pain
___ Neck pain

RESPIRATORY
___ Chest pain
___ Cough
___ Hemoptysis (bloody sputum)
___ Shortness of breath
___ Snoring
___ Sputum
___ Wheezing

NEURO/PSYCHIATRIC
___ Anxiety
___ Depression
___ Fainting
___ Headache
___ Incoordination (clumsiness)
___ Memory loss
___ Seizures
___ Weakness

VASCULAR
___ Pain or cramping in legs

Patient Name_____ Birthdate _____

Patients' Rights and Responsibilities

You Have the Right

- To be treated with respect, consideration and dignity at all times and to receive assistance in a safe and responsible manner.
- To receive accurate information about your health concerning diagnosis, pain management and associated risks that may be involved in your procedures and medical alternatives.
- To a second professional opinion and to ask about reasonable alternative treatments.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of alternative and likely consequences of your decision.
- To express a complaint to the manager, physician, or staff.

You Have the Responsibility

- To provide honest and complete information to those providing medical care to enable proper evaluation and treatment.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of the medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
- To inform physician if your condition worsens, what type of pain you may be experiencing, or any reaction that occurs from medications.
- To express your opinions concerns or complaints in a constructive and appropriate manner.
- To understand there may be times that the physic8ian may require you to return to the office for additional treatments or tests to aid in the diagnosis and proper care.
- To treat all personnel respectfully and courteously.
- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of your insurance plan services, including co-pay requirements, referral process, laboratory restrictions and outpatient faci8lities covered under your plan.
- To present your insurance card or worker's compensation information at your office visit and be prepared to pay all co-pays at the time of your visit.
- To keep scheduled appointments and notify the office promptly if you are delayed or unable to keep an appointment, and understand that late arrivals may result in the need to reschedule that appointment.
- Cancellation or rescheduling with 48 hours of appointment may result in a $25 rescheduling fee.

I have read and understand my rights and responsibilities as described. I give my consent to obtain treatment at Great Midwest Pain Center.

_____ _____

Patient Signature Date

Great Midwest Pain Center (262) 366-0665
17495 W. Capitol Drive, Brookfield, WI 53045

Patient Name_____ Birthdate _____

Consent to Release Information

I hereby give my consent to Great Midwest Pain Center to release any information regarding my care and treatment as may be required by any insurance carrier in connection with payment by the insurance carrier of any portion of my bill.

_____ _____
Patient Signature Date

Assignment of Benefits

I hereby authorize payment to be rendered directly to Great Midwest Pain Center for the benefits otherwise payable to me by any third party. The above authorizations are in effect permanently or until canceled by myself in writing.

_____ _____
Patient/Authorized Signature Date

Medicare Signature on File

I request that payment under the medical insurance program Medicare be made to either me or Great Midwest Pain Center on any bills for services furnished by me or by those physicians permanently or until this authorization is cancelled by me in writing. I also give Great Midwest Pain Center authorization to file claims to Medicare on my behalf.

_____ _____
Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Great Midwest Pain Center and that I have read or had the opportunity to read, if I so choose, and understand the notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____ _____
Signature Date

Person(s) authorized to view/discuss my medical records, including billing and insurance accounts.

____ Spouse Name _____

____ Other Name_____

Patient Name_____ Birthdate _____

Credit Policy Statement

Welcome to our facilities, where you will receive the highest quality outpatient surgical and clinical Pain Medicine services. The following is a statement of our financial policy for all companies listed above:

All non-covered services and co-pays are payable at the time of service. We accept cash, checks and MasterCard, Visa, and Discover.

Fees for services provided and not paid for at time of service are due and payable within 60 days. You will receive a statement each month for any unpaid balances. We will charge a $20 service fee for all returned checks.

All procedures performed have physician and separate facility charges.

Many patients are covered by health insurance contracts, which provide for reimbursement for specific medical fees. If you are not familiar with your policy, it is suggested that you discuss coverage with your carrier before charges are incurred. All insurance policies are between you and your insurance carrier. Your doctor's bill is an agreement between you and your physician. Our fees may be more or less than the payment schedule used by your insurance carrier. You are personally responsible for full payment of fees, regardless of any insurance carrier. You are personally responsible for full payment of fees, regardless of any insurance company's arbitrary determination of Usual & Customary. Our physicians are "Preferred Providers" for certain HMOs and PPOs. The contracts that we have signed with these specific carriers supersede our Usual & Customary policy. For our patients who are subscribers to these insurance plans, you will not be billed for amounts above our negotiated fee schedule, with the exception of co-pays, co-insurances, and deductible amounts as stated per your contract.

As a courtesy, we will submit insurance claims for you. We accept Medicare assignment. If the patient's insurance requires that a referral is necessary, it is the responsibility of the patient to obtain one from their primary care physician prior to their appointment. We reserve the right to refuse service to any patient who does not have a valid referral in our office at the time of their appointment. Many of the services that our office provides requires pre-authorization, and we ask that you be patient with our office obtain this authorization. Many insurance companies require documentation prior to authorizing services and we will do our best to comply in a timely fashion with their requests. **We reserve the right to charge a $25 fee if they fail to give at least a 24- to 48-hour appointment cancellation notice.** This fee will be paid by the patient, regardless of insurance.

Extended payment plans can be arranged through our billing office. These plans are based upon financial circumstances of each patient. We invite you to discuss any financial difficulties by calling (262) 797-4053.

I, the undersigned, have read and understand the above Credit Policy.

_____ _____

Signature of Patient/Authorized Person Date

_____

Patient Name (please print)

Patient Name_____ Birthdate _____

Opiate Treatment Policy

I, _____ , attest to the following statements:
Patient's Name (print)

1. I am not currently abusing illicit or prescription drugs and I am not undergoing treatment for substance dependence or abuse.
2. I have never been involved in the sale, diversion or transport of controlled substances.
3. I will obtain all prescriptions for narcotic analgesics from Great Lake Pain Specialists and reveal all other medications that I am taking.
4. I will use only one pharmacy for filling prescription analgesics.
5. I give my permission to allow Great Midwest Pain Center's staff and physicians to discuss my case with my other physicians and any pharmacists.
6. I agree to take my medications only as prescribed by Great Midwest Pain Center.
7. I agree to follow the advice of the physicians of Great Midwest Pain Center regarding the stopping of controlled substances as they advise.
8. I certify that I am not pregnant. I will use appropriate contraception during my treatment with narcotic analgesics. If I become pregnant, I will notify Great Midwest Pain Center staff and I understand that they will taper down and stop pain medications.
9. I understand that Great Midwest Pain Center reserves the right to order random urine drug screens at any time, and I will comply with such request.
10. I understand that Great Midwest Pain Center will make no allowance for lost prescriptions or medications.
11. I understand that Great Midwest Pain Center reserves the right to dismiss me from care should any violations of the above occur.

I authorize the release of medical records from all previous physicians, including psychological reports, to Great Midwest Pain Center.

I have read this entire agreement and have had the opportunity to ask questions. All of my questions have been answered satisfactorily. I consent to the use of analgesics under the terms outlined in this agreement. I will be given a copy of this policy for my reference.

_____ _____
Patient Signature Date

_____ _____
Patient's Name (Please print) Witness Signature

Patient Name_____ Birthdate _____

Prescription Policy

All patients are required to sign this Prescription Policy Contract. Failure to adhere to the rules and regulations of this contract could result in the dismissal of your care.

I _____, agree to the following in conjunction with my pain management treatment under the supervision of the physicians of Great Midwest Pain Center, and/or staff designated by the physicians of Great Midwest Pain Center. This program of treatment may include, but it not limited to the following

● Medication refill appointments must be scheduled at least two (2) weeks in advance. It is the patients' responsibility to keep track of the amount of medication remaining and to schedule appointments appropriately.

● All patients must refrain from excessive phone calls to our nursing staff. One phone call per 24 hours is appropriate.

● All narcotics must come from one physician. You must notify our doctors of any medication orders made by other physicians while under the care of Great Midwest Pain Center.

● All medications must be obtained at the same pharmacy.

● The prescribing physician has complete liberty to discuss fully all diagnostic and treatment details with the pharmacist at the dispensing pharmacy for purpose of maintaining accountability.

● Random urine toxicology screening may be done at any time. Failure to comply with random drug screens is reasonable cause for discharge from Great Midwest Pain Center.

●Medication will not be replaced if they are lost, fall into the toilet, are eaten by pets, left on the airplane, or any other reason. If your medications are stolen and you complete a police report regarding the theft, we may make an exception.

● All medications are to be kept in a safe place, especially away from children. They may be hazardous or lethal should they be inadvertently taken by any person other than who they were prescribed for.

● Take medications only as prescribed. Early refills will not be given. If you use a month's supply of medication in three weeks, the last week must be endured with no medication.

● Avoid the use of alcohol, which alters mental alertness, if receiving medication from our office. Refrain from the operation of an automobile and machinery while under the influence of medications that alter mental status. If you are unsure if the medication you are taking will alter mental status, check with our office.

● Script altering is a federal offense and we will report any violation to the proper authorities.

● Should your prescription need to be changed prior to your due date; all unused medication must be brought to our office prior to receiving a new prescription.

● We reserve the right to communicate with previous and present physicians that have cared for you and/or your previous or present insurance carriers.

If drug dependence, tolerance or addiction occurs, I agree to accept full responsibility for the risks taken secondary to my consent of narcotic consumption for the management of my pain. Should withdrawal symptoms be encountered, I will notify Great Midwest Pain Center. This medication should be stopped slowly with tapering. Medication is not to be stopped on your own without medical advice. Evidence of medication hoarding, increasing use of the medication without communication with pain clinic staff, refilling your prescription too frequently, getting the medication from multiple physicians or pharmacies, increasing amounts of medications, altering prescriptions, medication sales, unapproved use of other drugs (alcohol, sedatives, or street drugs) during narcotic analgesic treatment or other unacceptable behavior will result in tapering, discontinuing narcotic maintenance therapy, and potential discharge.

Side effects of narcotic medication may include drowsiness, dizziness, constipation, nausea, and/or confusion. Risk of psychological dependence with the use of these medications may occur. Physical dependence is frequently encountered in the use of long-term narcotic therapy. Medication needs to be withdrawn gradually to avoid uncomfortable withdrawal symptoms that may include excessive tearing, runny nose, dilated pupils, goose-pimple flesh, sweating, yawning, diarrhea, muscle aches, headache, and insomnia. Tolerance to the use of narcotic medication may occur, decreasing effectiveness.

_____ _____

Patient's Signature *Date*

_____ _____

Patient's Name (Please print) *Witness Signature*