



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. Our office bills your insurance for the Celeri- Blue Tablets. If your insurance applies that service towards your yearly deductible, then you may receive a bill.

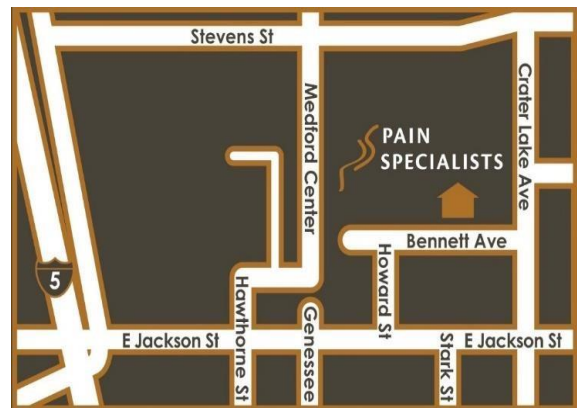
DIRECTIONS TO THE OFFICE From Grants Pass:

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

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 a 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: _____

Visit Related to: Work Comp: ☐ Yes ☐ No or Motor Vehicle Accident: ☐ Yes ☐ No

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:

If requested by:

Name

Name	Relationship	Phone Number
------	--------------	--------------

Name	Relationship	Phone Number
------	--------------	--------------

Name	Relationship	Phone Number
------	--------------	--------------

Patient Signature: _____ Date: _____

Representative Signature	Relationship	Date
--------------------------	--------------	------

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

PAIN QUESTIONNAIRE

Name: _____ DOB: _____ Appointment Date: _____

1. Indicate the area of pain that you would most like to address today (e.g. "neck", or "low back")

2. Which side does this primarily affect? (circle one)

left right both sides equally left more than right right more than left

3. Does this pain radiate anywhere? (circle one) No Yes

If yes, then where does it radiate to?

4. How long has this pain been present? _____

5. there any known event that caused this pain? (circle one) No Yes

If you answered "yes", please describe here: _____

6. Do you hurt all the time? (circle one) No Yes

7. Is there any one time of day that you reliably hurt more than others? (circle one) No Yes

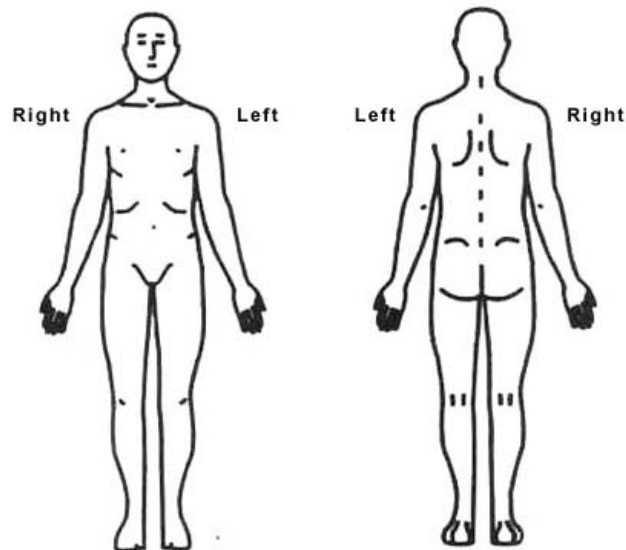
If you answered "yes", please indicate when: _____

8. Your pain occurs: ☐ Worse after activity ☐ Worse at the end of the day ☐ Worse during cold seasons ☐ Worse during the day ☐ Worse during the night ☐ Worse in the morning

9. Describe your pain: ☐ Aching ☐ burning ☐ cramp-like ☐ dull ☐ tingling ☐ sharp
☐ shooting ☐ stabbing ☐ other

PAIN QUESTIONNAIRE

10. On the diagram below, shade in the painful area that you indicated on the previous page.



11. ASSOCIATED SYMPTOMS (select all that apply)

NUMBNESS

- | | |
|---|--|
| <input type="checkbox"/> Left shoulder numbness | <input type="checkbox"/> Right shoulder numbness |
| <input type="checkbox"/> Left upper arm numbness | <input type="checkbox"/> Right upper arm numbness |
| <input type="checkbox"/> Left forearm numbness | <input type="checkbox"/> Right forearm numbness |
| <input type="checkbox"/> Left hand numbness | <input type="checkbox"/> Right hand numbness |
| <input type="checkbox"/> Left finger numbness | <input type="checkbox"/> Right finger numbness |
| <input type="checkbox"/> Left thigh numbness | <input type="checkbox"/> Right thigh numbness |
| <input type="checkbox"/> Left lower leg (below the knee) numbness | <input type="checkbox"/> Right lower leg (below the knee) numbness |
| <input type="checkbox"/> Left foot numbness | <input type="checkbox"/> Right foot numbness |

WEAKNESS

- | | |
|--|---|
| <input type="checkbox"/> Left arm weakness | <input type="checkbox"/> Right arm weakness |
| <input type="checkbox"/> Left leg weakness | <input type="checkbox"/> Right leg weakness |

OTHER

- | | |
|---|---|
| <input type="checkbox"/> Bladder incontinence | <input type="checkbox"/> Bowel incontinence |
| <input type="checkbox"/> Balance difficulties | <input type="checkbox"/> Groin numbness |

12. What activities make your pain worse? (i.e. prolonged sitting, lying down, bending, lifting, twisting, walking, etc.):

13. What makes your pain feel better? (i.e. rest, changing positions, exercise, pain medication, heat, ice, sitting, lying down):

PAIN QUESTIONNAIRE

14. What therapies have you used to treat these symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
Activity modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bracing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When did you last attend PT for this problem?	Month(s):	Year:	Number of sessions?

MEDICATIONS

Check mark all medications that apply below

Opioids		NSAIDS/Tylenol		Muscle Relaxants
<input type="checkbox"/> Tramadol	<input type="checkbox"/> Methadone	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Celebrex	<input type="checkbox"/> Soma
<input type="checkbox"/> Codeine	<input type="checkbox"/> Morphine	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Flexeril
<input type="checkbox"/> Nucynta	<input type="checkbox"/> Buprenorphine	<input type="checkbox"/> Naproxen	<input type="checkbox"/> Relafen	<input type="checkbox"/> Baclofen
<input type="checkbox"/> Dilaudid	<input type="checkbox"/> Hydrocodone	<input type="checkbox"/> Voltaren Gel	<input type="checkbox"/> Daypro	<input type="checkbox"/> Zanaflex
<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Oxymorphone	<input type="checkbox"/> Indocin	<input type="checkbox"/> Feldene	<input type="checkbox"/> Robaxin
				<input type="checkbox"/> Skelaxin
				<input type="checkbox"/> Valium
Antidepressants		Other		
<input type="checkbox"/> Elavil (amitriptyline)	<input type="checkbox"/> Paxil	<input type="checkbox"/> Neurontin (gabapentin)	<input type="checkbox"/> Lyrica (pregabalin)	
<input type="checkbox"/> Pamelor (nortriptyline)	<input type="checkbox"/> Prozac	<input type="checkbox"/> Tegretol	<input type="checkbox"/> Topamax	
<input type="checkbox"/> Cymbalta (duloxetine)	<input type="checkbox"/> Savella	<input type="checkbox"/> Imitrex	<input type="checkbox"/> Mexilitine	
<input type="checkbox"/> Effexor (venlafaxine)	<input type="checkbox"/> Zoloft	<input type="checkbox"/> Xanax	<input type="checkbox"/> Klonopin	
		<input type="checkbox"/> Ativan		

15. What procedure(s) have you had to treat the pain?

☐ No procedure
☐ Epidural steroid injection
☐ Facet joint injection
☐ Medial branch block trial
☐ Facet rhizotomy (ablation)
☐ Sacroiliac joint injection(s)
☐ Spinal cord stimulator
☐ Trigger point injection(s)
☐ Peripheral nerve injection
☐ Decompression surgery (laminectomy or discectomy)
☐ Spinal fusion surgery
☐ Other (Please write in here): _____

PAIN QUESTIONNAIRE

Medications (Please list all current medications or check the applicable box below)

- ☐ I brought a copy of my medication list (Please provide the list to the front desk receptionist)
- ☐ I am not currently taking any medications

Medication Name	Dosage	# of times dosage taken per day

Allergies (please list all known allergies or check applicable box below):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- ☐ I have no known drug allergies

<u>Medication</u>	<u>Please describe allergic reaction, severity & symptoms</u>

PAIN QUESTIONNAIRE

Past Medical History

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> GI ulcer |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other: _____ |

Family History

Please mark if a Blood Family Member has ever had any of these conditions. If so, please indicate their relationship to you.

<u>Disease</u>	<u>Relationship</u>
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Stroke/TIA	_____
<input type="checkbox"/> Alcohol abuse	_____
<input type="checkbox"/> Drug abuse	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Osteoarthritis	_____
<input type="checkbox"/> Scoliosis	_____

Social History

Marital status

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Single | <input type="checkbox"/> Married |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed/Widower |

Alcohol use

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Drinks per day: _____ |
| <input type="checkbox"/> Occasional | |

Drug use

- | |
|--|
| <input type="checkbox"/> History of drug abuse _____ |
| <input type="checkbox"/> Current drug abuse _____ |

Tobacco use

- | |
|---|
| <input type="checkbox"/> Never smoker |
| <input type="checkbox"/> Former smoker; Quit _____ |
| <input type="checkbox"/> Current smoker; Cigarettes per day _____ |

PAIN QUESTIONNAIRE
Review of Symptoms

Constitutional	Yes	Respiratory	Yes	Musculoskeletal	Yes
Activity change		Chest tightness		Joint pain	
Appetite change		Choking		Back pain	
Chills		Cough		Gait problem	
Abnormal sweating		Shortness of breath		Joint swelling	
		Stridor		Muscle pain	
HENT		Wheezing		Neck pain	
Congestion				Neck stiffness	
Dental problem		Cardio			
Drooling		Chest pain		Skin	
Ear discharge		Leg swelling		Color change	
Ear pain		Palpitation		Pallor	
Facial swelling				Rash	
Hearing loss		GI		Wound	
Mouth sores		Abdominal distension			
Nosebleeds		Abdominal pain		Immuno	
Postnasal drip		Anal bleeding		Environmental allergies	
Runny nose		Blood in stool		Food allergies	
Sinus pain		Constipation		Immunocompromised	
Sinus pressure		Diarrhea			
Sneezing		Nausea		Neurological	
Sore throat		Rectal pain		Dizziness	
Ringing ears		Vomiting		Facial asymmetry	
Trouble swallowing				Headaches	
Voice change		Genitourinary		Light-headedness	
		Difficulty urinating		Numbness	
Eyes		Pain with urination		Seizures	
Eye discharge		Involuntary urination at night		Speech difficulty	
Eye itching		Flank pain		Syncope	
Eye pain		Increased urinary frequency		Tremors	
Eye redness		Genital sore		Weakness	
Photophobia		Blood in urine			
Visual disturbance		Penile discharge		Hematologic	
		Penile pain		Enlarged lymph nodes	
		Penile swelling		Bruise/bleed easily	
		Scrotal swelling			
		Testicular pain		Psychiatric	
		Urinary urgency		Agitation	
		Decreased urine output		Behavior problem	
				Confusion	
				Decreased concentration	
				Bad mood	
				Hallucinations	
				Hyperactive	
				Nervous/anxious	
				Self-injury	
				Sleep disturbance	
				Suicidal ideas	

NO SHOW/MISSED APPOINTMENT POLICY

Pain Specialists of Southern Oregon understand that sometimes you need to cancel or reschedule your appointment and that there are family obligations or emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-48-hour notice). You can cancel appointments by calling the following number: 541-779-5228

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1-2) business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24-48 hours' notice: There is a waiting list to see our providers and whenever possible, we like to fill canceled spaces to shorten the waiting period for our patients.
2. If less than a 24-48 hour cancellation is given this will be documented as a "No-Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
4. If you have a "No-Show/Missed" appointment, you may receive a no-show fee of \$25.00.
5. Dismissal from the practice may be considered.

I have read and understand Pain Specialists of Southern Oregon "No Show/Missed Appointment Policy" and understand my responsibility to plan appointments accordingly and notify our clinic appropriately if I have difficulty keeping my scheduled appointments.

Patient Name

Date of Birth

Date

Patient Signature or Parent/Guardian if minor

Relationship to Patient

Staff Signature

Date

Thank you for your understanding and cooperating as we strive to best serve the needs of our patients



FINANCIAL POLICY

Please be assured that everyone in this practice provides medical care in the highest quality possible to all our patients, in an atmosphere of caring, trust and mutual respect.

Your complete understanding of your financial responsibilities is essential; the following is our financial policy that all patients are required to read and sign prior to seeing a healthcare provider. Please let us know if you need any clarification on our payment policies.

Please present to the office with a form of payment to meet your financial obligations to your insurance provider and to your healthcare provider. We accept cash, debit card, check, MasterCard, Visa, Discover and American Express.

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. Patient portion of payment is due at time of service unless prior arrangements have been made with the business office.

We accept assignment with most major insurance companies and participating provider plans. However, please note:

1. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not (to the extent of insurance contractual obligation).
3. Returned checks will be subject to any bank fees charged to our office, in addition to a service fee, and will be billed to you.
4. Unpaid balances are subject to collections process.

We understand that temporary financial problems may affect timely payment of your balance. Balances not paid within 90 days will be turned over to an outside collections agency, unless prior payment arrangements have been made with our business office. Patients turned over to a collection agency will also cease to be patients of Pain Specialists of Southern Oregon.

Due to the hardship imposed on the practice and other patients, scheduled appointments that are missed, cancelled and /or rescheduled with less than 24 hours' notice will result in a fee and may also result in discharge from the practice. The fee for missed appointments is determined based on the level of hardship it imposed on the practice. This fee will not be covered by your insurance and must be paid prior to you seeing the healthcare provider.

Prescriptions provided outside of an office visit due to missed, cancelled and/or rescheduled appointments are subject to a fee and payment will be required at the time prescription is provided.

I have read and understand Pain Specialists of Southern Oregon's "Financial Policy" as described above.

Patient Signature/Authorized Signature

Date

Printed Name of Patient / Printed Name of Authorized Signer

Relationship to patient if not patient

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photocopy or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Pain Specialists of Southern Oregon the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare. This authorization is in effect for all future claims until I choose to revoke it in writing.

Patient Signature/Authorized Signature

Relationship to patient if not patient

Date