

**ASSIGNMENT OF BENEFITS**

**Private insurance authorization for assignment of benefits and information release:**

I, the undersigned, authorize payment of medical benefits to Consultants in Pain Medicine for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Consultants in Pain Medicine to release to my insurance company, referring physician and other consultants on my case information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date \_\_\_\_\_ Signed \_\_\_\_\_

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**MEDICARE LIFETIME SIGNATURE ON FILE**

I request that payment of authorized Medicare benefits be made on my behalf to Consultants in Pain Medicine for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Date \_\_\_\_\_ Signed \_\_\_\_\_

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**CERTIFICATION**

Consultants in Pain Medicine, P.A. is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation. We will be happy to assist you in this process. Also, if this is a litigation case, our office needs to be informed before services are rendered.

*I \_\_\_\_\_ hereby certify that I am /am not seeking treatment for an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.*

MVA / Date of Incident \_\_\_\_\_

If applicable, Attorney's Name \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

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**Health Insurance Portability and Accountability Act**

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Consultants in Pain Medicine, P.A.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

403 Treeline Park, Suite 300  
San Antonio, Texas 78209  
210-582-6600 phone  
210-582-6601 fax  
[www.mypaindocs.com](http://www.mypaindocs.com)

I hereby authorize Consultants in Pain Medicine, Inc., to take my photograph for inclusion in my medical chart retained by the clinic. I understand this photograph is solely for the purpose of identification and familiarization by the office staff and the clinic physician(s).

\_\_\_\_\_  
Patient Signature

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Please fill out and sign the following release form so we can obtain copies of any medical records that may be needed in order to assess your condition more thoroughly.

Date: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize the release of my medical records to Consultants in Pain Medicine.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Information Form**

DATE: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phn # (\_\_\_\_) \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you work now? Yes No Part Time What does your work involve? \_\_\_\_\_

Name of Doctor who referred you? \_\_\_\_\_ List of other Doctors you have seen for this pain problem: \_\_\_\_\_

Names of other Doctors you see for other medical reasons: \_\_\_\_\_

Give details of injury or circumstances causing your pain: \_\_\_\_\_

Were you injured on the job? Yes No

How and when were you treated for this problem? \_\_\_\_\_

Have you had surgery for this problem? Yes No

If yes, give: Date Hospital Name of surgeon

_____	_____	_____
_____	_____	_____
_____	_____	_____

Tests performed: X-Rays MRI CT Scan EMG Bone Scan Discogram Other Tests

Where & When: \_\_\_\_\_

What is your pain status now? Worse Better Same Has it changed? \_\_\_\_\_ How? \_\_\_\_\_

What other treatments have you received? (i.e., bedrest, physical, therapy, hypnosis, chiropractic manipulation, acupuncture, injections) Please list details:

Treatment: \_\_\_\_\_

Where: \_\_\_\_\_

When: \_\_\_\_\_

**MEDICATIONS**

Please list medications to which you are ALLERGIC: \_\_\_\_\_

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Please list medications you have previously taken:

<b>MEDICATION</b>	<b>HELPFUL?</b>	<b>REASON FOR STOPPING USE</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list medications you are CURRENTLY TAKING FOR PAIN:

<b>MEDICATION</b>	<b>DOSAGE</b>	<b>HELPFUL?</b>	<b>DOCTOR</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list other medications you are CURRENTLY TAKING (include vitamins, etc.):

<b>MEDICATION</b>	<b>DOSAGE</b>	<b>DOCTOR</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle on a scale of 0 to 10 (0 is no pain.....10 is the worst imaginable)

- AT ITS BEST            0 1 2 3 4 5 6 7 8 9 10
- MOST OF THE TIME    0 1 2 3 4 5 6 7 8 9 10
- AT ITS WORST         0 1 2 3 4 5 6 7 8 9 10

For the following descriptions, place a SINGLE number for each word that describes your pain:

NONE = 0      MILD = 1      MODERATE = 2      SEVERE = 3

THROBBING _____	GNAWING _____	SPLITTING _____
SHOOTING _____	HOT/BURNING _____	TIRING/EXHAUSTING _____
STABBING _____	ACHING _____	SICKENING _____
SHARP _____	TENDER _____	FEARFUL _____
CRAMPING _____	HEAVY _____	PUNISHING/CRUEL _____

Married? Yes No

How many children do you have? \_\_\_\_\_

Level of Education? \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Have you lost or gained weight in the last six months? Yes No

How many pounds? Lost \_\_\_\_\_ lbs. Gained \_\_\_\_\_ lbs.

Do you: Drink alcoholic beverages? Yes (Amt) \_\_\_\_\_ No Smoke? Yes (Amt) \_\_\_\_\_ No

Drink caffeinated beverages? Yes (Amt) \_\_\_\_\_ No

Take vitamins? Yes No If yes, what kind? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever been treated for addiction? Yes No

**FAMILY HISTORY** (Circle all that apply TO YOUR FAMILY)

Asthma	Genetic Disorders	Kidney Problems
Arthritis	Headaches	Lung Problems
Cancer	Heart Problems	Seizures
Diabetes	High Blood Pressure	Tuberculosis

Other: \_\_\_\_\_

Please circle any of the following that APPLY TO YOU

Anxiety	Constipation	GI Bleed	Heart Problems	Kidney Problems	Tuberculosis
Arthritis	Depression	Glaucoma	HIV	Lung Problems	
Asthma	Diabetes	Hepatitis	High Blood Pressure	Stomach Ulcer	
Cancer	Genetic Disorder	Headaches	Impotence	Seizures	

Other: \_\_\_\_\_

DATE

PROCEDURE

SURGEON

HOSPITAL

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please mark the diagrams where you feel the symptoms described. You may have more than one body area affected by these symptoms and you may have more than one symptom in one specific area. Mark **each area** with **each symptom** you feel in **each location**.

As an example, if the symptom is described as burning: the mark for burning is **XXX**, put the **XXX** in the area where you feel a burning sensation. You may also experience **perspiration** in a specific area, but nowhere else; The symbol to mark in that area on the diagram is **PPP**. In addition, you may feel **numbness** in your fingers, but **dull/aching** pain in your shoulder. Mark these body areas with the corresponding symbols **+++** and **NNN**.

Burning = XXX

Blueness = BBB

Dull/Aching = NNN

Muscle Cramps = SSS

Numbness = +++

Perspiration = PPP

Pins & Needles = :::

Redness = RRR

Stabbing/Sharp = !!!

Sensitive to touch = ###  
(clothes, jewelry, pressure)

Sensitive to temp. changes = 000  
(to or from indoor/outdoor: cold to hot air)

Swelling = \*\*\*

