16. For women, I will do everything I can to avoid getting pregnant while taking medications unless otherwise approved by my doctor. To the best of my knowledge, I am not pregnant at this time.

I have read and understand this agreement with the clinic and have been given a copy of the narcotics information sheet.

Name: ____ DOB: ______________ Date: _______________

Witness: ____ Date: _______________

My family doctor is: ___________________________________ Phone number: __________________

My medications will be filled at: ____

Pharmacy phone number: ____

Pharmacy Address: ____

Referring Physician: ____

Patients Signature: ____

PAIN & REHABILITATION MEDICINE, LLC

NEW PATIENT REGISTRATION FORM

Name: ______________________________________ CHART #: _______________

Referring physician: ______________________________ DOB: ____________

PATIENT HISTORY QUESTIONNAIRE

1. When did your current pain begin? __________________________________
2. Have you had surgery for this problem? _____________________________
3. Are you currently working? ____

4. How did the current pain start? (check appropriate box)

[ ] suddenly	[ ] twisting	[ ] pulling	[ ] injured during sports
[ ] gradually	[ ] fall	[ ] injured at work	[ ] injured in an auto accident
[ ] lifting	[ ] bending	[ ] hit from behind	[ ] no apparent cause.

5. What activities make the pain worse? (check appropriate box)

[ ] exercise	[ ] reaching up	[ ] sitting	[ ] driving
[ ] sneezing	[ ] standing	[ ] walking	[ ] coughing
[ ] bending forward	[ ] bending backward		

6. Medical History (check appropriate box)

[ ] diabetes	[ ] COPD	[ ] gout	[ ] heart	[ ] fibromyalgia
[ ] headaches	[ ] cancer	[ ] stroke	[ ] anemia	[ ] bowel or bladder
[ ] glaucoma	[ ] ulcers	[ ] asthma	[ ] depression.	[ ] kidney disease
[ ] arthritis	[ ] GERD	[ ] seizures	[ ] hypertension	

7. Do you have allergies? ____
8. Do you drink alcohol, if yes, how much per day? __________________
9. Do you smoke, if yes, how many packs per day? ____________________
10. If you have a prior history of alcohol or smoking, when did you quit?____
11. Family medical history ____
12. List all medications you are currently taking __________________
____
13. Are you on Coumadin, Aspirin, Plavix, or NSAIDS (circle the medication if appropriate)?
14. Have you had an X-ray, CT scan, or MRI in the past year?
____

THIS INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

PATIENT’S SIGNATURE _______________________________________ DATE______________

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Frank J. Smith. RPA-C

DATE OF EXAM:____________________Account number#___________

PATIENT NAME: ______________________________
Responsible Party/ Policy Holder :________________________________
Insurance Company name: ______________ Member Id#_______________

How did the occurance happen?

____
____
____

What part of the body was injured/hurt?

____
____

Date of Onset: ________________________________

Address of Onset: ______________________________

Was this related to a Motor Vehicle accident yes / no

Was this a Work related accident yes / no

I affirm that the above statement is true and request the release of any monies from my insurance company to the Central Orthopedic Group, LLC.

I also give permission to the Central Orthopedic Group to release any information necessary to pay this claim to my health insurance company.

PATIENT SIGNATURE:__________________________ Date: _________

Responsible party Signature:_________________________Date: __________