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.,Brett Quave, M.D. and Daniel Kim, M.D are fellowship-trained in Pain Medicine. Dr. Savino and Dr. Quave are board-certified in Anesthesia, with a subspecialty certification in Pain Management. Dr. Johnston and Dr. Kim are 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.

## OUR LOCATIONS:

- 825 Bennett Ave., Medford, Oregon, 97504

- 3555 Lear Way, Medford, Oregon, 97504

Pain Specialists of Southern Oregon
P (541) 779-5228 * F (541) 772-1533

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 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

PAIN SPECIALISTS OF SOUTHERN OREGON

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

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 SPECIALISTS OF SOUTHERN OREGON

**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: _____

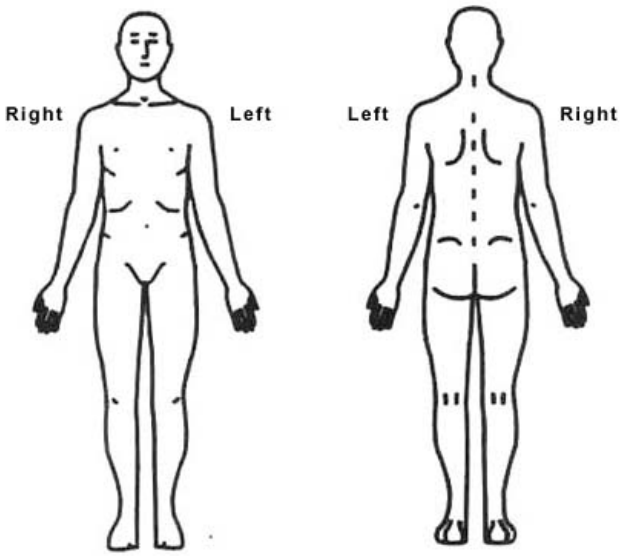
8. Your pain occurs: ☐ Worse after activity ☐ Worse at the end of the day ☐ Worse during cold seasons ☐ Worse during the day ☐ Worse during the night ☐ Worse in the morning

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

PAIN SPECIALISTS OF SOUTHERN OREGON

**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

- ☐ Left shoulder numbness
- ☐ Left upper arm numbness
- ☐ Left forearm numbness
- ☐ Left hand numbness
- ☐ Left finger numbness
- ☐ Left thigh numbness
- ☐ Left lower leg (below the knee) numbness
- ☐ Left foot numbness
- ☐ Right shoulder numbness
- ☐ Right upper arm numbness
- ☐ Right forearm numbness
- ☐ Right hand numbness
- ☐ Right finger numbness
- ☐ Right thigh numbness
- ☐ Right lower leg (below the knee) numbness
- ☐ Right foot numbness

WEAKNESS

- ☐ Left arm weakness
- ☐ Left leg weakness
- ☐ Right arm weakness
- ☐ Right leg weakness

OTHER

- ☐ Bladder incontinence
- ☐ Balance difficulties
- ☐ Bowel incontinence
- ☐ 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 SPECIALISTS OF SOUTHERN OREGON

**PAIN QUESTIONNAIRE**

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

| TREATMENTS | NO RELIEF | MODERATE RELIEF | EXCELLENT RELEIF |
|---|---|---|---|
| Activity modification | ☐ | ☐ | ☐ |
| Acupuncture | ☐ | ☐ | ☐ |
| Bracing | ☐ | ☐ | ☐ |
| Chiropractics | ☐ | ☐ | ☐ |
| Heat | ☐ | ☐ | ☐ |
| Ice | ☐ | ☐ | ☐ |
| Physical therapy | ☐ | ☐ | ☐ |

When did you last attend PT for this problem? Month(s): Year: Number of sessions?

MEDICATIONS — Check mark all medications that apply below

**Opioids**

☐ Tramadol
☐ Codeine
☐ Nucynta
☐ Dilaudid
☐ Oxycodone
☐ Methadone
☐ Morphine
☐ Buprenorphine
☐ Hydrocodone
☐ Oxymorphone

**NSAIDS/Tylenol**

☐ Tylenol
☐ Aspirin
☐ Naproxen
☐ Voltaren Gel
☐ Indocin
☐ Celebrex
☐ Ibuprofen
☐ Relafen
☐ Daypro
☐ Feldene

**Muscle Relaxants**

☐ Soma
☐ Flexeril
☐ Baclofen
☐ Zanaflex
☐ Robaxin
☐ Skelaxin
☐ Valium

**Antidepressants**

☐ Elavil (amitriptyline)
☐ Pamelor (nortriptyline)
☐ Cymbalta (duloxetine)
☐ Effexor (venlafaxine)
☐ Paxil
☐ Prozac
☐ Savella
☐ Zoloft

**Other**

☐ Neurontin (gabapentin)
☐ Tegretol
☐ Imitrex
☐ Xanax
☐ Ativan
☐ Lyrica (pregabalin)
☐ Topamax
☐ Mexilitine
☐ Klonopin

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 SPECIALISTS OF SOUTHERN OREGON

**PAIN QUESTIONNAIRE**

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

☐ I brough 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

| Medication | Please describe allergic reaction, severity & symptoms |
|---|---|
| | |
| | |
| | |
| | |

PAIN SPECIALISTS OF SOUTHERN OREGON

# PAIN QUESTIONNAIRE

## Past Medical History

- ☐ Anemia
- ☐ Arthritis
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar disorder
- ☐ Bleeding disorder
- ☐ BPH
- ☐ Breast cancer
- ☐ Bronchitis
- ☐ CHF
- ☐ Clotting disorder
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ GI ulcer
- ☐ Heart attack
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Osteoporosis
- ☐ Cancer _____
- ☐ Prostate cancer
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke
- ☐ Thyroid disease
- ☐ 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.

| Disease | Relationship |
|---|---|
| ☐ Cancer | _____ |
| ☐ Heart disease | _____ |
| ☐ Diabetes | _____ |
| ☐ Hypertension | _____ |
| ☐ Stroke/TIA | _____ |
| ☐ Alcohol abuse | _____ |
| ☐ Drug abuse | _____ |
| ☐ Depression | _____ |
| ☐ Seizures | _____ |
| ☐ Depression | _____ |
| ☐ Osteoarthritis | _____ |
| ☐ Scoliosis | _____ |

## Social History

**Marital status**

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed/Widower

**Alcohol use**

- ☐ None
- ☐ Drinks per day: ____
- ☐ Occasional

**Drug use**

- ☐ History of drug abuse _____
- ☐ Current drug abuse _____

**Tobacco use**

- ☐ Never smoker
- ☐ Former smoker; Quit _____
- ☐ Current smoker; Cigarettes per day _____

PAIN SPECIALISTS OF SOUTHERN OREGON

## PAIN QUESTIONNAIRE
## Review of Symtoms

| **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 | |

PAIN SPECIALISTS OF SOUTHERN OREGON

# 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**

PAIN SPECIALISTS OF SOUTHERN OREGON

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