

Cedar Rapids Pain Associates

PATIENT INFORMATION

PATIENT NAME:

DATE OF BIRTH:

SOCIAL SECURITY #

ADDRESS:

CITY:

STATE:

ZIP:

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

Please Circle the best number for us to reach you: HOME CELL WORK May we leave a message?
YES NO

EMAIL ADDRESS: _____

Race: Caucasian___ Black___ Asian___ Native American___ Asian Pacific American___ Pacific Islander___
Subcontinent Asian American___ American Indian or Alaskan Native___ Native Hawaiian___ Other Race___
Not Reported - Refused___ Not Reported - Unknown___

Ethnicity: Latino/Hispanic___ Non Latino/Hispanic___ Not Reported - Refused___

Primary Language: English___ Spanish___ Other (Please specify): _____

INSURANCE INFORMATION

SUBSCRIBER:

PRIMARY INSURANCE:

MEMBER ID#:

SUBSCRIBER:

SECONDARY INSURANCE:

MEMBER ID#:

CARE TEAM: (Please List any Doctors you currently see and their Specialty)

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

EMERGENCY CONTACT:

Name: _____ Phone: _____ Relationship: _____

Complete the following if accident-related

Work Accident Auto Accident Other Accident Date of Accident: _____

Insurance Carrier Name: _____ Carrier Billing Address: _____

Claim Number: _____ Adjuster Name & Phone Number: _____

Employer Name- if work- related: _____ Address/Phone: _____

CONSENT TO OBTAIN INFORMATION



4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 319-294-0095

Please PRINT all (except signature at bottom) and provide complete information in each section.

Patient's Legal Name Date of Birth

By signing this form I am authorizing Advanced Spine & Rehab Center/Cedar Rapids Pain Associates to obtain medical information concerning the above named patient from the person/facility listed below.

Name of Person and/or Institution requesting information from

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): Minimum necessary or specify below

- Entire Record
Medication list
Most recent history and physical or specify date(s)
Clinical notes related to visit(s), specify visits or date(s)
CD of Images (X-ray, MRI, CT), specify type and date(s)
Report of test results (i.e. lab, X-ray, etc.), specify type and date(s)
Billing information
Other, specify

As per my request, the reason for obtaining information is:

- Continued medical care
Legal
Insurance
Personal
Other (specify)

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Cedar Rapids Pain Associates, 4205 Glass Road N.E., Cedar Rapids, IA 52402 I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Office Manager at the above address.

I understand that Cedar Rapids Pain Associates may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (initial any category not to be released).

Substance Abuse Mental Health HIV-related information

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months)

Signature of Patient or Legal Guardian Date

Address/Street/P.O. Box City, State, Zip Code

Relationship, if Not the patient Witness Signature

CRPA use only:

Form Sent: Name Date

Original - medical record
Copies - deliver as requested above
- to patient

CONSENT TO RELEASE INFORMATION



4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 319-294-0095

Please PRINT all (except signature at bottom) and provide complete information in each section.

Patient's Legal Name Date of Birth

By signing this form I am authorizing Advanced Spine & Rehab Center/Cedar Rapids Pain Associates to release medical information concerning the above named patient to the person/facility listed below.

Name of Person and/or Institution releasing information to

Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): Minimum necessary or specify below

- Entire Record
Medication list
Most recent history and physical or specify date(s)
Clinical notes related to visit(s), specify visits or date(s)
CD of Images (X-ray, MRI, CT), specify type and date(s)
Report of test results (i.e. lab, X-ray, etc.), specify type and date(s)
Billing information
Other, specify

As per my request, the reason for release of information is:

- Continued medical care
Legal
Insurance
Personal
Other (specify)

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Patient Authorization

CEDAR RAPIDS PAIN ASSOCIATES/ADVANCED SPINE AND REHAB CENTER FINANCIAL POLICY

As a courtesy, Cedar Rapids Pain Associates/Advanced Spine and Rehab Center will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible, and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours – you will be billed for any balance not paid by your insurance.

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY

I authorize my insurer to pay benefits directly to Cedar Rapids Pain Associates/Advanced Spine and Rehab Center. I authorize Cedar Rapids Pain Associates/Advanced Spine and Rehab Center to release all information necessary to secure payment including documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information. I understand that I am financially responsible for all charges incurred at Cedar Rapids Pain Associates/Advanced Spine and Rehab Center. Any portion of these charges not covered by my insurer must be paid by me. I further understand that copayments are due at the time of my Cedar Rapids Pain Associates/Advanced Spine and Rehab Center visit and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with my insurer.

HIPAA NOTICE OF PRIVACY PRACTICES

I understand that Cedar Rapids Pain Associates/Advanced Spine and Rehab Center and its staff will make every effort to keep my protected health information confidential and private. My signature below acknowledges that: I understand that Cedar Rapids Pain Associates/Advanced Spine and Rehab Center may use and disclose my protected health information for treatment, billing to obtain payment, and for related health care operations; I have been offered a copy of, read or received Cedar Rapids Pain Associates/Advanced Spine and Rehab Center’s Notice of Protected Health Information Practices (Privacy Notice); and I may obtain a copy of the Privacy Notice at any time or view it on the Cedar Rapids Pain Associates web site at www.crpainfree.com.

I have read and agree to the terms to the information stated above.

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient _____

CONSENT FOR TREATMENT OF MINOR PARTY

In the event that I am unable to accompany my minor child (under 18 years of age) to his/her Cedar Rapids Pain Associates/Advanced Spine and Rehab Center appointments, I permit Cedar Rapids Pain Associates/Advanced Spine and Rehab Center to render treatment to my child while I am not present.

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient _____

MEDICAL HISTORY AND CONSENT FOR TREATMENT

I certify the medical information I have provided is accurate, complete and true.

I authorize Cedar Rapids Pain Associates/Advanced Spine and Rehab Center and any associates, assistants and other health care providers it may deem necessary to treat my condition. I understand in no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient _____

Cedar Rapids Pain Associates

Late Appointment Policy

Here at Cedar Rapids Pain Associates we strive on keeping our appointments on time for both our patients and providers.

In order to keep our providers on schedule and the wait time for our patients as little as possible, we do not take late appointments.

By signing this, you understand that if you are late to any appointment, you will not be seen and will need to be re-scheduled.

Patient Signature

Date

Witness Signature

Date

Patient Name: _____

Date: _____

Surgical History

Type of Surgery	Year

Family History

	YES	NO	COMMENTS
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	

History of Pain Treatment

Have you received or are you currently receiving any of the following treatments?

Type of Treatment	If treatment was received, did it help?		If it helped, how long did it help?		
	Yes	No	Yes	No	
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
- NSAIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
- Muscle relaxer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
- Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joint Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trigger Point Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Epidural Steroid Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nerve Blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Radiofrequency Ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Name: _____

Date: _____

Health History

Please complete the following regarding your health history. Mark all boxes that apply.

	YES	NO	COMMENTS
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
COPD	<input type="checkbox"/>	<input type="checkbox"/>	
Obstructive Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease (Hepatitis, Cirrhosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis
Kidney Disease (Failure, Stones)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kidney Failure <input type="checkbox"/> Stones
Gastrointestinal Disease (Ulcers, Reflux, Colitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ulcers <input type="checkbox"/> Colitis <input type="checkbox"/> Reflux
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Type:
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Anxiety <input type="checkbox"/> Schizophrenia
Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Parkinson <input type="checkbox"/> Neuropathy <input type="checkbox"/> CP <input type="checkbox"/> MS <input type="checkbox"/> Seizures <input type="checkbox"/> Migraines
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Pregnant currently	<input type="checkbox"/>	<input type="checkbox"/>	
Other Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Please list:

Patient Name: _____

Date: _____

Review of Systems

Please check all symptoms you have had regularly in the last MONTH:

GENERAL	YES	NO
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>

EYES	YES	NO
Eye disease or eye injury	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>

EARS, NOSE, and THROAT	YES	NO
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR	YES	NO
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Fast/irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY	YES	NO
Frequent coughing	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL	YES	NO
Frequent or recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Light headed or dizzy	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or seizure	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC	YES	NO
Memory loss or confusion	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL	YES	NO
Loss in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY	YES	NO
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Burning or painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Date of last menstrual period	___/___/___	

MUSCULOSKELETAL	YES	NO
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>

SKIN	YES	NO
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Skin infection	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE	YES	NO
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>

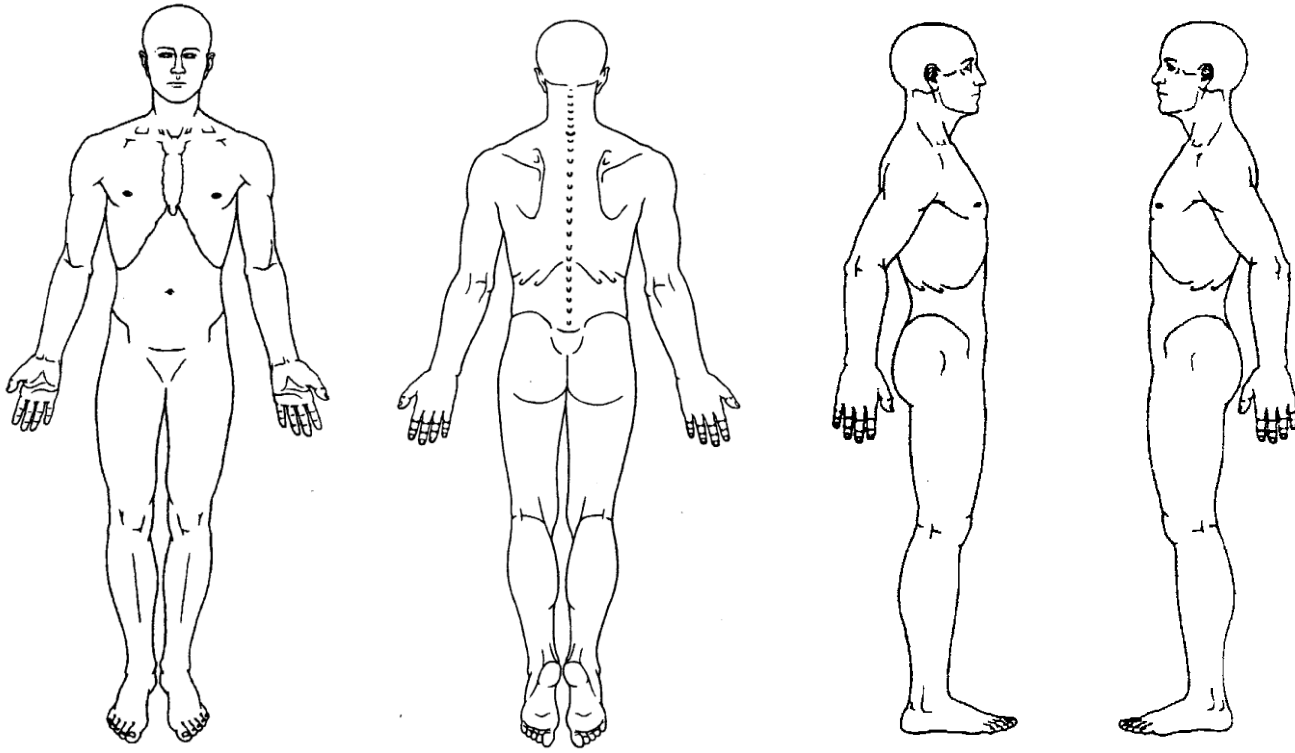
HEMATOLOGIC	YES	NO
Easily bruise or bleed	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy/radiation	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____

Date: _____

CURRENT PROBLEM

Please shade in where your primary pain is located using the diagrams below:



When did the pain begin? _____

Did it begin gradually or suddenly? _____ If suddenly, is it the result of an injury? ___Yes ___No

If result of an injury, describe the injury _____

If not a result of injury, what do you think caused your pain?

Since your pain started is it (Circle one) Worse Unchanged Intermittent Better N/A

Please describe your pain in as much detail as possible:

Do you have any other symptoms such as numbness, weakness, or pins and needles sensation? Please describe.
