Tricity Pain Associates
Quality Care, Delivered.

NEW PATIENT INTAKE

NAME: ____ DATE: ______________AGE:__________

ADDRESS:____

CITY: ____ STATE: _________________ ZIP: ______________

HOME PHONE: ___________________WORK PHONE: _________________CELL:______________________

EMAIL:____

DATE OF BIRTH: ________________________REFERRING PHYSICIAN: __________________________

PAST MEDICAL HISTORY

☐Kidney stones☐AIDS or HIV☐Liver Disease☐Anemia ☐Stroke☐Gout☐Cancer
☐Emphysema☐Shingles ☐Arthritis (Rheumatoid or Osteoarthritis) ☐Headaches/Migraines
☐Depression ☐Insomnia ☐Diabetes ☐ Asthma☐Lupus ☐Seizures☐Fibromyalgia
☐Heart disease/Attack ☐Hepatitis (A, B, C, D) ☐High blood pressure ☐Prostate enlargement
☐Tuberculosis ☐Panic attacks☐Kidney Disease☐Hypothyroidism ☐Schizophrenia or bipolar
☐Peripheral Vascular Disease ☐Bleeding Disorder ☐_____________

PAST SURGICAL HISTORY:

- ________________________________ • ____
- ________________________________ • ____

SOCIAL HISTORY:

Occupation: _______________________

Do you smoke? ☐ YES ☐ NO HOW MANYPACK/DAY?_______ YEARS?______

Drink alcohol? ☐ YES ☐ NO IF YES HOW MUCH? _________________________
Do you use any other drug(Marijuana, Cocaine, etc)? ☐ YES ☐ NO

Marital status? ☐ SINGLE ☐ MARRIED☐ DIVORCED ☐ WIDOWED

Do you live alone? ☐ YES ☐ NO IF NO WHO DO YOU LIVE WITH? _______________

FAMILY HISTORY

Please list any disease, illness, or ailments in your IMMEDIATE FAMILY(i.e. mother-breast cancer, father- diabetic, grandfather-heart disease).

1. _______________________________ 2. _____________________________
3. _______________________________ 4. _____________________________

CURRENT MEDICATIONS:

_______________________ _______________________ __________________________

_______________________ _______________________ __________________________

ALLERGIES:

1. _____________________ 2. _______________________

Physicians: Urfan Dar, MD / Sridhar Vasireddy, MD / KanishkaMonis, MD / Michael Zeitlin, MD
Physician Assistance: Howard Kagan, PA & Chris Watson, PA

Latex: ☐ YES ☐ NO Adhesive: ☐ YES ☐ NO Betadine: ☐ YES NO Injection Dye: ☐ YES ☐ NO

History of Present Ilness:

- When did it start: ____
- What happened and when/what caused your pain?(car accident, fall, nothing, etc)
  ____
- Is your pain constant or comes and goes? _________________________
- Where does your pain start?____________________________________
- Where does it go? ____
- **Qualityof your pain**(circle all that apply)

Numbness Pins & Needles Burning Aching Stabbing Shooting

- **What aggravates your pain?** (Circle all that apply)

Sitting Bending Walking Lying down Leaning forward Leaning Back

Coughing/sneezingClimbing upstairs Going downstairs

- **What makes your pain better?** (Circle all that apply)

Sitting Bending Walking Lying down Leaning forward Leaning BackStretching Rest Heat

Cold MedicationIf medication which ones? _______________________________________

- **What treatments Have you tried?** (Circle all that apply)

Physical Therapy Chiropractor TENS Injections Massage Therapy

Ibuprofen/Aleve/Motrin Over the counter ointments (Ben-gay, Icy-Hot, Myoflex)

- Any of the above treatments help? If so which one? ____________________

  ____

REVIEW OF SYSTEMS:

Are currently experiencing any of the following symptoms?

GENERAL:

Loss of appetite ....☐YES ☐NO Recent weight loss ....☐YES ☐NO
Fever or chills ....☐YES ☐NO Low energy/Fatigue ....☐YES ☐NO

ENDOCRINE:

Thyroid disease....................☐YES ☐NO Heat/Cold intolerance..................☐YES ☐NO

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CARDIOVASCULAR:

Chest pain……………………… ☐YES ☐NO Palpitations………………………… ☐YES ☐NO

Leg Swelling…………………… ☐YES ☐NO Orthopnea……………………………. ☐YES ☐NO

RESPIRATORY:

Shortness of breath ………….. ☐YES ☐NO Chronic cough …………………….. ☐YES ☐NO

Wheezing……………………… ☐YES ☐NO

EYES:

Blurred vision…………………… ☐YES ☐NO Double vision……………………….. ☐YES ☐NO

Loss of vision…………………… ☐YES ☐NO Eye Pain……………………………. ☐YES ☐NO

KIDNEY/BLADDER/URINE:

Painful urination………………… ☐YES ☐NO Blood in urine……………………….. ☐YES ☐NO

Frequent Urination……………. ☐YES ☐NO

SKIN:

Rash……………………………… ☐YES ☐NO Itching……………………………….. ☐YES ☐NO

Frequent Rashes……………… ☐YES ☐NO

GASTROINTESTINAL:

Nausea or vomiting……………. ☐YES ☐NO Heartburn……………………………. ☐YES ☐NO

Blood in stool…………………… ☐YES ☐NO Constipation…………………………. ☐YES ☐NO

HEAD/EARS/NOSE/THROAT:

Hoarseness……………………… ☐YES ☐NO Hearing loss………………………… ☐YES ☐NO

Trouble swallowing……………. ☐YES ☐NO Ear pain……………………………… ☐YES ☐NO

NEUROLOGICAL

Tremor…………………………… ☐YES ☐NO Dizziness……………………………. ☐YES ☐NO

Seizures………………………… ☐YES ☐NO Tingling……………………………… ☐YES ☐NO

PSYCHIATRIC:

Depression……………………… ☐YES ☐NO Suicidal Thoughts………………….. ☐YES ☐NO

Drug/Alcohol addiction………… ☐YES ☐NOTrouble sleeping(Insomnia)……….. ☐YES ☐NO

HEMATOLOGICAL/LYMPHATIC:

Easy bruising…………………… ☐YES ☐NO Easy bleeding……………………… ☐YES ☐NO

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PATIENT REGISTRATION

(Please Print) All information will be strictly confidential. **DATE:**_______________

Patient's Name Referred by:	Sex M / F	Birth Date ____/____/_____ Age__________	Marital Status Single **[ ]** Married **[ ]** Widowed [ ] Divorced [ ]

Residence address City State Zip	Home Phone:	Patient Social Security #

Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/_____	Guarantor's Social Security #

Name of Spouse/Parent	Birth date	Social security #	Business phone

Person to contact in case of emergency:	Relationship to patient	Phone

Workers' Compensation? Yes [ ] No [ ] Motor Vehicle? Yes [ ] No [ ] **If Yes-put W/C or MVA carrier above**	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #

Primary insurance **MedicareYes [ ] No [ ]Medicaid Yes [ ] No [ ]**Address	Is insurance through your employer?

Subscriber Name **Subscriber SS#**	**Subscriber birth date**	Policy #	Group #

Secondary insurance name Address		

Subscriber Name **Subscriber SS#**	**Subscriber birth date**	Policy #	Group #

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Assignment of Benefits/Medicare Lifetime Signature

I hereby authorize payment directly to the physician of the surgical or medical benefits, if any, for his services, I realize I am responsible for noncovered services, co-payments and deductibles, I also understand that this assignment does not relieve my liability on these services. I request payment of authorized Meidcare benefits be make on my behalf to Interventional Pain Management Physicians, P.A. for any service furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Signature____**Date**_________________________

Release of Information

I hereby authorize the physician to release any information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company(ies).

Signature____**Date**___________

Consent ForTreatment

____, the patient and/or legal guardian of said patient do hereby give my consent for medical examination and treatment under the care of the practice and deemed necessary.

Signature____**Date**___________

Acknowledgement of Receipt of Notice of Privacy Practice

I,_________________________________ have received a copy of this office's Notice of Privacy Practice.

Signature____**Date**___________

Acknowledgement for Billing of No Show Appointments

I,_________________________________ understand that as of Dec. 15, 2010 all patients will be charged a fee of $30 for missed appointments when the office is not give a 24 hour notice. This charge will not be billed to my insurance.

Signature____**Date**___________

Physicians: Urfan Dar, MD / Sridhar Vasireddy, MD / KanishkaMonis, MD / Michael Zeitlin, MD
Physician Assistance: Howard Kagan, PA & Chris Watson, PA