

MARYLAND PAIN AND SPINE CENTER, LLC REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one)	
						Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		Social Security no:		Birth date: / /	Age:
							Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Email Address		Home phone no.: ()	
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:				Employer phone no.: ()	
Ethnicity: Check one							
<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Not Hispanic/Latino		<input type="checkbox"/> Refused to Report		<input type="checkbox"/> Undefined	
Race: Check one							
<input type="checkbox"/> Asian		<input type="checkbox"/> Black or African American		<input type="checkbox"/> Other Race		<input type="checkbox"/> White	

FINANCIAL AUTHORIZATION AND RELEASE
<p>I am ultimately responsible for payment of all charges for service rendered by Maryland Pain and Spine Center, LLC. For all contracted insurance carriers, I understand that I will be responsible for any co-payments, deductibles, co-insurance or any services that are not considered medically necessary by my insurance company and will be collected at the time of service.</p> <p>I hereby authorize the release of pertinent medical information including the diagnosis and records of any treatment or examination rendered to me or my child, to my insurance carriers for the purpose of processing the claim.</p> <p>I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing.</p>
<p>Signature of patient or parent if a minor (seal) _____ Date _____</p>

HIPAA AUTHORIZATION						
<p>I acknowledge that I have been explained and/or reviewed this office's notice of Privacy Practices in accordance with HIPAA regulations:</p>						
<p>Signature of patient or parent if a minor _____ Date _____</p> <p>I authorize Maryland Pain and Spine Center, LLC to use and disclose my health information to provide treatment or services to coordinate or manage my health care or for medical consultations or referrals.</p>						
<p>Signature of patient or parent if a minor _____ Date _____</p> <p>*****I hereby decline to authorize any release of my information to anyone other than my insurance:</p>						
<p>Patient's signature: _____ Date _____</p> <p>I hereby authorize this office to release my information to the following person(s):</p>						
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black;">Name.</td> <td style="width: 20%; border-bottom: 1px solid black;">Phone Number</td> <td style="width: 40%; border-bottom: 1px solid black;">Relationship</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Name</td> <td style="border-bottom: 1px solid black;">Phone Number</td> <td style="border-bottom: 1px solid black;">Relationship</td> </tr> </table>	Name.	Phone Number	Relationship	Name	Phone Number	Relationship
Name.	Phone Number	Relationship				
Name	Phone Number	Relationship				



We are interested in understanding more about your pain. Please help us by filling out this questionnaire. Please *bring the completed questionnaire with you for your first appointment. Your appointment may be delayed if you do not arrive with the completed questionnaire. If you need assistance completing the form, contact the pain management center.*

Name _____ Date of Birth: _____

Primary Care Physician:

Referring Physician (if different):

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

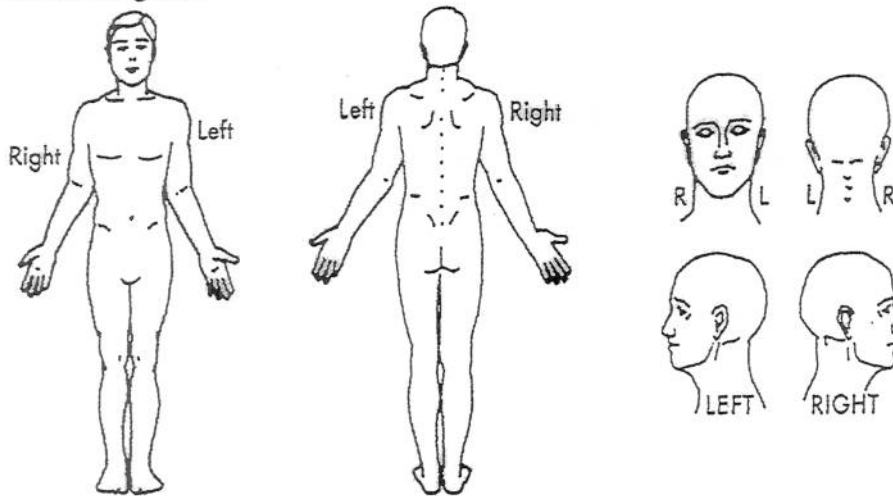
Phone: _____

Have you ever been to a pain specialist before? YES NO If yes, list name of Physician/practice: _____ Phone: _____

When did you pain begin? _____

Where is your pain?

Please use the diagram below to indicate where your most painful areas are located. Shade in these areas darkly and shade in your less painful areas lightly. If the pain radiates or travels from one place to another, please include it on the diagram.



Using the scale below, please rate the level of your pain on a scale of 0 (no pain) to 10 (worst pain imaginable) for the following:

0 1 2 3 4 5 6 7 8 9 10
 (No Pain) (Worst pain imaginable)

PRESENT level of pain: _____ **WORST** level of pain you've had: _____ **LEAST** level of pain you've had: _____

Using the same scale (0-10), what level of pain is acceptable to you or tolerable for you? _____