CORNERSTONE PAIN MANAGEMENT

PATIENT INFORMATION

First Name: ○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Miss	**MI:**	**Last Name:**	
Social Security:	**Age:**	**Date of Birth:**	**Gender:** ○ Male ○ Female
Address:	**City:**	**State:**	**Zip:**

Primary phone number: ○ **Cell** ○ **Home** ○ **Work**

Cell Phone:	**Home Phone:**	**E-mail:**

Employment Status: ○ Full-time ○ Part-Time ○ Unemployed ○ Retired ○ Student ○ Other:

Employer Name:	**Address:**	**Phone:**

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced ○ Legally Separated ○ Other:

Emergency Contact:	**Relationship:**	**Phone:**

INSURANCE INFORMATION (Please allow receptionist to photocopy your insurance ID cards)

PRIMARY INSURANCE

Plan name:	**Policy ID#**	**Policy Group#**	**Effective Date**
Insurance Claims Address		**Insurance Phone#**	
Relationship to guarantor of patient: ○ **Self** ○ **Spouse** ○ **Mother** ○ **Father** ○ **Other:** *If you checked self, there's no need to fill out the following portion*			
Insured's First and Last Name		**Insured's SS#**	**Insured's DOB**
Insured's Address:	**Insured's Phone:**	**Insured's Employer and Phone:**	

SECONDARY INSURANCE

Plan name:	**Policy ID#**	**Policy Group#**	**Effective Date**
Insurance Claims Address		**Insurance Phone#**	
Relationship to guarantor of patient: ○ **Self** ○ **Spouse** ○ **Mother** ○ **Father** ○ **Other:** *If you checked self, there's no need to fill out the following portion*			
Insured's First and Last Name		**Insured's SS#**	**Insured's DOB**
Insured's Address:	**Insured's Phone:**	**Insured's Employer and Phone:**	

PLEASE REVIEW THE FOLLOWING. THEN INITIAL WHERE INDICATED.

→ _____ **Authorization to release information**: I hereby authorize Cornerstone Pain Management to release my information and records that may be necessary for treatment, such as referral for services, or the processing of insurance benefits.

→ _____ **Assignment of benefits**: I hereby authorize payment of my insurance directly to Cornerstone Pain Management.

→ _____ **Financial responsibility**: I understand and agree that I am responsible for understanding my medical insurance coverage and benefits. I understand that I am financially responsible for these charges not paid by my insurance company for any reason.

→ _____ **Consent to treat:** I hereby consent to evaluation, testing, and treatment as directed by my Cornerstone Pain Management physician or his or her designee.

→ _____ **No-show fees:** There will be a $30 fee added to your account for failing to show up to follow-up appointments, and $50 for failing to show up for a scheduled procedure appointment.

→ _____ _____

Signature of patient or representativee Date

CORNERSTONE PAIN MANAGEMENT

W. Amer Sardar, MD
501 Rita Lane Suite 101, Arlington, TX 76014 | 309 Regency Pkwy Suite 205, Mansfield, TX 76063 | Ph: 817.419.9048 | Fax: 817.419.3336

MEDICATION CONTRACT

Name	DOB

To avoid confusion over medications prescribed by Dr. Sardar, we ask you to **read and INITIAL** next to the following information:

→_____ 1. Patients are asked to use only one pharmacy.

2. **Patients must receive their pain medications from one doctor only.** Receiving a narcotic based pain medication from more than one doctor at a time, without informing all doctors that another doctor is prescribing that similar pain medication is a violation of state law. **Patients found receiving pain medication from Cornerstone Pain Management and another doctor at the**
→_____ **same time will be excused from the Cornerstone Pain Management practice.**

3. **Refills:** If its is time for your refill and you have made your regular office visit as scheduled,
→_____ your prescriptions will be refilled at the time of your office visit.

4. **Medications should never be taken at a faster rate than the prescribed rate on the**
→_____ **medication bottle. This will not be tolerated and medications will not be refilled early.**

5. If you are having problems with your medication and feel that you need an adjustment or
→_____ change, please call the office to schedule an office visit.

6. **If your medication is stolen, a police report of the theft will be needed to receive a new prescription.** Please submit a copy of the police report to the front desk. **Replacement of the**
→_____ **stolen medication will only be done once. Keep your medications in a secure place.**

→_____ 7. **Lost medications or prescriptions will not be replaced.**

→_____ 8. **We reserve the right to do random urine / blood tests.**

I have read and agree to the following guidelines that have been fully explained to me. I understand that failure to follow the above guidelines may cause Cornerstone Pain Management to release me from their care. A copy of this document can be provided at my request.

This agreement is entered into on _____ **20** _____ .

_____
Patient Signature

_____
Witnessed by

CORNERSTONE PAIN MANAGEMENT

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Protected Health Information

Name	DOB

AUTHORIZATION FOR VERBAL RELEASE OF PROTECTED HEALTH INFORMATION

[ ] **STANDARD DISCLOSURE**: I authorize Cornerstone Pain Management discuss my medical history, diagnosis, treatment and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse. **Please list the names and relationships of those who you'd like us to disclose information to:**

Name _____ **Relationship:** ○ Spouse ○ Children ○ Parent ○ Other: _____

Name _____ **Relationship:** ○ Spouse ○ Children ○ Parent ○ Other: _____

Name _____ **Relationship:** ○ Spouse ○ Children ○ Parent ○ Other: _____

Name _____ **Relationship:** ○ Spouse ○ Children ○ Parent ○ Other: _____

[ ] **NO INFORMATION:** I do not authorize release of any information concerning my treatment. Only my referring doctor and insurance company may receive information if so requested.

This authorization may be revoked at the request of the patient at any time. This authorization will expire upon discharge, or the conclusion of treatment with Cornerstone Pain Management.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Cornerstone Pain Management representatives or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to revoke this authorization at any time by notifying Cornerstone Pain Management to that effect in writing.

Please Initial: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I AUTHORIZE CORNERSTONE PAIN MANAGEMENT TO RECEIVE ALL MEDICAL RECORDS PERTAINING TO MY TREATMENT.

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Cornerstone Pain Management 501 Rita Ln Suite 101 Arlington, TX 76014. A revocation is not effective to the extent that a person has relied on it for use or disclosure of the protected health information, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Please Initial: _____

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	DATE	WITNESS

New Patient

Patient name	DOB	Age	Referring Physician	Family Doctor

Greatest area of pain _____

Other areas of pain _____

When did it start?
Mo/yr: _____

Was this due to an injury? [ ] Yes [ ] No

Please Describe: _____

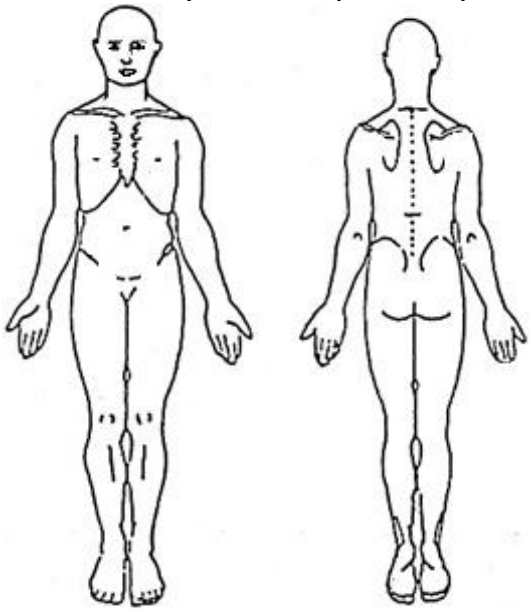
RATE YOUR PAIN ON A SCALE OF 1 (BEST) TO 10 (WORST)…

… at its most SEVERE:
best 0 1 2 3 4 5 6 7 8 9 10 worst

… TODAY:
best 0 1 2 3 4 5 6 7 8 9 10 worst

… at its BEST:
best 0 1 2 3 4 5 6 7 8 9 10 worst

Please shade in your areas of pain in the picture below:



When is your pain the worst?
[ ] Morning [ ] Midday [ ] Evening [ ] Night

Check if you have: Where is it located?

[ ] Numbness _____
[ ] Tingling _____
[ ] Weakness _____
[ ] NEW bowel or bladder changes?

How do you describe your pain?
[ ] aching
[ ] burning
[ ] dull
[ ] electrical
[ ] knifelike
[ ] sharp
[ ] shooting
[ ] stabbing
[ ] stinging
[ ] throbbing
[ ] tingling
[ ] toothache
[ ] other: _____

What makes your pain worse?
[ ] arching your back
[ ] bending over
[ ] bowel movements
[ ] cooking
[ ] coughing
[ ] getting out of a chair
[ ] lying down
[ ] sex
[ ] sitting
[ ] sneezing
[ ] standing
[ ] twisting
[ ] vacuuming
[ ] walking
[ ] climbing stairs
[ ] walking down a hill
[ ] other: _____

What makes your pain better?
[ ] sitting
[ ] standing
[ ] lying down
[ ] walking
[ ] stretching
[ ] hot bath or shower
[ ] application of heat
[ ] ice
[ ] relaxation
[ ] massage
[ ] TENS unit
[ ] acupuncture
[ ] chiropractors
[ ] previous injections: _____
[ ] pain medications: _____

Are there any legal actions related to your pain? [ ] Yes [ ] No

Have you tried any of the following for your current pain? Did it help?

[ ] Chiropractor	[ ] Yes	[ ] No
[ ] Physical Therapy	[ ] Yes	[ ] No
[ ] Injections	[ ] Yes	[ ] No
[ ] TENS Unit	[ ] Yes	[ ] No

Do you have or have you had any of the following?	Date of diagnosis:	Have you had surgery before?	Year:	Do you have any of these symptoms?
[ ] Heart attack		[ ] Back surgery		[ ] fever
[ ] Hypertension		[ ] neck surgery/fusion		[ ] weight loss
[ ] Chest Pain (angina)		[ ] lumbar spine surgery		[ ] weight gain
[ ] Congestive heart failure		[ ] lumbar fusion		[ ] visual problems
[ ] Atrial Fibrillation		[ ] Cardiac surgery		[ ] chest pain
[ ] Asthma		[ ] bypass		[ ] shortness of breath
[ ] COPD (emphysema)		[ ] angioplasty		[ ] new cough
[ ] Lung disease		[ ] pacemaker/AICD		[ ] swelling
[ ] Kidney failure/disease		[ ] Hysterectomy		[ ] joint pain
[ ] Cirrhosis		[ ] Appendectomy		[ ] new rashes
[ ] Liver disease		[ ] Tonsillectomy		[ ] urinary problems
[ ] Hepatitis A? - B ? - C?		[ ] Cancer surgery		[ ] bowel problems
[ ] Diabetes - insulin: [ ]Y [ ]N		[ ] Lung surgery		[ ] dizziness
[ ] Thyroid problems		[ ] Brain Surgery		[ ] depression
[ ] Peptic ulcers		[ ] Carpal Tunnel release		[ ] headaches
[ ] Stroke or TIA's		[ ] Other/details:		[ ] anxiety
[ ] Seizures				[ ] insomnia
[ ] Multiple sclerosis				[ ] nausea
[ ] Bleeding disorders				[ ] vomiting
[ ] Sickle cell disease				[ ] abdominal pain
[ ] HIV or immune disease				[ ] impotence
[ ] Alcoholism		Surgeons:		
[ ] Drug addiction				
[ ] Psychiatric disorders				

MEDICATIONS

Please list the medications you are currently taking:

Medication	Dose	How many per day	Medication	Dose	How many per day

Have you had side effects from pain medications?

Medication	Side effect

ALLERGIES TO MEDICATIONS:

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FAMILY HISTORY

Living	Deceased	Family Member	Please list any major health problems
[ ]	[ ]	Mother	_____
[ ]	[ ]	Father	_____
[ ]	[ ]	Brothers	_____
[ ]	[ ]	Sisters	_____
[ ]	[ ]	Children	_____

SOCIAL HISTORY

Occupation _____ Currently working? [ ] Yes [ ] No

Are you receiving disability? [ ] Yes [ ] No Disability diagnosis: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Do you live: [ ] independently or [ ] do you require home health assistance or [ ] in an assisted facility?

Do you smoke? [ ] Yes [ ] No Amount: _____

Do you drink alcohol? [ ] Yes [ ] No Amount: _____

Do you use illegal drugs? [ ] Yes [ ] No _____

Do you have an Advance Directive or Living Will? [ ] Yes [ ] No

Preferred hospital: _____

Primary Care Physician _____ Preferred Pharmacy _____

Address / Phone: _____ Address / Phone: _____

_____ _____

_____

Patient / authorized signature Date

_____

Staff signature