810 Shoney Dr. Ste. 105
Huntsville, AL 35801
Phone (256) 429-9779
Fax (256) 489-9568

PLEASE BRING THE FOLLOWING ITEMS WITH YOU:

***Your insurance cards**

***Your driver's license or picture I.D.**

If your insurance company requires a doctor's letter of referral, please BRING IT WITH YOU

***Payment for your co-pay, or deductible if not met this year**

***If your visit is covered by worker's compensation, bring the name and phone number of your case manager so we can verify coverage.**

As a new patient your appointment will take significantly longer than a follow up visit. Dr. Cosgrove is dedicated to providing all of our new patients with an extensive exam and a thorough consultation in order to assess your pain management needs.

Thank you!

PATIENT INFORMATION

Date: _____ How did you hear about us? _____

First Name: _____ MI: _____ Last Name: _____

Problem Area: (circle) Neck Low Back Other: _____

SSN#: _____ DOB: _____ Sex: _____

Address: _____

City: _____ Sate: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____

Emergency Contact: _____ Phone: _____

Do you have any x-rays or MRIs for this problem area? _____

If you don't have the films, where did you get them done?_____

Did a physician refer you to us for today's visit? ____ If so, Physician name: _____

Referring Physician Address/City :_____ Phone:_____

INSURANCE INFORMATION

Type: (circle) Auto Worker's Compensation Major Medical Medicare

Primary Insurance: _____ Effective Date:_____

Policy Number: _____ Group Number: _____ Accident Date: _____

Policy Holder Name: (name on card) _____ Relationship to Patient: _____

SSN #: _____ DOB: _____ Sex: _____

Policy Holder Employer: _____

Secondary Insurance: _____ Effective Date:_____

Policy Number: _____ Group Number: _____ Effective Date:_____

Policy Holder Name: (name on card) _____ Relationship to Patient: _____

SSN #: _____ DOB: _____ Sex: _____

Policy Holder Employer: _____

Acceptance as Patient

I understand and agree that the doctors of Alabama Paincare have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conduction of a physical examination are not considered treatment, but are part of the process of the information gathering concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly or to the doctor. I understand and agree that should my account(s) be refused to a collection agency and/or attorney for collection I will be responsible for any collection of this account. I further agree that I will at no time file a waiver of exemption against any type of legal seizure of personal property involved in the collection of this account.

_____ _____

Signature of patient (or parent, if patient is a minor) Date

Consent To Treatment
Authorization to Release Information to Insurance Providers or Payers

I am consenting to treatment at Alabama Paincare**.** I hereby authorize Alabama Paincare or its agents to furnish information to Medicare, Insurance carriers, or other third party payors concerning my illness, and treatment. I hereby assign to the physicians for medical service to myself, or to my dependents.

I understand that I am responsible for the cost of the medical services rendered and agree to pay any, and all amounts not paid by others within thirty (30) days from the date billed unless I made previous arrangements with my insurance company. I further agree to pay all collection costs, including, but not limited to court costs, and reasonable attorney's fee, if it becomes necessary to turn this account over to an outside party for collection.

This authorization and release is in effect until I choose to revoke it.

Patient/ Responsible Party: _____ Date: _____

Patient Signature: _____ Date: _____

List of Current Medications

Name:
Date:
Primary Care Physician:

	Medicine	Dose/mg	Frequency	Doctor	Pharmacy
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Patients Please do not write below this line

Office Use Only:

Pain Scores:

Today: _____

Average This Month: _____

Activities:

Self Care _____

Housebound _____

Exercise _____

Aberrant Behaviors: _____

Adverse Reactions: _____

Analgesic (Effectiveness): _____

PERSONAL MEDICAL INFORMATION FORM

NAME _____ APPOINTMENT DATE _____

HEIGHT _____ WEIGHT _____ BIRTHDATE _____ AGE _____

FAMILY DOCTOR (Name, Address)
_____

REFERRING DOCTOR (Name, Address)
_____

Person filling out form, if not self: Name_____ Relation _____

PLEASE RANK ONLY YOUR MAIN 3 PAIN COMPLAINTS:

1) _____

2) _____

3) _____

Briefly describe WHEN, WHERE, and HOW you began having your pain complaint:

_____

_____

_____

Accident or Injury date, if applicable _____

Injury occurred:_____ At work or work related

_____ At home

_____ In a car accident

_____ Unknown cause (happened spontaneously)

_____ Other _____

Were you taken off work by a doctor? Yes / No Doctor's Name_____

Have you ever been treated for Substance Abuse? Yes / No When and where?_____

Are you currently or have you ever been enrolled in a Methadone Clinic? Yes / No

Methadone Clinic Date of Last Visit and Dosage_____

Have you been charged with any crime concerning illegal drugs or prescription medications? Yes / No

Are you or have you ever been enrolled in law enforcement or court ordered program because of alcohol or illegal drugs or prescription medications? Yes / No

TESTS PERFORMED example: MRI X-Rays Labs Myelograms Etc…	PERFORMED WHEN AND WHERE?	ORDERING PHYSICIAN?	TEST RESULTS REVEALED WHAT FINDINGS?	RECOMMENDED TREATMENT?

When is your worst time of day? Not Applicable / Morning / Afternoon / Evening / Night

What activities or positions cause your pain to ***worsen*** or start?_____

_____

What positions, activities, treatments ***improve*** your symptoms?_____

_____

How long have you had this pain?_____

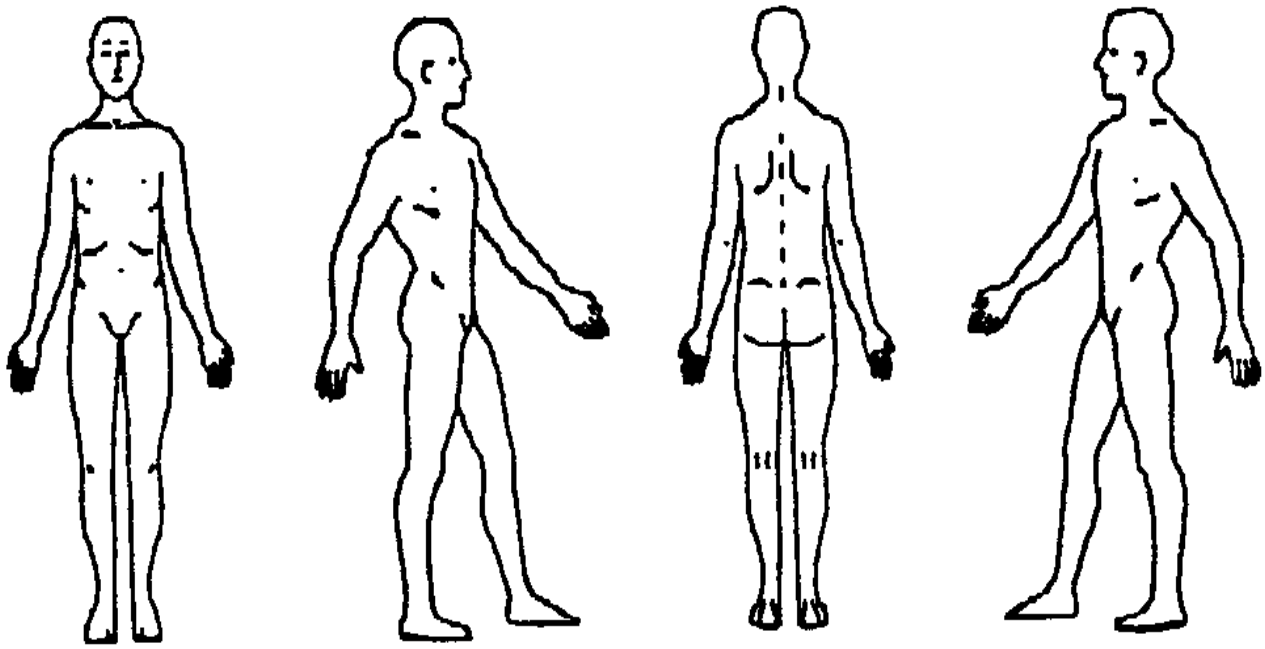
How often does the pain occur and how long does it last?_____

_____

√ Check all that apply	**Pain Description**	***WHERE* is this type of pain locate**
	constant	
	comes and goes	
	dull ache	
	sharp stab	
	throbbing	
	knots	
	cramps	
	burning	
	electrical	
	tingling / pin pricks	
	stiffness	
	soreness	
	tightness	
	stationary	
	radiates (moves)	
	numbness	

PRESENT SYMPTOMS:

Mark primary pain areas with xxxxx
Mark areas of numbness with ……..
Mark areas of weakness with ////////



ZERO = NO PAIN >>>>>>>>>>>>>>> TEN = WORST PAIN *EVER* EXPERIENCED

Circle the number that best describes your pain at its **worst during the last month**.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain at its **least during the last month**.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain **on average during the last month**.

0 1 2 3 4 5 6 7 8 9 10

Circle the number that best describes your pain as it is **right now**.

0 1 2 3 4 5 6 7 8 9 10

Present Functioning

How long are you able to walk?_____minutes / hours

What prevents you from walking longer?_____

How long can you comfortably sit?_____

I am able to perform household duties/chores: Almost Always / Most of the time / Occasionally / Rarely

I sleep about _____hours at night. My sleep is….Good….Fair….Poor

If you have trouble sleeping, what interferes with your sleep?_____

List your usual activities/hobbies/chores that you enjoy and indicate if you have been able to do them since your condition has occurred:

_____

_____

_____

Past or Present Treatment: √ Check ALL that you are CURRENTLY using or used in the PAST

	Modality	Last Time Used or Performed	Results
	Rest at Home		
	Home Exercise program		
	TENS Unit		
	Chiropractic Care		
	Accupuncture		
	Physical Therapy		
	Occupational Therapy		
	Work Hardening		
	Epidural Nerve Blocks/Duramorphs		
	Spinal column Stimulator		
	Implanted Medication Pump		
	Other		

Past Medications that Have Helped	**Past Medications that were NOT Helpful**
_____	_____
_____	_____
_____	_____

What Medications cause you an ALLERGIC Reaction?—Please describe the type of reaction

_____

_____

Your Past Medical History - Please √ check or List all OTHER medical conditions:

- [ ] Heart Disease
- [ ] Lung Disease
- [ ] Kidney Disease
- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Peptic Ulcer Disease or severe Heart Burn
- [ ] Arthritis
- [ ] Other _____
- [ ] Other _____
- [ ] Other _____

Your Past Surgical History - Please list all operations and procedures you have had

DATE	OPERATION	SURGEON

Social History

Marital Status: ____Single ____Divorced ___Separated

____*Married* ____*Remarried* ___*Widowed*

Children:	number	ages	live at home	deceased
boys				
girls				

Do you smoke? YES / NO How much? _____ How long have you smoked? _____

Do you drink alcohol? YES / NO What type?_____ How much? _____

Do you currently use "Street" drugs like marijuana, cocaine, etc? YES / NO What kind?_____

Family History

Mother: Living / Deceased Medical Problems: _____

Father: Living / Deceased Medical Problems: _____

How many:
Brothers _____ Medical Problems _____

Sisters _____ Medical Problems _____

Work/Employment History (more than one may be marked as needed)

- ☐ Employed by _____
- ☐ Currently working
- ☐ Currently off work for now because of this medical condition
- ☐ When was the last time you worked? _____
- ☐ Retired
- ☐ Early Retirement because of disability
- ☐ Temporary Disability from Worker's Compensation — MMI given? Y N Date_____
- ☐ Permanent Disability from Worker's Compensation — PPI _____% By:_____ _____
- ☐ Personal or Group Temporary Disability — FCE done? Y N Date_____
- ☐ Personal or Group Permanent Disability — Restrictions:_____
- ☐ Applying for group Disability or Early Retirement — _____
- ☐ On Social Security Disability Income — _____
- ☐ Applying for Social Security Disability — Restrictions given by:_____
- ☐ Other_____

Do You Now Have or Ever Have Had Problems With Any of the Following Areas?

___ENT ___Eyes ___Heart or Vessels ___Abdomen ___Genitourinary

___Skin ___Hormones ___Muscles ___Psychological/Psychiatric Treatment

___ *Weight Swings* ___*Hepatitis* ___*HIV (Aids Virus)*

___*Other:*_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to Privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments

I have received, read and understand your *notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____