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
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 Anesthesiology with special certification in Pain Medicine
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
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___________
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

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!
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
# 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. Woibers MD MPH**
**www.PainClinicOfMontereyBay.com**

## 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 Address________________________

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:____________
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

INSURANCE INFORMATION  Name ________________________________

WORKERS COMPENSATION
Date of Injury ____________________________ Claim # ____________________________
Insurance Company ________________________ ________________________________
Ins. Co. Address __________________________ City: __________ State ___ ZIP ________
Phone ___________________ FAX ___________________ Ins. Co. Phone __________
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 ___________________________
   ___________________________ 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

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>dose of medication (mg)</th>
<th># of pills per day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
28. Please list any medications that you are allergic to.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Type of reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29. Please list any other medications you have tried in the past for your pain and state why you are no longer taking it (e.g., didn’t work or had side effects):

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Reason for stopping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relative(s) with this condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Diabetes</td>
<td></td>
</tr>
<tr>
<td>___ Heart disease</td>
<td></td>
</tr>
<tr>
<td>___ High blood pressure</td>
<td></td>
</tr>
<tr>
<td>___ Lung disease</td>
<td></td>
</tr>
<tr>
<td>___ Cancer</td>
<td></td>
</tr>
<tr>
<td>___ Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>___ Bleeding problems</td>
<td></td>
</tr>
<tr>
<td>___ Chronic Pain Condition</td>
<td></td>
</tr>
</tbody>
</table>

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