Patient Information

Thank you for choosing Rockford Pain Management. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information.

Submit via Email

Today's date _____

First Name _____ M.I. _____ Last Name _____

Nick-name preferred: _____

Date of Birth _____ ☐Male ☐Female Soc. Sec # _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Occupation _____

Were you referred by ☐Friend ☐Insurance Carrier ☐Physician ☐Phone Book ☐Advertisement ☐Gift Certificate/Groupon ☐Internet ☐Attorney Workshop: ☐Knee ☐Fibro ☐Pain

Referral Source? _____

Who is your family physician? _____ Phone # _____

Are you seeing the doctor due to a: ☐ Auto Accident ☐ Workman's Comp. Injury ☐ Personal Injury

Insurance Patients

	Primary Insurance	**Secondary Insurance**
Relation to Insured:	☐self ☐spouse ☐child ☐other	☐self ☐spouse ☐child ☐other
Complete the following insured information if *RELATION* is other than *SELF*.		
Insured's Name:		
Insured's Birthdate:		
Insured's Ins. ID:		
Group Number:		
Benefits Phone #:		

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process insurance claims by provider or agent. I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing. I designate SCPC and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b) 4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits insurance of health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of doctor services.

Patient Signature: _____ Date: _____

Office Use: F/C: INS MC MD IO WC AA PI SP CCC# _____
Atchd: Insurance Card Claim Form Referral Event: _____

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

Did it come on: ☐ Suddenly ☐ Built up over several days ☐ Gradually worse over a long time.

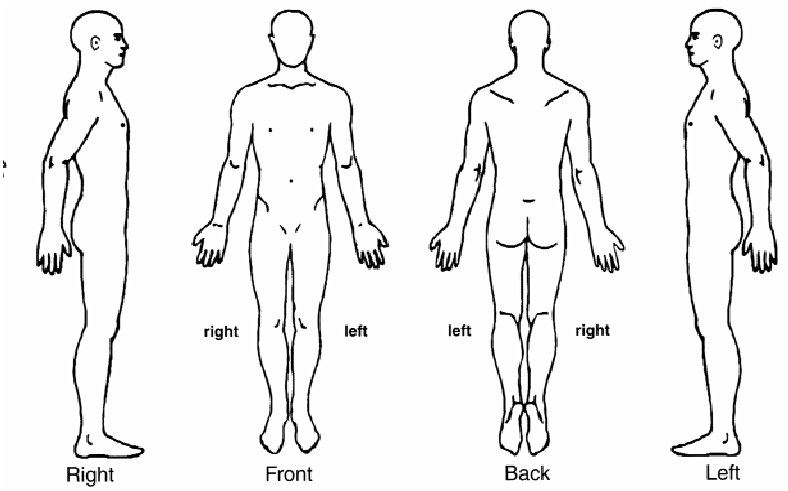
If you were injured was it: ☐ At Work ☐ At Home ☐ Due to Auto Accident ☐ Other Injury

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT. **Circle** the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time and how frequent.

AREA 1 pain is (1-10) Constant or Intermittent
At _____% of my day

AREA 2 pain is (1-10) ___ Constant or Intermittent
At _____% of my day.

AREA 3 pain is (1-10) ___ Constant or Intermittent
At _____% of my day



Please help us understand your pain: **Circle the words** for each area that best describes your pain and activity during your day.

Area 1 is:	Worse in AM	At Night	After exertion	It is:	Sharp	Stabbing	Dull	Achy	Throbbing	Burning	Tingling
Area 2 is:	Worse in AM	At Night	After exertion	It is:	Sharp	Stabbing	Dull	Achy	Throbbing	Burning	Tingling
Area 3 is:	Worse in AM	At Night	After exertion	It is:	Sharp	Stabbing	Dull	Achy	Throbbing	Burning	Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am : Ambulatory without assistance Need to use: Support Brace _____ Walker Cane Crutches Wheelchair

Please help us better understand **your personal circumstances** and assist us in providing you customized treatment and care.

I Am Now: ☐ Working Full Time Part Time ☐ Homemaker ☐ Full Time Student ☐ Unemployed ☐ Retired

Occupation: _____

☐ On sick leave ☐ On Temp disability ☐ On Full Disability My last day worked was _____

Age _____ Single Married Separated Filing for Divorce Divorced

Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.

I Now ◯ Smoke ___ Packs per day Stopped _____ ◯ Use Alcohol Type and Amt _____

◯ Consume Caffeine: Type/ Amt _____ ◯ Use recreational drugs _____

I am now or have in the past been : ◯ Addicted to drugs alcohol ◯ Treated for alcohol or drug addiction

WOMEN ONLY Can you become pregnant? YES NO Date of last period _____ Normal Yes No

If not, why? _____ Date of last Mammogram _____ Normal Yes No

Are you now or could you be pregnant ? ? YES NO Pap Smear _____ Normal Yes No

Patient Signature

Pertinent History/ Please advise us of any special circumstances, previous tests, therapy or conditions.

Are you allergic to any medications? NO YES (If yes, please list and describe your reaction)

If you previously had any of the following procedures, please list the date and place they were performed.

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE RECENT PAST.

Severe headaches / Chest pain / Angina / Kidney Stones / Digestive problems / Hypertension / Renal disease
Gout / Stroke / Heart murmur / Diabetes / Arthritis / Epilepsy / Arrhythmia / Endocrine disease / HIV / AIDS
Fatigue / Congenital heart disease / Urinary, genital problems / Dizziness / Fainting / Anemia / Reumatic fever /
Scarlet fever / Prostat e problems / Ulcers / Gall Stone s / Sexual dysfunction / Venereal disease / Pancreatitis
Shortness of breath / Menstrual dysfunction / Mental Illness / Asthma / Liver disease / Alcohol or Drug problems.

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. *(Prescription and over the counter)*

Name of medication and Strength	**# of doses / *day***

HOSPITALIZATION and SURGERY

PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)

FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

condition	who?	condition	who?
☐ Heart Disease		☐ Epilepsy	
☐ Hypertension		☐ Glaucoma	
☐ Stroke		☐ Bleeding disorders	
☐ Cancer		☐ Kidney disease	
☐ Diabetes		☐ Thyroid disease	

If you are over 65, have you had a pneumonia vaccination? ☐ Yes ☐ No

If you are a woman 40-69 years old, have you had a mammogram? ☐ Yes ☐ No

Thank you for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To verify that the information is correct as given to us by you, please affix your signature in the area (x) provided below.

Patient Signature: X