

# NEW PATIENT INFORMATION

Please fill out all fields below. If you have questions feel free to contact our office at 402-614-1999 or by email at [info@omahapainphysicians.com](mailto:info@omahapainphysicians.com).

## IDENTIFICATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Gender  Male  Female      DOB \_\_\_\_/\_\_\_\_/\_\_\_\_      SSN \_\_\_\_\_

## CONTACT INFORMATION

Address \_\_\_\_\_ Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone (     ) \_\_\_\_\_-\_\_\_\_\_      Mobile Phone (     ) \_\_\_\_\_-\_\_\_\_\_

E-Mail \_\_\_\_\_

## INSURANCE

Type of Insurance:  Private     Medicare     Medicaid     Worker's Comp     Auto Insurance

### PRIMARY

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Primary Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_

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### SECONDARY

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Primary Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_

## ADDITIONAL INTAKE INFORMATION

Emergency contact name \_\_\_\_\_ Phone (     ) \_\_\_\_\_-\_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Who referred you / how did you hear about us? \_\_\_\_\_

List all **current** medications (you may attach an additional sheet if you choose) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List surgical history (you may attach an additional sheet if you choose) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_

## MEDICAL HISTORY

Primary Care Physician \_\_\_\_\_

Pain Physician's you have seen before \_\_\_\_\_

List allergies to any drugs/medication? \_\_\_\_\_

Topical Allergies:  Latex  Iodine  Tape  IV Contrast

Alcohol Use:  Never  Social use  Daily use  Alcoholism (past)  Alcoholism (present)

Tobacco Use:  Never  Former  Current  Packs per day? \_\_\_\_\_  How many years? \_\_\_\_\_

Illegal Drug Use:  Never  Former  Current

Have you ever abused narcotic or prescription medications?:  Yes  No

## DIAGNOSTIC TESTS & IMAGING

Please let us know if you have had any of the following tests for your pain. If none, leave blank.

MRI of the \_\_\_\_\_ Year \_\_\_\_\_

X-Ray of the \_\_\_\_\_ Year \_\_\_\_\_

CT Scan of the \_\_\_\_\_ Year \_\_\_\_\_

EMG/NCV of the \_\_\_\_\_ Year \_\_\_\_\_

Other \_\_\_\_\_ Year \_\_\_\_\_

## PAIN HISTORY

Where is your worst area of pain located? \_\_\_\_\_

Does the pain radiate? If so, where? \_\_\_\_\_

List additional areas of pain: \_\_\_\_\_

Approximately when did this pain begin? \_\_\_\_\_

Previous pain medications used for pain complaint? \_\_\_\_\_

What caused your current pain episode?

Motor Vehicle Accident  Personal Injury  Other \_\_\_\_\_

How did your current pain episode begin?  Gradually  Suddenly

Since your pain began, how has it changed?  Decreased  Increased  Stayed the same

## PAIN DESCRIPTION

Check all that describe your pain:

Aching  Cramping  Dull  Tingling/Pins & Needles  Hot/Burning  Numbness

Shock-like  Shooting  Spasming  Squeezing  Stabbing/Sharp  Throbbing

Tiring/Exhausting

Name \_\_\_\_\_

## REVIEW OF SYSTEMS

Please check any of the following symptoms that you are experiencing currently.

<b>CONSTITUTIONAL:</b>	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Weight loss
	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Decreased energy	<input type="checkbox"/> Loss of appetite	
<b>HEENT:</b>	<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/> Hearing loss
	<input type="checkbox"/> Vision changes			
<b>SKIN:</b>	<input type="checkbox"/> Rash	<input type="checkbox"/> Non healing skin lesions		
<b>NEUROLOGIC:</b>	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Tremors	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Weakness in extremity
<b>CARDIAC:</b>	<input type="checkbox"/> Chest pain/Angina	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Rapid Heart Rate	<input type="checkbox"/> Swelling in extremity
<b>RESPIRATORY:</b>	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Blood stained sputum
	<input type="checkbox"/> Dyspnea			
<b>GASTROINTESTINAL:</b>	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Constipation
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Hepatitis	
<b>GU/NEPHRO:</b>	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Chronic renal failure	
<b>ENDOCRINE:</b>	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Thyroid problems
<b>HEMATOLOGIC:</b>	<input type="checkbox"/> Abnormal bruising/bleeding	<input type="checkbox"/> Swollen lymphnodes		
<b>MUSCULOSKELETAL:</b>	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Muscle pain
	<input type="checkbox"/> Joint restrictions			
<b>PSYCHIATRIC:</b>	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Drug abuse	
<b>IMMUNOLOGIC:</b>	<input type="checkbox"/> HIV/AIDS			

## MARK THE FOLLOWING YOU HAVE BEEN TREATED FOR IN THE PAST:

**GENERAL**     Cancer - Type \_\_\_\_\_     Diabetes - Type \_\_\_\_\_

**CARDIOVASCULAR/HEMATOLOGIC**     Anemia     Heart Attack     Coronary Artery Disease

High Blood Pressure     Peripheral Vascular Disease

**GASTROINTESTINAL**     GERD (Acid Reflux)     Gastrointestinal Bleeding     Stomach Ulcers     Constipation

**UROLOGICAL**     Kidney Disease     Kidney Stones     Urinary Incontinence     Dialysis

**NEUROPSYCHOLOGICAL**     Multiple Sclerosis     Peripheral Neuropathy     Seizures     Depression

Anxiety     Schizophrenia     Bipolar Disorder

**HEAD/EARS/EYES/NOSE/THROAT**     Headaches     Migraines     Head Injury     Hyperthyroidism

Hypothyroidism     Glaucoma

**RESPIRATORY**     Asthma     Bronchitis/Pneumonia     Emphysema/COPD

**MUSCULOSKELETAL/RHEUMATOLOGIC**     Bursitis     Carpal Tunnel Syndrome     Fibromyalgia

Osteoarthritis     Osteoporosis     Rheumatoid Arthritis     Chronic Joint Pain

## DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, HEALTHCARE INFORMATION AND FINANCIAL

I understand I can request and review a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

Please list family members or other persons, if any, whom we may inform of your general medical condition and your diagnosis (including treatment, payments, and healthcare options):

NAME: \_\_\_\_\_ NAME: \_\_\_\_\_  
NAME: \_\_\_\_\_

My personal medical information may/may not be left at the following:

Home/Cell Phone Number: _____ <input type="checkbox"/> May <b>only</b> leave providers name and number <input type="checkbox"/> May leave detailed information (lab results, appointment reminders) <input type="checkbox"/> May <b>NOT</b> leave message
Work Phone Number: _____ <input type="checkbox"/> May <b>only</b> leave providers name and number <input type="checkbox"/> May leave detailed information (lab results, appointment reminders) <input type="checkbox"/> May <b>NOT</b> leave message

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

## OMAHA PAIN PHYSICIANS HIPPA NOTICE OF PRIVACY

I understand that I can request and review Omaha Pain's full HIPPA Notice of Privacy policy that provides a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. By signing below I acknowledge that Omaha Pain Physicians, legal entity name Pain Centers of the Midlands may use or disclose your protected health information when needed for treatment, payment, appointment reminders, requirements by law, and other operations listed on the full HIPPA Notice. By signing below I consent.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

## OMAHA PAIN PHYSICIANS FINANCIAL POLICY

I understand that I can request and review Omaha Pain's full financial policy that provides a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. By signing below I agree to paying for any medical treatment billed to me from Omaha Pain Physicians, legal entity name Pain Centers of the Midlands, LLC.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date