Date of Appointment:				Time of Appointment:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security#:	Home phone #: ( )

Cell Phone ( )	City:	State:	ZIP Code:

Email:	Employer:	Employer phone #: ( )

Please Select the Appropriate Box Referring Dr. Telephone #:

❑Auto Accident ❑Work Comp ❑Other Date of Injury:

INSURANCE INFORMATION

Primary Injury Related Insurance:
(Auto/Work Comp)

Adjuster's Name and Contact:

Policyholder:	Birth date: / /	Address (if different):	Home phone #: ( )

Claim Number:	Policy Number:	Social Security #:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Patient/Guardian signature *Date*

ATTORNEY INFORMATION

Attorney Name:

Mailing Address:	City:	Zip code:	Office Number #: ( )

Contact Person:	Fax Number: ( )

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO PAY AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the________________________Insurance Co. to pay by check made out and mailed directly to:

New Day Pain and Wellness
342 E. Bloomingdale Ave
Brandon, FL 33511

I hereby authorize to the above captioned doctor, the medical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for the all professional services that were rendered.
This payment shall not exceed my indebtedness to the above-named assignee, and I have agreed to pay, IN CURRENT MANNER, any balance of said professional service charges over and above the insurance payment.

With this form I give my consent and authorization to release any necessary medical information required to process this claim.

Signed:__________________________Date:________________________

INSURANCE COMPANY:___________________________

For and in consideration of the above-mentioned provided agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services. I hereby irrevocably assign to the aforementioned medical provided (New Day Pain and Wellness, LLC) any Personal Injury Protection benefits I may have in accordance with Florida Statue 627.756(5). This in includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the provider to prosecute said action and collect legal expenses as they see fit. This DOCUMENT CONSTITUES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the Provider against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict, which may be paid to me as a result of the injuries or illness for which the Provider has treated me. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided.

I agree to cooperate with the Provider and any attorney that the Provider chooses and to do all things reasonable to effect payment of the bills by the insurance company to the Provider including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the Provider and those costs (including, but not limited to attorney's fees, court costs and interest) necessary in procuring payment form the above-named insurance company, etc. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deduction or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the Provider will pursue collection against the insurance company on my behalf. I hereby instruct and direct my insurance company to pay my benefits by check, made payable to and mailed to the Provider at the address listed above. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the Provider at the address listed above. Furthermore, I hereby give the Provider limited power of attorney to endorse/sign my name on any and all checks for payment to the Provider. This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the Provider, if any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

PRINTED NAME____

PATIENT SIGNATURE____DATE___________

WITNESS SIGNATURE____DATE___________

PATIENT FINANCIAL AGREEMENT & AUTHORIZATION FOR LIEN ON SERVICES

Patient Name____Date of Accident ___/___/___

In the event that I,_______________________________________ recover funds from a

settlement of my claim relating to the accident dates above, I direct my attorney to withhold from my settlement sufficient funds to pay for all medical care provided by **New Day Pain and Wellness**

(FEIN#83-1865714), up to the lesser of a.) funds received from the recovery of the above-named patient / client or b.) the balance of the account, unless otherwise approved.

My attorney will use his / her best efforts to request a confirmation of my account balance when the recovery is imminent.

If the net recovery of settlement is less than the total outstanding charges owes to all healthcare providers covered by a letter of protection or any other lien holder, excluding Medicare or Medicaid, New Day Pain and Wellness has priority to have the account balance paid first, after attorney fees and costs.

In the event that I am no longer represented by an attorney, I authorize any and all lien holders to pay New Day Pain and Wellness directly, for all funds due on my account related to the above accident.

I understand that if I object to the amount of the bill, my attorney or any other lien holder will withhold an amount sufficient to pay my bill in a trust account. My attorney or any other lien holder will not thereafter pay any portion of the funds withheld, either to the doctor or myself, until a written agreement is made by all parties involved. The only exception is an Order of Court competent jurisdiction directing that such funds be paid to either myself, or New Day Pain and Wellness

By signing below, I have read and understand the above written statements. I authorize my attorney to protect my bills for the treatment outlined above. I also understand and agree that I am ultimately responsible to New Day Pain and Wellness for the payment of all services rendered for my benefit.

________________________ ________________________________ __________

Name of Representing Attorney Signature of Patient Date

OFFICE USE ONLY

_____Patient given copy of Financial Agreement / Lien on Services

_____Copy faxed to Representing Attorney

MEDICAL RECORDS RELEASE AGREEMENT AND HEALTH INSURANCE DISCLOSURE

Patient Name: ____________________________ Date of Injury:____________________

I hereby authorize New Day Pain and Wellness to furnish my attorney of record, with a full report of my examination, diagnosis, imaging, treatment, prognosis, etc. concerning the injury/illness for which I am treated.

A photocopy of this document shall be sufficient to authorize any person having medical treatment, services, or supplies pertaining to me, to release copies of the same to New Day Pain and Wellness or any insurer providing coverage in connections with processing any claim pertaining to payment for care. A photocopy of this document shall be as binding as an original signature page.

If I currently do not have an attorney, but retain an attorney in the future, or change my attorney of record, I understand I am responsible for communicating that change to New Day Pain and Wellness as soon as possible.

I constitute and appoint New Day Pain and Wellness to endorse any checks, drafts, or money orders written in both our names where such check is in payment for services regarding my injury. Furthermore, I allow New Day Pain and Wellness to sign any document that will be necessary to enhance, expedite, and / or allow payment to said provider. This may include insurance forms and other statements.

I understand that I may have health insurance or be a member of an HMO and that I may be a third party beneficiary of an agreement between my health insurer. After careful consideration, it is my decision to decline benefits available through my personal or group health insurance. I understand the reason for this is related to properly pre-approving care, timely filing limits of claims, and other such standards and rules pertaining to health insurance payments. By signing this acknowledgement, I knowingly waive any rights I may have as a third party beneficiary to any agreements my healthcare provider may have with any insurance company.

If I have Medicare Insurance and I am treating for a liability related injury, I understand that the provider has a choice of billing the liability insurer, filing a lien against the court settlement, or billing Medicare. I authorize New Day Pain and Wellness to release to the Centers of Medicare (CMS) any information needed to determine these benefits, or benefits payable to related services. I agree to pay any portion of my charges that my Medicare carrier deems my responsibility.

I am also fully aware that in the event of an unfavorable judgment in my personal injury matter, I am responsible for all charges incurred for my care at New Day Pain and Wellness.

Today's Date:____

Patient Printed Name:____

Patient Signature:____

DISCLOSURE, ACKNOWLEDGMENT, AND NOTICE OF INITIATION OF TREATMENT PURSUANT TO SECTION 627.736 FLORIDA STATUES

On this date of initial treatment or service provided, the undersigned physician hereby gives noticeof providing medical services upon which a claim for personal injury protection is based, and likewise, follows the requirements of law by signing below and requiring the patient's signature below for executing this acknowledgment and disclosure form, to agree and reflect the following:

A. The insured, or his/her guardian, signs below attesting to the fact that the services identified as: a comprehensive history and physical examination with complex medical decision making were actually rendered.

B. The insured, or his/her guardian, has both the right and the affirmative duty to confirm that the services were actually rendered.

C. The insured, or his/her guardian, was not solicited by any person to seek any service from themedical provider.

D. The physician rendering services for which payment is being claimed, explained to the services tothe insured or his/her guardian.

E. If the insured notifies the insurer in writing of a billing error, the insured may be entitled to a certain percentage of a reduction in the amounts paid by the insured's motor vehicle insurer.

F. The Acknowledgment, Disclosure and Notice shall also serve as a notice of initiation of treatment.

______________________________	______________________________
Provider's Handwritten Signature	**Patient's Handwritten Signature**
______________________________	______________________________
Date	**Patient's Printed Name**

STANDARD DISCLOSURE AND ACKNOWLEDGMENT FORM

The undersigned insured person (or guardian of said person) affirms the following:

1. The services that are described below were actually rendered. These services have already been provided.

____

____

2. It is my right and my duty to confirm that the services have already been provided.

3. No one solicited me to seek any services from the medical provider who gave the services described above.

4. The medical provider clearly explained the services to me for which payment is being claimed.

5. If the insurer is notified by me in writing of a billing error, this may entitle me to receive a portion of anyreduction in the amounts paid by my motor vehicle insurer. If I am entitled to receive payment, the share Ireceive would be no less than 20% of the amount of the reduction up to a maximum of $500 USD.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (Print or Type): ___________________________

Signature:__________________________________

Date:______________________________________

The licensed medical professional or medical director whose signature is appended, if required, confirms the statement numbered 1 (one) above. They also affirm:

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to besolicited to make a claim for Personal Injury Protection benefits.

B. The insured person had the treatment or services rendered clearly explained to them, or in the case of aminor, his or her guardian. The explanation was sufficient for the person to sign this form with informed consent.

C. The statement or bill that accompanies this document has been properly completed with all relevant information and all material provisions provided therein. All requests for information have been responded to truthfully, accurately, and in a substantially complete manner.

D. Proper coding procedures have been followed on the accompanying statement or bill. Services have notbeen uncoated, unbundled, and do not include invalid or not medically necessary diagnostic tests as defined by section 627.732(14) and (15) Florida Statues or section 627.736 (5)(b)6, Florida Statues.

Licensed medical professional rendering treatment/services or medical director, if

applicable. (Signature must be in his/her own hand)

Name (Print or Type): ___________________________

Signature:_____________________________________

Date:____

Anyone who knowingly and with intent to injure or defraud or deceive any insurer files a statement claim or an application containing false, incomplete, or misleading information is guilty of a felony of the 3rd° per 817.234(1) (b) Florida Statues

Note: The original this form must be provided by the insurer pursuant to section 627.736(4)(b) Florida Statues. These documents may not be electronically furnished. Failure to furnish this form could result in a nonpayment of the claim.

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO____

NAME OF FACILITY

ADDRESS_________________________________

CITY______________**FL**_________**ZIP** __________

I HEREBY AUTHORIZE THAT MY MEDICAL RECORDS BE RELEASED TO:

New Day Pain & Wellness
342 E. Bloomingdale Ave.
Brandon, FL 33511

Phone (813) 938-6627
Fax (866) 357-5209

New Day Pain & Wellness
110 Southern Oaks Dr.
Plant City, FL 33563

Phone (813) 938-6627
Fax (866) 357-5209

I AUTHORIZE A COPY OF THE SIGNATURE TO ALWAYS SERVE AS AN AUTHORIZATIONFOR RELEASE OF MEDICAL RECORDS.

______________________ ______________

Patient Signature **Date**

______________________ ______________

Social Security Number **Date of Birth**

Disclosure of Policies

HIPAA Policy:

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

Privacy Notice:

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Authorization to Release Information:

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Financial Policy:

New Day Pain and Wellness participates with many forms of health insurance, such as HMO's, PPO's, Workman's Compensation and Medicare. However, few insurance carriers cover all medical costs and a balance on your account may result from co-payments, co-insurance, deductibles, or non-covered services. The patient is responsible for full payment of any and all balances deemed "patient responsibility" by their insurance carrier. We will file medical insurance claims as a courtesy to our patients.

Motor Vehicle and Worker's Compensation: In order for our office to submit your claims for you, you must provide us with the following information: insurance company name, address and telephone number, as well as your claim number, date of accident and claims adjuster's name. In the event that your insurance denies or terminates your benefits, you will be responsible for full payment for services rendered. Please note for all Workers' Compensation patients, your initial appointment must be scheduled by your nurse case manager or Worker's Compensation adjustor. Authorization must be received prior to the initial office visit. Motor Vehicle patients, please note prior to your initial office visit your auto benefits must be confirmed and verified by our office.

Payment Policy:

All co-payments, co-insurance, and deductibles are paid at the time of service to help control costs of medical care. Payments may be made by cash, check, Visa, MasterCard, American Express, and Discover. For larger amounts, such as surgical fees not covered by insurance, New Day Pain and Wellness will work with you to arrange a payment plan. Self pay patients and Surgical Pre-pay patient's payments will only be accepted via credit card, cash payment, and/or money orders.

Treatment of Patients:

Throughout your treatment at New Day Pain and Wellness, the medical providers may order diagnostic testing to help determine your diagnosis or create a better treatment plan for you, the patient. These tests include lab work, x-rays, MRI's, CT scans, Bone Scan's, etc. Failure to schedule or obtain the recommended diagnostic studies in a timely manner or to schedule a follow up appointment to review the diagnostic tests in a timely manner; will constitute as a breech of our recommendations and is Against Medical Advice {AMA). Therefore, New Day Pain and Wellness employees and medical providers will not be held responsible for lack of patient responsibility and purposeful disregard of our medical recommendations. Non- compliance may result in an adverse complication to the patient's medical result/ outcome.

Code of Conduct:

Requirements: In an effort to provide and maintain a safe and healthy environment for employees, visitors, patients and other occupants I have been informed that unacceptable, disruptive behaviors and/or communications (mail, telephonic, electronic, voicemail) of any form will not be tolerated and/or permitted within New Day Pain and Wellness facilities. The following behaviors are prohibited and will be resolved as indicated through proper public law enforcement assistance; destruction of property, verbal or gesturing threats and/or implications of violence, possession of any/all weapons, cursing/profanity, physical assault or threats and/or other derogatory verbal or non-verbal remarks. No hostile communication or gestures regarding an individuals' race, ethnicity, language or sexuality is permitted within New Day Pain and Wellness facilities. Appropriate attire, shoes must be worn. Nudity and/or inappropriate exhibition and/or exposure will not be tolerated and removal from the premises will be requested.

HIPPA Policy and Privacy Notice

I have received and read a copy of New Day Pain & Wellness Notice of Privacy Practices (Notice).

By initialing I have read and understand the above_______

Authorization to Release Information

I consent to the use or disclosure of my protected health information by New Day Pain & Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my Health care bills or to conduct health care operations of New Day Pain & Wellness.

By initialing I have read and understand the above_______

Financial Agreement & Payment Policy

I understand that I am financially responsible for services rendered by New Day Pain & Wellness providers. I also understand that few insurance carriers cover all costs for services rendered. New Day Pain & Wellness will submit claims to your insurance carrier. I will be responsible for the balance on my account that my insurance company does not cover. I will pay any co-payments, co-insurance, and deductibles at the time of service at New Day Pain & Wellness.

By initialing I have read and understand the above_______

Authorization for treatment

Throughout your treatment at New Day Pain & Wellness the medical providers may order diagnostic testing (lab work, bone scan's, x-rays, MRI's, CT scans. etc) that will help determine your diagnosis and future treatment. Failure to schedule or obtain the recommended diagnostic studies or failure to schedule a follow up visit in a timely manner to review the diagnostic studies and discuss the results will constitute as a breach of our recommendations. New Day Pain & Wellness employees and medical providers will not be held accountable for your lack of responsibility and purposeful disregard of our medical recommendations.

By initialing I have read and understand the above______

I hereby authorize the medical staff of New Day Pain & Wellness to render medical services and treatments as deemed necessary. I understand that failure to comply with our medical recommendations is against medical advice. (AMA)

By initialing I have read and understand the above_______

Code of Conduct Policy

I have read and understand New Day Pain and Wellness Patient Code of Conduct.

By initialing I have read and understand the above_______

By signing, I have read, understand and agree to comply with ADA policies so noted in the Notice of Privacy Practices {Notice).

Signature _____________________________________Date ___/___/___

Printed Name____

If patient is a minor {under 18):

Minor's Name ________________________Guardian's Name (printed)______________________

Signature_____________________________ Relationship_______________________

Date ___/___/___

Consent for the Release of Protected Health Information to Personal Representatives

I, ____________________, give my written consent for New Day Pain and Wellness to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

Personal Representatives that New Day Pain and Wellness may share my Protected Health Information with:

Name: ___________________________ Relationship: ________________________

Name: ___________________________ Relationship: ________________________

Name: ___________________________ Relationship:_________________________

_____**Do not discuss my Protected Health Information with anyone other than myself at any time.**

New Day Pain and Wellness may leave a message:

At Home At Work

Patients' Signature _____________________ Date:_________

Form Fee Agreement

Please note: The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

NO Charge:

- Workers Compensation requested Disability and Work Status forms

- Auto Insurance Carrier requests for Work Status and Treatment Plans

$35.00:

- Disabled Parking Applications

- Credit Card deferment forms

- Private Disability Insurance Forms

- Family Medical Leave Act {FMLA) forms

$150.00- $300.00

- For completion of any dictated letter describing medical care and limitations

- For any narrative report detailing diagnosis, treatment, and future medical care including work capacity statements. Functional Capacity Evaluation testing may be necessary prior to, or in addition to the narrative report. The fee for the FCE test is determined by the facility that the testing is completed at.

I have read and understand the above. By signing I agree to comply with the Form Fee policy of ADA. Fees subject to change without notice.

Patient Name (printed) ___________________Signature ______________________Date________

New Day Pain & Wellness
Interventional Pain Specialist

Official use only:

Attorney:

___Forwarded **pages 2-8 and 23** to attorney
___**W9**
___**Visit notes**

Insurance:

___Forwarded **pages 2 and 7-8** to insurance
___Forwarded **page 23** to insurance
___**W9**
___**Visit notes**

Clerical:

___Scan **pages 1-15 and 23** to chart
___Visit notes (dictated from pages 17-22)

<u>Please complete this form</u>

Patient Name: ____

Today's Date: ___/___ /___ DOB: ___/___ /___ **Date of Accident:___/___/___**

(please circle): M F Right handed Left handed HEIGHT: _____
WEIGHT: _____

Pain: _____ BP: _____ HR: _____ RR: _____ Temp: _____ O2 Sat: _____

RACE/ETHNICITY (please circle): WHITE HISPANIC AFRICAN AMERICAN PACIFIC ISLANDER
OTHER

PRIMARY CARE_____________________________

PREFERRED LANGUAGE (please circle): ENGLISH SPANISH OTHER

Please complete all fields. If it does not apply, please mark N/A

Were you the: driver / passenger / pedestrian

Were you struck from: behind / front / drivers side / passenger side / other

Did another car strike yours? Yes / No Did your car strike another car? Yes / No

Were you wearing your seatbelt? Yes / No Was a citation issued to you? Yes / No

Did airbags deploy? Yes / No Did you go to the hospital? Yes / No

By Ambulance? Yes / No / N/A Did you lose consciousness? Yes / No / I don't recall

What part of the body did you injure? (Please specify right or left)

New Day Pain & Wellness
Interventional Pain Specialist

Please circle the symptoms you've been experiencing since this accident.

Headache	Tingling in Arms	Buzzing in Ears
Neck Pain	Tingling in Legs	Loss of Balance
Neck Stiffness	Numbness in Toes	Fainting
Dizziness	Numbness in Fingers	Diarrhea
Back Pain	Shortness of Breath	Stomach Upset
Back Stiffness	Fatigue	Constipation
Nervousness	Light Sensitivity	Cold Sweats
Chest Pain	Loss of Memory	Fever
Sleep Disruption	Ringing Ears	Other

What is your chief complaint today?

Have you been treated for this accident? Yes / No

If yes, by whom? (list all doctors, physical therapists, Hospital ER, etc.)

Are you taking any medications for this injury? Please list.

Have you had any diagnostic testing for this injury? (MRI, CT, X-Ray) Please indicate facility and date.

Rate your pain by circling the number that best describes your pain at it's worst

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Pain as bad as you can imagine

Rate your pain by circling the number that best describes your pain on average

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Pain as bad as you can imagine

---

Since the pain began, how has the pain changed? ___decreased ___increased ___stayed the same

N | New Day Pain & Wellness
Interventional Pain Specialist

Please circle the description of the pain you've been experiencing.

Aching	Tiring/Exhausting	Cramping
Numbness	Shock-like	Shooting
Spasming	Squeezing	Tingling/Pins & Needles
Throbbing	Hot/Burning	Dull

How often does the pain affect you? ___Constant ___Intermittent

When does the pain get worst? ___Mornings ___During the Day ___Evenings ___Middle of the night

What makes your pain better? ____

What makes your pain worse? ____

Have you missed work? Please list dates____

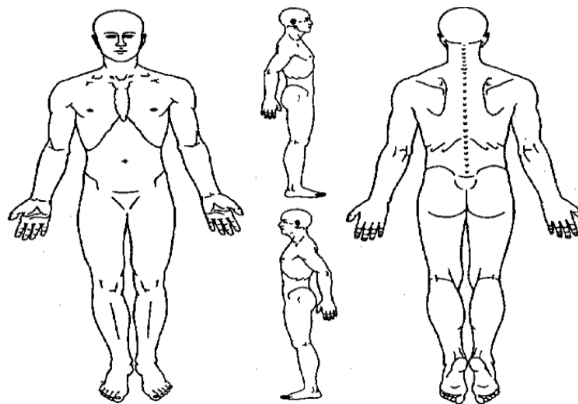
Is your condition preventing you from participating in certain activities? Yes / No - Please list.

____

Have you had any previous injuries not related to this accident? (Previous auto accidents, fractures, surgeries, etc.) Please list the year.

____

Official use only:



Plan:

New Day Pain & Wellness
Interventional Pain Specialist

CURRENT MEDICATIONS (name, strength and dose):

1. 2. 3.

4. 5. 6.

7. 8. 9.

PHARMACY NAME ____

ADDRESS/CROSS STREETS__________________________________

PHONE# ____

PAST MEDICAL HISTORY: (please circle all that apply)

Arthritis	heart attack	Osteoporosis
Asthma	hepatitis a, B, or C	Pacemaker
bleeding disorders/blood clots	high blood pressure	renal disease
Cancer	high cholesterol	Rheumatoid
COPD	HIV/aids	Stroke
Diabetes	liver disease	thyroid disease
GERD	neurologic disorders	
GI disorders	other	

ALLERGIES (please circle): Aspirin Codeine Latex Penicillin Sulfa None Other: ___________________

Reaction:____

LIST ALL PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES: □ NONE

1. YEAR

2. YEAR

3. YEAR

4. YEAR

5. YEAR

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, list your relative

□Diabetes_______ □High Blood Pressure_______ □Rheumatoid Arthritis_______

□Difficulty with anesthesia_______ □Bleeding Problems_______ □None known

New Day Pain & Wellness
Interventional Pain Specialist

SOCIAL HISTORY (please circle): Smoking Qty Drinking Qty Drugs Type/Qty

MARITAL STATUS (please circle): Single Married Divorced Widow Separated Student

EMPLOYMENT STATUS (please circle): Employed Unemployed Disabled Retired Occupation______________________________

REVIEW OF SYSTEMS

Have you ever had any of these symptoms? If no, mark NONE		NONE	YEAR	Details/Comments
1. GI	□Heartburn, Ulcers □Nausea, Vomiting □Blood in Stool	□	____	______________
2. ENDO	□Thyroid Disease □Heat or Cold Intolerance	□	____	______________
3. CON	□Weight Loss □Loss of Appetite □Fatigue	□	____	______________
4. EYE	□Blurred Vision □Double Vision □Vision Loss	□	____	______________
5. ENT	□Hearing Loss □Hoarseness □Trouble Swallowing	□	____	______________
6. CV	□Chest Pain □Palpitations	□	____	______________
7. RS	□Chronic Cough □Pneumonia □Shortness of Breath	□	____	______________
8. GU	□Painful Urination □Blood in Urine □Kidney Problems	□	____	______________
9. SK	□Frequent Rashes □Skin Ulcers □Lumps □Psoriasis	□	____	______________
10. NEU	□Headaches □Dizziness □Seizures □Numbness	□	____	______________
11. PSY	□Depression/Anxiety □Drug/Alcohol Addiction □Sleep Disorder	□	____	______________
12. HEM	□Easy Bleeding □Easy Bruising □Anemia	□	____	______________

13. Are you HIV Positive? □Yes □No

14. Have you ever had Hepatitis A, B, or C? □Yes □No If yes what type?

15. Are you pregnant? □Yes □No

16. Are you Claustrophobic? □Yes □No

New Day Pain & Wellness
Interventional Pain Specialist

Patient Assessment

The physicians at New Day Pain and Wellness are concerned about your health and want to make sure that we are evaluating those factors which may impact your wellbeing. The following questions are intended to give the physicians at New Day Pain and Wellness information about your general health.

Please circle the correct answer or fill in the blanks.

1. Have you been on medicine to treat osteoporosis? Yes No

    If yes, has it been prescribed within 12 months? Yes No

    What medicine are you taking to treat your osteoporosis?

2. Do you take Calcium and Vitamin D? Yes No

3. Have you ever had a fracture of your arm, hip, or spine? Yes No

4. Have you fallen more than twice or fallen and hurt yourself in the past year? Yes No

5. Have you had the influenza vaccination for the current flu season? Yes No

6. Have you ever had the pneumococcal vaccine? Yes No

7. Do you have an Advanced Care Plan? Yes No

8. Have you used or smoked tobacco products in the last 24 months? Yes No

    If yes, are you a tobacco smoker? Yes No

9. Do you consume alcoholic beverages? Yes No

    If yes, how much per setting? ________ Per week?__________

Please understand that smoking and consuming alcoholic beverages can impair your general health as well as your health.

Are you interested in quitting? Yes No

Print name:____

Patient signature:____________________________________ Date:________________

NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

1. The below injured patient, has in the opinion of this medical provider, suffered an Emergency Medical Condition, as a result of the patient's injuries sustained in an automobile accident that occurred on ______________________ **(fill in date of accident).**
2. The basis for the finding of an Emergency Medical Condition is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health; b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

Physician's Name (PRINT) | **Signature of medical provider** | **Date**

The undersigned injured person or legal guardian of such person affirms:

1. The symptoms I reported to the medical provider are true and accurate.
2. I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injuries I suffered in the care accident.
3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:
______________________ (name of patient).

Patient's Name (PRINT) | **Signature of injured patient/guardian** | **Date**