PAIN SPECIALISTS
OF SOUTHERN OREGON

Dear Sir or Madam,

Welcome to Pain Specialists of Southern Oregon. We are committed to providing you with state-of-the-art interventional pain management and clinical services. Thank you for choosing us for your care.

Joseph Savino, M.D., George Johnston, D.O. are fellowship-trained in Pain Medicine. Dr. Savino is board-certified in Anesthesia, with a subspecialty certification in Pain Management. Dr. George Johnston is board-certified in Physical Medicine & Rehabilitation, with a subspecialty certification in Pain Management. Their goal is to partner with the referring physician to optimize your care.

## APPOINTMENTS

Enclosed you will find several forms. Please complete each form and bring them to your appointment. Please also bring any records, imaging on discs or CDs, and imaging reports pertaining to your condition.
We ask that you arrive to your first appointment at least 30 minutes early so we have the opportunity to collect and organize your records. We look forward to meeting you. Please do not hesitate to contact me directly with questions.

## FINANCIAL POLICY

We participate with most major insurance companies. Co-payments and/or co-insurance payments are due at the time of service. For patients who do not have insurance and are unable to pay in full at the time of service, please contact our office prior to your appointment to discuss a financial payment plan. As a convenience to our patients we accept cash, checks and/or VISA/MasterCard/Discover and American Express.

Sincerely,
**Pain Specialists of Southern Oregon**

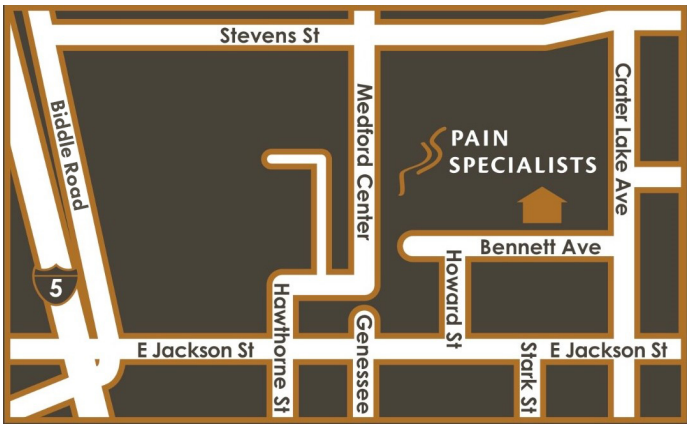
P (541) 779-5228  F (541) 772-1533

## DIRECTIONS TO THE OFFICE

**From Grants Pass:**
Take the CRATER LAKE HWY exit, Exit 30
Turn LEFT on CRATER LAKE HWY
Turn RIGHT onto BIDDLE RD RAMP
Turn LEFT onto BIDDLE RD.
Turn LEFT onto E JACKSON ST.
Turn LEFT onto CRATER LAKE AVE
Turn LEFT onto BENNETT AVE

End at 825 Bennett Ave Medford, OR 97504

**From Ashland:**
Take the CRATER LAKE HWY exit, EXIT 30
Get into the FAR RIGHT HAND LANE on freeway off ramp
Turn RIGHT onto BIDDLE RD RAMP
Turn LEFT onto BIDDLE RD.
Turn LEFT onto E JACKSON ST.
Turn LEFT onto CRATER LAKE AVE
Turn LEFT onto BENNETT AVE
End at **825 Bennett Ave Medford, OR 97504**

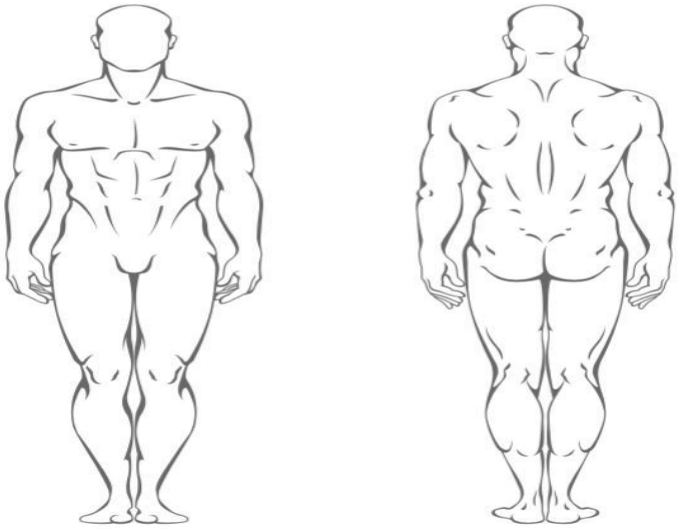


PAIN SPECIALISTS OF SOUTHERN OREGON

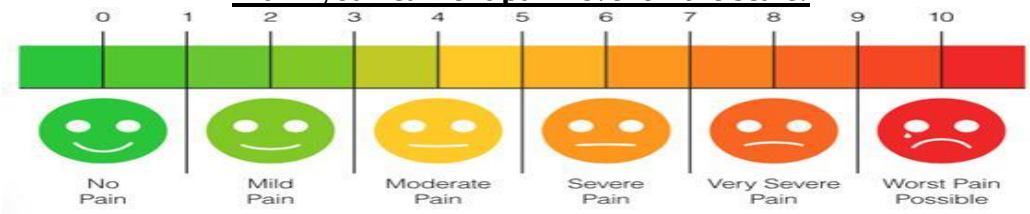
Date:_____

Patient's Name: _____ DOB:_____

**Place an (X) in the area of pain that you would like to address today:**



**Mark your current pain level on the scale:**




Please describe your pain in a few words: _____

Pain has been present for: _____

Pain is relieved by: _____

Pain is worsened by: _____

PAIN SPECIALISTS OF SOUTHERN OREGON

Patient's Name:_____

**Circle any previous treatment / imaging you have had:**

Physical Therapy TENS Acupuncture Chiropractic Injections_____

X-Ray MRI CT

**For Internal Use Only**

Ht:_____ Wt:_____ Pain Level: ____/10 02Sat: _____% Resp:_____

Medication Reviewed ☐ Allergies Reviewed ☐

**Past Medical History:**

Check (X) the box next to and medical history which you have had.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Arthritis | | Chronic Pain | | Asthma | | Hypertension | |
| Heart Disease | | Hepatitis | | Diabetes | | Hypothyroidism | |

Please describe any current or past medical treatment not listed above:

_____

_____

**Surgical History:**

Check (X) the box next to any surgical procedures which you have had.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Tonsilectomy | | Appendectomy | | Cholecystectomy | | Colectomy | |
| Gastric Bypass | | Hysterectomy | | Hernia Repair | | Breast | |
| Heart Surgery | | Low Back Surgery | | Neck Surgery | | | |

Others:_____

_____

**Family History:**

Check (X) the box next to any disease diagnosed in your blood relatives.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heart Disease | | Cancers | | Hypertension | | Diabetes | |

Others:_____

PAIN SPECIALISTS OF SOUTHERN OREGON

Patient's Name:_____

**Allergies:**

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Medications:**

| Name | Milligram | Amount Per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Social History:**

| | Yes (X) | Type | Duration | Amount Per Day | No (X) |
|---|---|---|---|---|---|
| Do you drink alcohol? | | | | | |
| Do you use tobacco? | | | | | |

Do you have a history of substance abuse? If so please explain: _____

_____

PAIN SPECIALISTS OF SOUTHERN OREGON

Patient's Name:_____

**Do you have any of the following conditions? Check (X) if yes.**

| | |
|---|---|
| Numbness | |
| Weakness | |
| Headaches | |

| | |
|---|---|
| Abnormal Bleeding | |
| Abnormal Bruising | |

| | |
|---|---|
| Nausea | |
| Vomiting | |
| Constipation | |
| Diarrhea | |

| | |
|---|---|
| Increased frequency of urination | |
| Incontinence | |
| Diabetes | |

| | |
|---|---|
| Trouble seeing | |
| Eye pain | |
| Double vision | |
| Loss of hearing | |

| | |
|---|---|
| Rash | |
| Fatigue | |
| Night Sweats | |
| Weight change | |

| | |
|---|---|
| Anxiety | |
| Depression | |
| Bipolar disorder | |


RELEASE OF INFORMATION

I,_____, hereby authorize
Patient Name

Pain Specialists of Southern Oregon to release information about my:

- □ Medical Information
- □ Billing Information
- □ Appointment Information
- □ Other:_____

*Required by Pain Specialists of Southern Oregon:

*Referring Provider:_____
Name

*Primary Care Provider:_____
Name

If requested by:

_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

Patient Signature:_____ Date:_____

_____
Representative Signature Relationship Date

PAIN SPECIALISTS OF SOUTHERN OREGON

DEMOGRAPHICS

Today's Date: _____

Patient Name: _____ Date of Birth: _____
Last First M.I

Soc Sec#: ___ - ___ - ___ Drivers Lic#: _____ Marital Status: _____

Language: English: _____ Other: _____ Race: _____ Ethnic Group: _____

Physical Address: _____ City: _____

State: _____ Zip Code: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Ok to Leave a Detailed Message? Yes____or No_____ Ok to Send Text Message? Yes_____ or No_____

Email Address: _____

Employer: _____ Employer Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Provider: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Pharmacy Name: _____ City: _____ Phone: _____


ADVANCED CARE

Do you have a health care proxy in the event you are unable to make your own medical decisions?

☐ Yes

☐ No

Designee's Name:_____Phone Number: _____

Do you have a living will?

☐ Yes

☐ No

Which statement best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Patient Signature:_____ Date:_____

_____

Representative Signature Relationship Date