



## Coastal Interventional Pain Management

929 Boston Post Road, Old Saybrook, CT 06475

T: (860) 661-5960 | F: (860) 321-5897 | [info@coastalinterventionalpain.com](mailto:info@coastalinterventionalpain.com)

### **WELCOME TO COASTAL INTERVENTIONAL PAIN MANAGEMENT**

The following questionnaire needs to be completed and returned before your initial appointment can be scheduled. This appointment will be an evaluation. **No injections/Procedures will be given at this visit.**

**ALL PATIENTS:** To be seen the following must be presented at the time your initial visit: (this includes Worker's Comp and No-Fault patients)

- Driver's License/Picture ID
- Medical insurance card, front and back.
- A referral from your Primary Care Doctor if required by your health insurance policy.

**WORKER'S COMP PATIENTS:** To be seen the following must be presented at the time your initial visit:

- Driver's License/Photo ID
- Insurance card and referral if required by said insurance
- Completed Worker's Comp information form

**NO FAULT PATIENTS:** To be seen the following must be presented at the time your initial visit:

- Driver's License/Photo ID
- Medical insurance card and referral if required by said insurance
- Completed No Fault forms

Completed forms can be faxed or mailed to Coastal Interventional Pain Management. If faxing, please bring the originals with you to the appointment. If mailing, it is highly recommended that you take a copy of the completed forms before mailing them.

**Please bring MRI and X-Ray films/image disk and their written reports to your initial visit**

If you should need to change your appointment, a 48-hour notice is required, or a cancellation fee of \$50 may apply.

**Thank you. We look forward to seeing you.**



**Coastal Interventional Pain Management**

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**NEW PATIENT INFORMATION**

**FULL LEGAL NAME**

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

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

Telephone # ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Marital status:  single  married  divorced  widow

E Mail Address: \_\_\_\_\_ Social Security # \_\_\_\_\_ -- --

**PATIENT EMPLOYER INFORMATION**

Currently employed  Unemployed  Retired  Legally disabled

**IF MARRIED, PLEASE LIST SPOUSE’S EMPLOYMENT INFORMATION**

Spouse’s Name \_\_\_\_\_ Spouse’s Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

Address \_\_\_\_\_

**REFERRING PHYSICIAN:** \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

Address \_\_\_\_\_

**PRIMARY INSURANCE CARDHOLDER INFORMATION (If different from patient)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Cardholder’s Employer \_\_\_\_\_

**PRIMARY INSURANCE:** Insurance Company \_\_\_\_\_ Cardholder’s Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY INSURANCE:** Insurance Company \_\_\_\_\_ Cardholder’s Name \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**WORKER’S COMPENSATION INFORMATION – NO FAULT INFORMATION AS APPLICABLE**

Date of Injury \_\_\_\_\_ WCB # \_\_\_\_\_ Workers Compensation Carrier \_\_\_\_\_

Telephone # \_\_\_\_\_ Adjuster: \_\_\_\_\_ Adjuster Phone#: \_\_\_\_\_

Employer at time of injury \_\_\_\_\_ Telephone # \_\_\_\_\_ Job title: \_\_\_\_\_

Employer’s address: \_\_\_\_\_

**NAME OF PHARMACY** \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ telephone ( ) \_\_\_\_\_ --



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**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I authorize the use or disclosure of the above-named individual’s health information from/to my referring physician and other specialists involved in my care. The following additional individual or organization is authorized to make/receive the disclosure i.e. Pharmacy, Lawyer, Spouse, etc.

\_\_\_\_\_ The type and amount of information to be used or disclosed is the entire medical chart including medical records, office notes, hospital records, pharmaceutical records, laboratory records, X-ray and MRI films, CAT scans, any other radiological films, and medical bills.

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, pregnancy, and/or family planning.

This information may be disclosed to and used by the following individual or organization for medical evaluation and treatment: Coastal Interventional Pain Management, 929 Boston Post Road, Old Saybrook, CT 06475.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall be in full force and effect until such time as the medical provider no longer maintains the health insurance.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re- disclosure, and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as the original.

- INSURANCE AUTHORIZATION - I hereby authorize Coastal Interventional Pain Management, LLC, to furnish information to my insurance carriers concerning my illness and treatment.
- ASSIGNMENT OF BENEFITS - I hereby assign to Coastal Interventional Pain Management, LLC, all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.
- OUT OF NETWORK- I understand it is my responsibility to know my insurance plan benefits and whether or not a provider is in my network. I agree that I am fully responsible for any costs incurred.
- TREATMENT AUTHORIZATION - I hereby authorize Coastal Interventional Pain Management, LLC, to render health care to me during my visit.
- APPOINTMENT AUTHORIZATION – I hereby authorize Coastal Interventional Pain Management, LLC, to communicate with me regarding my appointments using my answering machine, other Voice Mail, and authorized

persons. AUTHORIZED PERSONS NAME: \_\_\_\_\_

Signature/date: \_\_\_\_\_ Witness/date \_\_\_\_\_



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## PAIN QUESTIONNAIRE

Complete and return this form before your arrival for your first appointment. Your answers will help us to understand your pain. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g., Worker's Compensation Claims)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # \_\_\_\_\_

### PRIOR PAIN PROCEDURES:

Have you previously had any pain procedures, blocks, or injections?  YES  NO

If your answer is YES please specify: \_\_\_\_\_

Why are you seeking treatment? \_\_\_\_\_

Have you seen another pain doctor? Who? \_\_\_\_\_

**PAIN DURATION:** How long have you had your current pain? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS

**ONSET OF PAIN:** How did your current pain start?

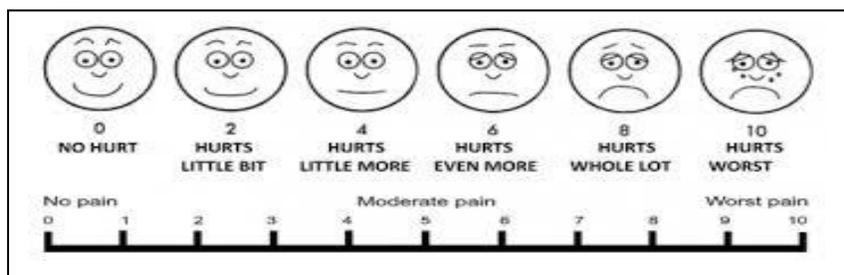
- Injury at work
- Motor vehicle accident
- Undetermined
- Illness, non-injury
- Other, please specify \_\_\_\_\_

**TIMING OF PAIN:** How often do you have your pain? (Please check one)

- Constantly (100% of the time)
- Intermittently (30% to 60% of the time)
- Nearly constantly (60% to 95% of the time)
- Occasionally (less than 30% of the time)

**PAIN QUALITY:** How would you describe the pain?

- Burning
- Cramping
- Pins & Needles
- Sharp
- Numbness
- Shooting
- Aching
- Throbbing
- Pressing
- Other \_\_\_\_\_



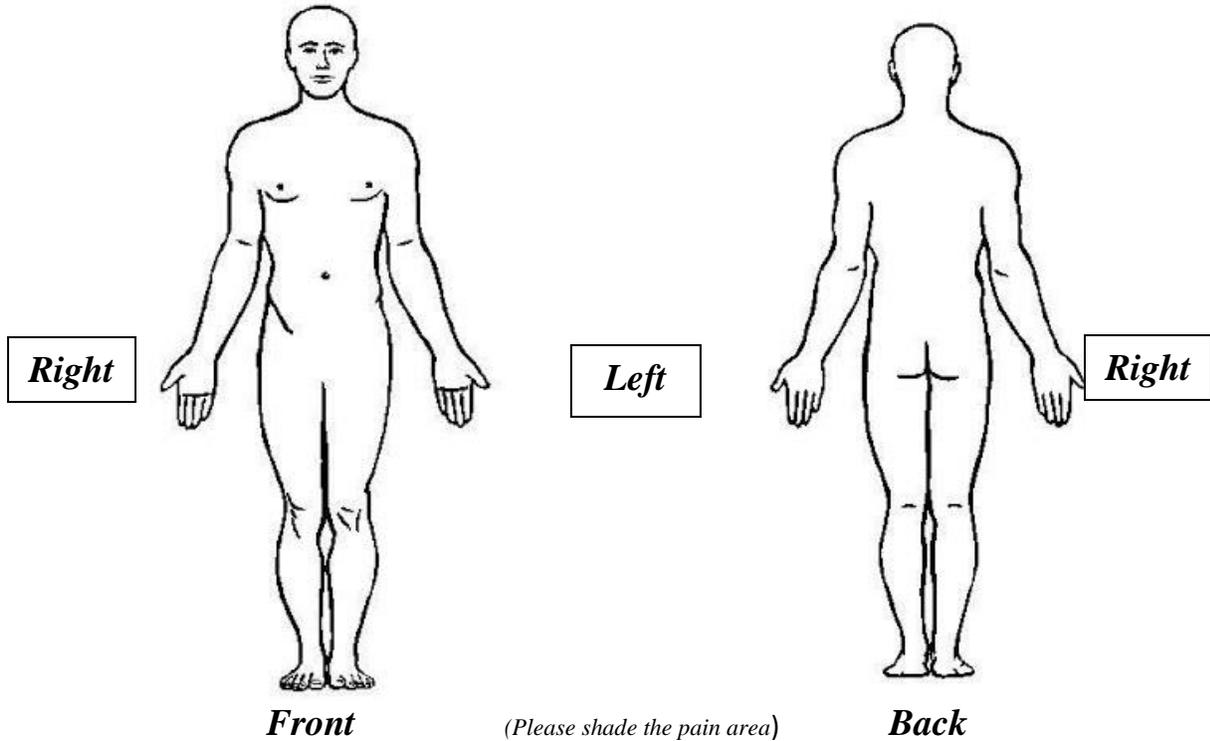


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Patient Name \_\_\_\_\_



PAIN LOCATION: Please describe the location(s) of your pain \_\_\_\_\_

RELIEVING AND AGGREVATING FACTORS:

How do the following affect your pain?

Please check one for each item

	INCREASED	NO CHANGE	DECREASED
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coughing/Sneezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How long can you walk before having to stop due to pain? \_\_\_\_\_ Minutes \_\_\_\_\_ Hours

How long can you sit before having to get up? \_\_\_\_\_ Minutes \_\_\_\_\_ Hours

How long can you stand before you have to sit down? \_\_\_\_\_ Minutes \_\_\_\_\_ Hours



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

### PAIN TREATMENTS:

Check all of the treatments you have tried and then indicate the amount of relief if any

How do the following affect your pain?

Please check one for each item

	DATE(Approx)	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
Traction		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acupuncture		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TENS Unit		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heat Treatment		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chiropractic		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? YES  NO  If Yes When \_\_\_\_\_

### EMPLOYMENT:

Current employment status (please check all that apply):

Employed full-time

Employed part-time

Unemployed Homemaker

Retired

Student

If you are currently unemployed, please specify how long you have been off work: \_\_\_\_\_

### LEGAL ISSUES:

Indicate any of the following you have filed related to your pain:

Workers' compensation

Social Security Disability Insurance (SSDI)

Personal injury/liability (Unrelated to work)

Other insurance

None



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

### SOCIAL HISTORY:

Marital Status: \_\_\_\_\_ Lives with \_\_\_\_\_ Number of children \_\_\_\_\_

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

Exercise:  YES  NO Type of exercise \_\_\_\_\_

Tobacco use:  YES  NO Caffeine use:  YES  NO

Alcohol use:  YES  NO Contraception?  YES  NO

Ever felt the need to cut down alcohol use? \_\_\_\_\_  YES  NO

Ever been angry when criticized about your alcohol use? \_\_\_\_\_  YES  NO

Ever felt guilty about something that happened while drinking? \_\_\_\_\_  YES  NO

Ever needed an "Eye Opener" in the morning? \_\_\_\_\_  YES  NO

Illegal drug use? \_\_\_\_\_  YES  NO

### SUBSTANCE ABUSE:

Do you have a history of alcoholism? \_\_\_\_\_  YES  NO

Have you ever been in a detoxification program for drug abuse? \_\_\_\_\_  YES  NO

Alcoholics Anonymous? \_\_\_\_\_  YES  NO

### FAMILY HISTORY:

Alcoholism	YES	NO
Bleeding Disorders	YES	NO
CAD/Coronary Artery Disease	YES	NO
Cancer	YES	NO
CVA/Stroke	YES	NO
Diabetes	YES	NO
Headaches	YES	NO

Heart Disease	YES	NO
Hypertension	YES	NO
Liver Disease	YES	NO
Lung Disease	YES	NO
Pain	YES	NO

ARE YOU CURRENTLY PREGNANT?  YES  NO

ARE YOU TRYING TO BECOME PREGNANT?  YES  NO







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**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Number to Leave Message: \_\_\_\_\_

By signing below, I hereby authorize the Coastal Interventional Management to leave my protected health information including, but not limited to, results, prescriptions and appointments at the following number:

\_\_\_\_\_ or \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

**People to Leave Messages:**

By signing below, I hereby authorize the Coastal Interventional Pain Management to leave my protected health information including, but not limited to, results, prescriptions and appointments with

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Released to fax:**

By signing below, I hereby authorize the Coastal Interventional Pain Management to fax my protected health information to the following number: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_



## Coastal Interventional Pain Management

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### NO SHOW AND CANCELLATION POLICY

Thank you for choosing Coastal Interventional Pain Management to assist you with your care. We appreciate your trust and are committed to provide you with high quality, compassionate care.

We value our patients and to tailor their treatment plans according to their unique needs, in doing so we allocate time for each appointment accordingly. We realized that circumstances may occur beyond your control that may not allow you to provide 24-hours notification. Failure of a patient to notify the office to cancel or change their appointments without 24-hours' notice is considered a **"No Show"**. To help remind patients of their appointments we will call patient the day before the appointment. Please ensure we have the most-up-to-date phone numbers or email address at all times throughout the course of your treatment to allow us to better serve you.

The "No Show" appointments will be documented in the patient record.

#### Charges for "No show" appointments as follow:

Office Visit	\$50
Procedure/Surgical Center Visit	\$100

This letter will serve as notice about the office "No Show" policy and fees

I acknowledge that I have read and understand the policy

Patient Name (print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_