NEW PATIENT CHECKLIST

- Read through carefully.
- Sign and fill out all paperwork.
- Return the completed packet of information back to our office **ASAP** – in order to start the scheduling process.
- Once we have received the packet, the doctors can review the information and our office will try to obtain additional information that will be needed in order to schedule you.
- Please bring with you at the time of your appointment, all MRI, CT or Radiology films for the doctor to examine and review with you.
- The doctor requests that you bring all medication bottles in a bag with you at the time of your appointment, so that the dosages and directions can be reviewed.
- Please have your primary care and referring physician's contact information available when you check in.

NOTE: IF WE HAVE NOT RECEIVED THE PACKET FILLED OUT WITHIN TWO WEEKS FROM THE TIME IT WAS SENT TO YOU, A LETTER WILL BE SENT TO YOUR REFERRING DOCTOR LETTING THEM KNOW YOU HAVE NOT RETURNED THE INFORMATION REQUIRED.

IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE CALL US AT 831-684-0600

Pain Clinic of Monterey Bay, Inc.
8057-A Valencia St. Aptos, CA 95003
Phone: (831) 684-0600 Fax: (831) 684-0606
Lawrence R. Poree MD MPH PhD and Linda L. Wolbers MD MPH
www.PainClinicOfMontereyBay.com

Dear prospective patient,

Welcome to the Pain Clinic of Monterey Bay. We are an interdisciplinary pain management clinic dedicated to helping you understand the nature of your pain and assisting you to take control of it through a personalized treatment plan.

Because we use a multi-disciplinary approach, we require a psychological evaluation prior to prescribing any medications, unless the referral is for a life threatening illness. The psychological evaluation is not generally done for patients referred only for a procedure.

Please complete the following forms and return them to our office. As soon as we **receive** them, we will contact you for an initial consultation appointment. ***Please complete all forms in their entirety and return as soon as possible. Failure to do so will result in scheduling delays.***

Also, please bring copies of your pertinent X-Ray's, MRIs, EMG studies and other relevant tests to your appointment. Expect to be in our office for 2 or more hours for your first appointment.

(***Please* note** that there will be a **$50** charge for missed appointments and/or cancellations without a minimum of a 48 hour notice.)

Please feel free to call us for further information. You may contact us at 831-684-0600. We look forward to helping you.

Sincerely,

Linda L. Wolbers MD MPH
Diplomat of the American
Board of Pain Medicine
Diplomat of the American
Board of Family Practice

Lawrence R. Poree MD MPH PhD
Diplomat of the American
Board of Pain Medicine
Diplomat of the American Board of
Anesthesiology with special
certification in Pain Medicine

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Financial and Medical Records Release Agreement

Credit Agreement for Patients with private insurance coverage:

The Pain Clinic of Monterey Bay is currently contracted with some private insurance companies, please contact our office to find out if we have a contract with your insurance. Our preference is to negotiate with individual patients rather than insurance companies. Payments from your insurance carrier will be promptly credited to your account. **For comprehensive medication management consultations and procedural consultations we require a deposit at the time of your first appointment, if we are not contracted with your insurance company.** Any remaining balance must be paid within 30 days. Under special circumstances we do offer a sliding fee schedule based on income. We make a special effort for patients with life threatening illnesses. Our pledge to our community is that we are committed to reaching a workable financial agreement with all patients with life threatening illnesses.

Please initial here to confirm you have read and understand our credit agreement. __________

Medicare Patient's Release of Information

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I understand I am responsible for any remaining balance not covered by other insurance.

Release of Information

I authorize and give consent to Pain Clinic of Monterey Bay to release all of my medical records including all psychological reports to my referring physician, my insurance company, attorney (if applicable) and to other health care professionals who are involved with my treatment. Data collected may be used for research purposes however patient identification will not be revealed. I hereby certify that the information is true and correct. I understand that I am financially responsible for the unpaid balance of all accounts in the event the authorization is insufficient to liquidate my account. I understand that the financial information herein supplied to me may be provided to a consumer credit bureau and / or to other health care providers involved in the performance of patient care. I understand that should my account be sent to a collection agency or require litigation to liquidate; I will be responsible for any and all costs or fees incurred, including reasonable attorney fees.

Assignment of Benefits

The undersigned assigns and hereby authorizes direct payment to the Pain Clinic of Monterey Bay, all insurance and plan benefits otherwise payable to or on behalf of the patient for services rendered. It is understood that he/she is financially responsible for charges not covered by this assignment.

PRINT: Patient/Parent/Guardian/Conservator/Responsible Party **Date**

Signature: Patient/Parent/Guardian/Conservator/Responsible Party **Date**

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CLINIC POLICY REGARDING INSURANCE AND PATIENT SERVICE

You have been referred to the Pain Clinic of Monterey Bay for comprehensive pain management services for your chronic pain problem. We serve people suffering from severe chronic pain conditions. This type of pain problem is best treated using an interdisciplinary approach which includes an evaluation and treatment with a pain psychologist and other health care providers as determined on your first visit.
Please note that Medicare and Federal Guidelines mandate a psychological evaluation be done prior to performing certain specialty pain management services.

This document explains the Pain Clinic of Monterey Bay's general policy concerning financial arrangements with our patients. **Please read it carefully and initial each point of reference**.

- All patients (except Workers Compensation, Medicare, and some private insurances) are responsible for a deposit (if we are not contracted with your insurance), which is expected on the first appointment. If you are unable to pay the full amount or have any questions, you may discuss payment options with the Office Manager

  Initials___________

- We do contract with some private insurance companies, but if we don't have a contract with yours, as a courtesy we will bill for your services associated with treatment. We will **NOT** bill any claims to **Physicians Medical Group** (**PMG**) by request of PMG.

  Initials___________

- Any fees associated with psychological services must be negotiated with the psychologist who has your case. The psychologists are not financially associated with the Pain Clinic of Monterey Bay.

  Initials___________

- **No controlled medication prescriptions will be written for new patients prior to an evaluation by a psychologist specialist in pain management that coordinates patient care with the Pain Clinic of Monterey Bay.**

  Initials___________

- **There will be a $50 charge for missed appointments and/or cancellations without a minimum of a 48 hour notice**.

  Initials___________

Lawrence R. Poree, M.D. MPH PhD
Linda L. Wolbers, M.D. MPH

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The *following page* is a medical records release. The Pain Clinic of Monterey Bay uses this form to obtain necessary information and records for the evaluation and treatment of your pain.

PLEASE SIGN THE SIGNATURE LINE ONLY

PLEASE LEAVE ALL OTHER FIELDS BLANK

THANK YOU!

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RECORDS RELEASE

Date____________________

To____

I, ____

hereby authorize you to release to the Pain Clinic Of Monterey Bay any information including the diagnosis and records of any treatment, examination or psychiatric reports rendered to me during the period from ______________________ to

__________________________.

____
Patient Signature

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REGISTRATION DATE______________________

PATIENT INFORMATION

Name____

Date of Birth____________ Age:_____ Sex: M__ F___ SS#___________________________________

Home Address____

City____________________________________State__________ZIP___________________________

Home Telephone Number____________________________FAX_________________________________

E-mail Address____

Employer____

Work Adddress____

City____________________________________State__________ZIP___________________________

Work Telephone Number ___________________________ FAX: _________________________________

Emergency Contact___________________________ Phone__________________ Relationship_______

PROFESSIONAL CONTACT INFORMATION

Referring Physician____

Address:____ CA ____ZIP_______________

Office Telephone:________________________________ Office FAX:______________________________

Primary Care Physician or Clinic____

Address____ CA ______ ZIP___________

Office Telephone:_______________________________ Office FAX:______________________________

Type of Insurance: Worker's Compensation____ Medicare_______ Private_______ Self _______

Attorney: ____

Address:____ CA ____ZIP_______________

Office Telephone:_______________________________ Office FAX:______________________________

Case Manager:____

Address:____ CA ____ZIP_______________

Office Telephone:________________________________ Office FAX:_________________________________

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INSURANCE INFORMATION **Name** ________________________________

WORKERS COMPENSATION

Date of Injury__________________________ Claim #____________________________________

Insurance Company ____

Ins. Co. Address _________________________City: ________________State ____ ZIP__________

Phone____________________________________ FAX____________________________________

Insurance Adjuster _____________________________ Phone____________________________

Name of Attorney__________________________ Phone_______________ FAX________________

PRIVATE INSURANCE or MEDICARE

Insurance Company____

Contract #_________________ Group #__________________ Subscriber #______________________

Person Responsible for Account____

Relationship to Patient______________________ Birth date ____________ SS#_________________

Address (if different than patient's)____

Employer of responsible person: ____

Address____ State _____ZIP________________

Work Phone _________________________________ Work Fax ______________________________

ADDITIONAL INSURANCE

Are you covered under any other insurance? Y___ N___

Insurance Company____

Contract #_________________ Group #__________________ Subscriber #______________________

Person Responsible for Account____

Relationship to Patient______________________ Birth date____________ SS#_________________

Address (if different than patient's)____

Pain Clinic of Monterey Bay, Inc. Patient Questionnaire

1. **Name**____ Age _______Height________ Weight______

2. **When did your pain problem first start?** Date: ___________ was there an injury? Y______ N_______
If there was an initial injury please describe what happened:

---

3. **Please list the doctors/providers you have seen since your pain began and what sorts of treatments they have done. Please use the back of the sheet if you need more room.**

Doctor/Provider Name and Specialty	Treatment
____	______________________________________
____	______________________________________
____	______________________________________

4. Location of pain (circle any that apply): leg low back mid back upper back neck shoulders head arm/hand fingers buttocks foot toes chest face jaw abdomen pelvis other _________.

5. Circle the words below that describe your ***present*** pain for each location of pain listed above.

Pain Location #1 (please state location) ____
dull aching throbbing sharp stabbing burning shooting electrical
pins and needles cold cramping other ___________

Is this pain constant______ or does it come and go______? (check one)

Pain Location #2 (please state location) ____
dull aching throbbing sharp stabbing burning shooting electrical
pins and needles cold cramping other ___________

Is this pain constant______ or does it come and go______? (check one)

Pain Location #3 (please state location) ____
dull aching throbbing sharp stabbing burning shooting electrical
pins and needles cold cramping other ___________

Is this pain constant______ or does it come and go______? (check one)

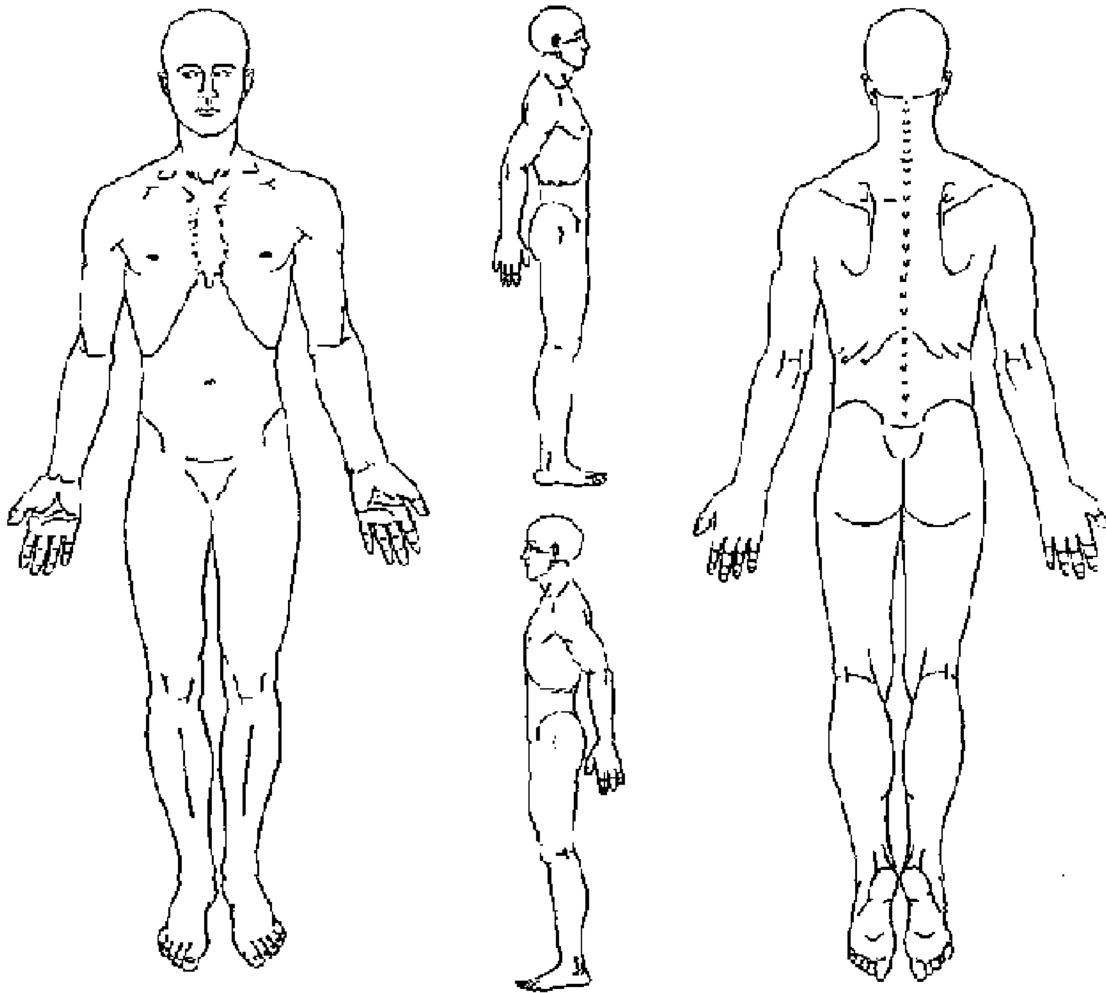
6. **Please mark one spot on the following lines representing your current and average intensity of pain.**
Current intensity of pain:

No pain |____| Worse pain imaginable

Average intensity of pain over past week:

No pain |____| Worse pain imaginable

7. Please shade in the area of your pain and mark the locations described above.



8. What activities, can you no longer participate in because of your pain? List the 4 most significant.

1. ____________________________________ 2. ___________________________________

3. ____________________________________ 4. ____________________________________

Please list the amount of time or distance you can comfortably perform the activities below.

9. Does your pain interfere with your ability to sit? Yes____ No ____ Time_________

10. Does your pain interfere with your ability to stand? Yes____ No ____ Time_________

11. Does your pain interfere with your ability to walk? Yes____ No ____ Time_________

12. Does your pain interfere with your ability to drive? Yes____ No ____ Time_________

13. Does your pain interfere with your ability to write? Yes____ No ____ Time_________

14. Does pain interfere with your ability to dress yourself? Yes____ No _____

15. Does your pain interfere with your ability to sleep? Yes____ No ____

16. How many hours do you sleep at night? ____

17. How many hours do you spend each day lying down or reclining when you are not usually sleeping? Enter the number of hours: 0 – 24 __________________________________

18. How many hours are you active and not reclining each day? 0 -24 ___________________

19. What makes your pain worse? ____

____

20. What makes your pain better? ____

____

21. What percentage of improvement would you need in order to have an acceptable quality of life?
0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

22. The following is a list of various treatments often used to treat chronic pain. Please state whether you have used any of these treatments by checking the space in front of it and circle whether this treatment helped your pain or did not help your pain.

___ acupuncture:	helped	did not help
___ transcutaneous electrical nerve stimulation (TENS):	helped	did not help
___ manipulation (e.g., osteopathic, chiropractic):	helped	did not help
___ physical therapy	helped	did not help
___ home exercise program:	helped	did not help
___ pool/hydrotherapy:	helped	did not help
___ heat:	helped	did not help
___ ice:	helped	did not help
___ prosthetics (braces, supports, etc):	helped	did not help
___ biofeedback or relaxation therapy:	helped	did not help
___ counseling/psychotherapy:	helped	did not help
___ medication:	helped	did not help
___ trigger points injections:	helped	did not help
___ nerve blocks (e.g. epidurals, facet blocks etc)	helped	did not help

23. Please circle any diagnostic studies you have had done for your current pain problem and write in the space where these studies were done.

PLEASE BRING ALL RELAVENT FILMS AND REPORTS TO FIRST APPOINTMENT

X-Rays ____

CT scan ____

MRI ____

Nerve conduction Studies/EMG____

Laboratory results ____

PAST MEDICAL HISTORY

24. Please check any medical conditions that you have been diagnosed with.

____Diabetes ____Heart disease ____Lung disease

____High blood pressure ____Bleeding problems ____Thyroid problems

____Cancer ____Seizures ____Other

25. Have you been admitted overnight to a hospital for any reason other than surgery or childbirth in the past 5 years? No___ Yes____ Use the back if you need more room.

Problem	Year of hospitalization
____	____________________
____	____________________

26. Please list any surgeries you have had in your life.

Type of Surgery	Year of Surgery
____	______________
____	______________
____	______________

27. Please list all your medications (prescription and over the counter) you currently take. (**PLEASE BRING ALL YOUR MEDICATIONS WITH YOU TO YOUR FIRST APPOINTMENT**)

Name of medication	dose of medication (mg)	# of pills per day
________________________________	_______________________	_______________
________________________________	_______________________	_______________
________________________________	_______________________	_______________
________________________________	_______________________	_______________
________________________________	_______________________	_______________
________________________________	_______________________	_______________

28. Please list any medications that you are allergic to.
Medication **Type of reaction**

_______________________________ _______________________________________

_______________________________ _______________________________________

29. Please list any other medications you have tried in the past for your pain and state why you are no longer taking it (eg.. didn't work or had side effects):
Name of Medicine **Reason for stopping**

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

30. FAMILY HISTORY: Please check any medical conditions that have been diagnosed in your immediate family and indicate which relative. (Mother, Father, Brother, Sister, Children)

Condition: Relative(s) with this condition:

_____Diabetes ______________________________

_____Heart disease ______________________________

_____High blood pressure ______________________________

_____Lung disease ______________________________

_____Cancer ______________________________

_____Thyroid disease ______________________________

_____Bleeding problems ______________________________

_____Chronic Pain Condition ______________________________

SOCIAL HISTORY:

31. Married / Single / Divorced / Widowed? Children? Yes / No If yes, how many? _____ ages_____

32. Are you currently working? Yes No If no, are you retired? ____ disabled?____

33. Current or former occupation? ____

34. Do you drink alcohol? Yes No
If yes, how many drinks per day_____, week_____, month_____, or year_____?

35. Do you use tobacco products? Yes No If yes, how much / day__________________________
36. Have you ever used any other recreational drugs? Yes No
If yes, please list what substances and date last used.

____

REVIEW OF SYSTEMS

37. **Please review the symptoms for each category below and circle any symptoms you have had in the past year.**

1. **Constitutional symptoms**:
   a. Weight loss/gain Yes___ No__
   b. fever; Yes___ No__
   c. general fatigue. Yes___ No__
2. **Skin**:
   a. Rash Yes___ No__
   b. Itching Yes___ No__
   c. changes in color Yes___ No__
   d. changes in hair/nails. Yes___ No__
3. **Hematologic/Lymphatic**:
   a. swollen glands Yes___ No__
   b. easy bruising/bleeding Yes___ No__
   c. low blood count Yes___ No__
4. **HEENT**:
   a. frequent headaches Yes___ No__
   b. trouble with vision Yes___ No__
   c. hearing problems Yes___ No__
   d. ringing in ears Yes___ No__
   e. sinus trouble Yes___ No__
   f. nosebleeds Yes___ No__
   g. sore throat Yes___ No__
   h. hoarseness Yes___ No__
   i. trouble swallowing Yes___ No__
5. **Respiratory**:
   a. recurrent cough; Yes___ No__
   b. shortness of breath Yes___ No__
6. **Cardiac**:
   a. chest pain Yes___ No__
   b. palpitations Yes___ No__
   c. swelling in feet Yes___ No__
7. **Abdominal**:
   a. abdominal pain Yes___ No__
   b. nausea Yes___ No__
   c. vomiting Yes___ No__
   d. constipation Yes___ No__
   e. diarrhea Yes___ No__
   f. stool loss of control Yes___ No__
8. **Urinary**:
   a. frequent urination Yes___ No__
   b. urine loss of control Yes___ No__
   c. difficulty urinating Yes___ No__
9. **Reproductive:**
   a. sexual dysfunction Yes___ No__
   b. menstrual problems Yes___ No__
10. **Endocrine**:
    a. excessive thirst Yes___ No__
    b. heat/cold intolerance Yes___ No__
11. **Musculoskeletal**:
    a. muscle cramps Yes___ No__
    b. difficulty walking Yes___ No__
    c. joint aching Yes___ No__
12. **Neurologic:**
    a. fainting Yes___ No__
    b. dizziness Yes___ No__
    c. seizures Yes___ No__
    d. weakness/paralysis Yes___ No__
    e. difficulty concentrating Yes___ No__
    f. memory problems Yes___ No__
13. **Psychiatric**
    a. Depression Yes___ No__
    b. Anxiety Yes___ No__

Physical Exam: BP ________ HR ____ SpO2 _____ Height ________ Weight ______

Heart Lung