



DAYTON OUTPATIENT CENTER  
PAIN MANAGEMENT

PHONE: (937) 252-2000  
FAX: (937) 252-3700

**\*\*WELCOME NEW PATIENT\*\***

**Dear:** \_\_\_\_\_

Your appointment at Dayton Outpatient Center with \_\_\_\_\_ is  
scheduled for \_\_\_\_\_ at our \_\_\_\_\_ location.

**\*\*PLEASE REMEMBER TO BRING YOUR PHOTO ID & INSURANCE CARDS WITH YOU\*\***

## LOCATIONS & DIRECTIONS

<p><b><u>Woodman Drive</u></b> 1010 Woodman Drive Dayton, OH 45432 (Back of the building on 2<sup>nd</sup> floor)</p> <p><b>From the North:</b> Take I-75 South to OH-35 East towards Xenia (via Exit 52-B). After 4.7 miles you will take the Woodman Drive Exit off of OH-35. Turn Left onto Woodman Drive and we are located ¼ of a mile on the right hand side of the road. (Drive around to the rear of the building and come up to the 2<sup>nd</sup> floor, suite 200)</p> <p><b>From the South:</b> Take I-75 North to I-675 North towards Columbus (via Exit 43). Remain on I-675 for 6.05 miles and merge onto OH-35 West towards Dayton (via exit 13-B). After 1.3 miles you will take the Woodman Dr. exit off OH-35. Turn right onto Woodman Dr. and we are located ¼ mile on the right hand side of the road.</p>	<p><b><u>Huber Heights</u></b> 6229 Troy Pike Huber Heights, OH 45424 (Old Access MD Urgent Care)</p> <p><b>From the North:</b> Take I-75 South to I-70 East towards Columbus (via Exit 61). After 3.1 miles you will take the OH-202 exit toward Old Troy Pike/Huber Heights (via Exit 36). Turn Right onto Troy Pike/OH-202 after 1.61 miles the Office will be on the right side of the road. (Located in the old Access MD urgent care beside Tranquility Spa &amp; Salon)</p> <p><b>From the South:</b> Take I-75 North towards Dayton to the Stanley Ave exit (via Exit 56). Keep right to take the Stanley Ave East ramp and merge onto Stanley Ave. After 0.67 miles turn Left onto Troy Pike/OH-202. Remain on Troy Pike/OH-202 for 4.55 miles and we are located on the left side of the road. (Located in old Access MD urgent care building)</p>	<p><b><u>Dayton Mall</u></b> 8210 Springboro Pike Miamisburg, OH 45342 (Next to Red Lobster in Urgent Care)</p> <p><b>From the North:</b> Take I-75 South towards Dayton to OH-725 exit toward Centerville/Miamisburg (via Exit 44). Turn Left onto OH-725/Miamisburg-Centerville Rd after 0.47 miles turn Right on Springboro Pike/OH-741. After 0.48 miles we will be located on the left side of the road.</p> <p><b>From the South:</b> Take I-75 North towards Dayton to OH-725 exit toward Centerville/Miamisburg (via Exit 44). Merge onto OH-725/Miamisburg-Centerville Road towards Centerville. Take the 2<sup>nd</sup> Right onto Springboro Pike/OH-741. After 0.48 miles we are located on the Left. (Located in Access MD urgent care building beside Red Lobster)</p>	<p><b><u>Troy</u></b> 1430 West Main Street Troy, OH 45373 (In Trojan Plaza Behind Urgent Care)</p> <p><b>From the North:</b> Take I-75 South towards OH-41 exit towards Covington/Troy (via Exit 74) Turn left off the exit onto West Main St. and continue for 0.44 miles. Our office is located on the right hand side of the road directly behind Taco Bell in the Hometown Urgent Care building. (separate entrance on side of building)</p> <p><b>From the South:</b> Take I-75 North towards OH-41 exit towards Covington/Troy (via Exit 74) Turn Right off the exit onto West Main Street and continue for 0.25 miles. Our office is located on the right hand side of the road directly behind Taco Bell in the Hometown Urgent Care building. (We have our own separate entrance towards the rear of the building)</p>
<p><b><u>Springfield</u></b> 1301 West First Street Springfield, OH 45504 (Located inside the Hometown Urgent Care)</p> <p><b>From the North:</b> Take I-75 S and merge onto I-70 E (via Exit 61-A). After 13.19mi merge onto OH-4 towards Enon/Springfield (via Exit 47). Continue for 1.47mi and merge onto US-68-N towards Urbana. After 1.47mi take OH-41 toward Troy/Springfield, Turn Right on W. 1<sup>st</sup> St. then take the Second Right on Hillcrest and an immediate Left on W. 1<sup>st</sup> St. (We are on the right in the Urgent Care)</p> <p><b>From the South:</b> Take I-75 N and merge on I-675 N. (via Exit 43). After 26.13mi merge on I-70 E(via Exit 26A) Continue to OH-4 towards Enon/Springfield (via Exit 47). Continue for 1.47mi and merge onto US-68-N towards Urbana. After 1.47mi take OH-41 toward Troy/Springfield, Turn Right on W. 1<sup>st</sup> St. then take the Second Right on Hillcrest and an immediate Left on W. 1<sup>st</sup> St.</p>	<p><b><u>Good Sam North</u></b> 9000 North Main Street Englewood, OH 45415 (Take elevator to the 4<sup>th</sup> Floor, Suite 401)</p> <p><b>From the North:</b> Take I-75 South towards Dayton. Merge onto I-70 E towards Indianapolis (via Exit 61). Continue for 4.83 miles to OH-48 toward Clayton/Englewood (via Exit 29). Turn Left off the exit onto South Main Street and continue for 0.6 miles and we will be located on the left in the Good Sam North Hospital. (Park in the front of the building and take the elevator to 4<sup>th</sup> floor, suite 401)</p> <p><b>From the South:</b> Take I-75 North towards Toledo. Merge onto I-70 W towards Indianapolis (via Exit 61). Continue for 4.83 miles to OH-48 toward Clayton/Englewood (via Exit 29). Turn Left off the exit onto South Main Street and continue for 0.6 miles and we will be located on the left in the Good Sam North Hospital. (Park in the front of the building and take the elevator to 4<sup>th</sup> floor, suite 401)</p>	<p><b><u>Greenville</u></b> 1403 Wagner Ave Greenville, OH 45331 (Located inside the Access MD Urgent Care)</p> <p><b>From the North:</b> Depending on your exact location there are multiple routes that can be taken to get to the Greenville office. We advise using a GPS system if you have one available or <a href="http://www.mapquest.com">www.mapquest.com</a> online. If neither of these options are available feel free to Call into the office at (937) 252-0000ext 358 and we will be glad to look exact directions up online for you over the phone.</p> <p><b>From the South:</b> Take I-75 North towards I-70 W towards Indianapolis (via Exit 61). Continue for 10.34mi and take OH-49 N exit Toward Phillipsburg/Greenville (via Exit 24). Stay straight on OH-49 for 19.7mi and merge onto US-127 N. after 3.98mi turn left onto Kruckeburg Rd (Kruckeburg becomes East Russ Rd) after .84mi turn Right onto Wagner Ave. We are .14mi on the Right side of road.</p>	

**\*\*PLEASE ARRIVE 15 MINUTES EARLY WITH THIS PACKET COMPLETED\*\***



DAYTON OUTPATIENT CENTER

### Pain Management

## PATIENT DEMOGRAPHIC FORM

(THIS FORM MUST BE UPDATED EVERY CALENDAR YEAR OR WHEN ANY INFORMATION CHANGES)

<b>PATIENT INFORMATION</b>	PATIENT NAME (LAST, FIRST)		M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		AGE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DOMESTIC PARTNER		
	RACE <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER		ETHNICITY <input type="checkbox"/> LATIN <input type="checkbox"/> OTHER		PREFERRED LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> OTHER	
	MAILING ADDRESS		APT/UNIT	CITY, STATE		ZIP CODE
	HOME PHONE	CELL PHONE		WORK PHONE/EXT	E-MAIL ADDRESS	
	EMPLOYER			EMPLOYER ADDRESS		
	EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> FULL-TIME STUDENT			JOB TITLE		
	PRIMARY CARE PHYSICIAN <input type="checkbox"/> NONE		LOCAL PHARMACY / PHONE NUMBER			
	<u>EMERGENCY CONTACT</u>				Due to HIPPA regulations; we are required to have the name of the person we are authorized to discuss your healthcare issues; in the event of a critical matter or emergency.	
NAME		RELATIONSHIP	NAME		RELATIONSHIP	
PHONE NUMBER	ALT PHONE		PHONE NUMBER	ALT PHONE		
<b>INSURANCE</b>	PRIMARY <input type="checkbox"/> NONE		SECONDARY <input type="checkbox"/> NONE			
	INSURANCE COMPANY NAME AND ADDRESS			INSURANCE COMPANY NAME AND ADDRESS		
	ID#	GROUP NAME OR NO.		ID#	GROUP NAME OR NO.	
	SUBSCRIBER'S NAME <input type="checkbox"/> SAME AS PATIENT		RELATIONSHIP	SUBSCRIBER'S NAME <input type="checkbox"/> SAME AS PATIENT		RELATIONSHIP
	SUBSCRIBER'S SOCIAL SECURITY NO.		SUBSCRIBERS DOB	SUBSCRIBER'S SOCIAL SECURITY NO.		SUBSCRIBERS DOB

The above subscriber hereby authorizes their insurance company to issue indemnity checks to the above listed medical provider for services provided.

#### AUTHORIZATION

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to my insurance carrier or Medicare for payment. I authorize any holder of medical and other information about me to release to insurance carriers or the Health Care Financing Administration and its agents or the Social Security Administration or its intermediaries or any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. The patient or his/her representative recognizing the need for healthcare, consents to the above listed medical provider rendering services ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct

. \* Privacy policy DOC Pain Management and its Affiliates do not share or sell your email address information. If you do not wish to receive e-mail correspondence from Dayton Outpatient Center or its affiliates please check this box.

#### FINANCIAL POLICY

Patients are responsible for all co-pays, deductible and any other charges for the services performed by us and not paid by patient's insurance. Patients are responsible to verify with their insurance if we, the provider of medical services, are covered medical provider and also to find the benefits available to patient for our services. Patients are responsible to arrange the referral from their PCP and/or any other authorization, if required by the patient's insurance. Our staff is available to assist patient in this regard or to answer any question the patient might have. Co-payment and deductibles are expected at the time of service. We accept cash, checks, and credit cards. Self-pay patients are required to pay their charges on the date of service. **If at any time the patient defaults on this agreement resulting in collection proceedings, the patient understands that he/she shall be responsible for any and all of the a) interest, b) collection costs including but not limited to third-party collection fees and costs, and c) all legal fees and court costs.**

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



### **No Show Policy**

1. Dayton Outpatient Center requires at least 24 hours notice to cancel an appointment in order to allow our staff to reschedule another person in need for that time slot.
2. Our staff will perform a reminder call the day before your appointments. A message will be left on the answering machine to the best number we have on our records that you have provided.
3. Every no show event will be documented in the chart and you will be assessed a fee of \$25.00 payable prior to your next scheduled office visit.
4. At the next scheduled appointment after each no show, the Doctor/PA will discuss with you the reason for the no show, the importance of keeping scheduled appointments and review our no show policy. Your treatment plan may be adjusted accordingly based on any information obtained during this discussion.
5. After 3 no shows (consecutive or non-consecutive), no additional appointments will be scheduled for you. You will need to pay for all no shows before you can be scheduled for an appointment. If you report a need for an appointment that appears to be urgent or emergent, you will be transferred to the Doctor/PA for a telephone interview.

Your signature below indicates that you have read this policy,  
understand it and agree to comply with its requirements.

\_\_\_\_\_

Patient Name

\_\_\_\_\_

Signature of Patient or Legally Responsible Person

\_\_\_\_\_

Date



## **CONSENT TO NOTICE OF PRIVACY PRACTICES**

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 indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

For judicial & administrative proceedings according to specific requirements.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the Notice of Privacy Practices covers all entities of Dayton Outpatient Center practices such as Pain Clinic, Ambulatory Surgery Center, Physical Therapy, Counseling, Pharmacy, Dental Clinic, Family Medicine, Occupational Medicine and any other service areas). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

**Unless there is an objection we may do any of the following:**

**Call patients to confirm an appointment and may leave a message**

**Call regarding an account (at the phone # provided by the patient)**

**Call and/or leave a message regarding treatment/test results.**

**We are only permitted to return calls left by our patients. We will not return calls left by a spouse, family member, or friend.**

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

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

Representative Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## **CONTROLLED SUBSTANCE (NARCOTIC) AGREEMENT**

The successful management of chronic pain involves many modalities including, but not limited to, physical therapy (PT), surgical consultation, injection therapy, behavioral counseling and oral medications. Occasionally, upon the mutual agreement of the patient and the pain management physician, it may be necessary to institute long-term opiate administration to achieve satisfactory pain control.

Because these drugs have the potential for abuse, strict accountability is necessary when prolonged use is required. For this reason, the following policies are agreed upon by you as the patient and your Physician and/or Physician Assistant.

1. You may not share, sell, trade or exchange your medications. You agree to keep these medications in a secure place. Medications will not be replaced if they are lost, misplaced, stolen or destroyed. **No exceptions will be made.**
2. You agree that you will use your medication at a rate no greater than the prescribed rate unless it is discussed directly with a Pain Management prescriber.
3. Early refills will not be given.
4. Changes in prescriptions can only be made during scheduled appointments and not via phone.
5. You agree that continued refill of medications may be contingent upon compliance with any chronic pain treatment modalities recommended by your Physician and/or Physician Assistant such as Physical Therapy, Psychological Therapy and Pain injections.
6. At any time, a request could be made at random by a Pain Management Physician to present the original dispensed container of medications to the office at each visit to document compliance and to prevent overuse.
7. You agree not to attempt to get pain medications from any other health care provider without telling them that you are currently under treatment by a pain management physician. If you are prescribed pain medications from another provider, you must notify us immediately with the information so we can document this in your chart as well as inform you as to whether or not you can take the medicine.
8. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacies or other professionals who provide your health care.
9. Unannounced, random urine or serum toxicology screens may be requested by your Pain Management Provider to determine compliance with this agreement and your regimen of pain control medications. Tests may include screens for any illegal substances. Your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorders. Refusal of such testing may subject you to an abrupt rapid wean schedule in order for the medication to be discontinued or prompt termination of our care.
10. Unannounced, random pill counts may also be requested by your Pain Management Provider to determine compliance with medication regimen and compliance of this agreement. You may be asked to bring all current medications to the office so that a staff member can verify the quantity of



medications remaining. A time frame will be given to report to the office. Failure to show up for a pill count may result in the discontinuation of medications or prompt termination of our care.

11. You agree not to use any illegal substances (cocaine, heroin, marijuana, crystal meth, ecstasy, ketamine, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of care at PMA effective immediately.
12. You will keep all scheduled appointments in the Pain Management Clinic. No-shows or late cancellations could result in a \$25-\$100 fee depending on if this is for an office visit or for a procedure in our ambulatory surgery center.
13. You cannot request to change to another of our physicians if you have been discharged. All doctors are within one practice. If your physician has discharged you and referred you to an Addictionologist; it is highly recommended you are compliant and complete a rehabilitation and/or counseling program. Please remember that just because you do actually go through a program, does not mean our pain physicians will take you back as a patient.

### **NARCOTIC THERAPY- POSSIBLE SIDE EFFECTS, RISKS AND COMPLICATIONS**

The patient understands that narcotic analgesics may result in physical dependence that ultimately may require slow weaning once the pain condition improves. Immediate discontinuation of this medication is not advised and severe life threatening conditions may occur.

Tolerance to the medication may develop after long-term usage which means that ultimately these medications may become less effective.

Other side effects may include the following which could be life threatening if not taken as instructed:

- ❖ Respiratory depression resulting in respiratory arrest and/or death, as well as resultant cardiac arrest and/or death
- ❖ Tolerance and/or physical dependence
- ❖ Withdrawal phenomenon with abrupt discontinuation of the medication causing significant side effects such as heart palpitations, sweating, elevated pulse and blood pressure
- ❖ Disorientation, resulting in falls and resultant significant injury
- ❖ Constipation, bowel obstruction or difficulty urinating
- ❖ Allergic and/or anaphylactic reactions to the medications resulting in low blood pressure, fast heart rate, arrhythmias, excessive itching, rash, throat swelling, respiratory or cardiac arrest and death
- ❖ **(Males Only)** may cause low testosterone levels
- ❖ **(Females Only)** Narcotic analgesics should not be used during pregnancy. Possible birth defects or physical opiate dependence could occur

### **Precautions and/or contraindications:**

- ❖ Patients taking anticoagulants (blood thinners: Plavix, Coumadin)
- ❖ Extremes of age
- ❖ Patients with significant other medical problems



- ❖ Patients taking sedative medications or central nervous system depressants (Valium, Soma, Xanax, Ativan, etc.)
- ❖ Narcotic analgesics should not be used during pregnancy
- ❖ Patients on multiple other medications

**Recommendations as to what to avoid while taking narcotics until you see how you respond:**

- ❖ Any kind of activity where judgment is required - i.e. signing legal documents, caring for the sick, the elderly or the very young
- ❖ Driving
- ❖ Operating heavy machinery.
- ❖ Working in high-risk areas (i.e. construction sites, elevated work sites, working with power tools, etc.).
- ❖ Drinking alcohol is prohibited while on narcotics due to potent and unpredictable enhancement of central nervous system depression of these two substances when taken together.

I have read this form or have had it read to me. I understand all of it and have had a chance to have my questions regarding this treatment answered to my satisfaction. I am signing this form voluntarily. I give my consent for the treatment for my pain with possible narcotic pain medications. I am aware of the many potential risks versus benefits and will make every effort to follow these guidelines during my pain management. I also understand that should this agreement be broken by non-compliance on my part that I may be discharged from the practice.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Name of Pharmacy: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_



## CLINIC POLICIES

In order to better serve our patients, we have found it necessary to put some long-standing “unwritten rules” on paper. It is our hope that by doing so, our patients will better understand the rationale behind these rules. This is a brief overview of policies; the narcotic agreement goes into further detail about some important and common issues not allowed.

### Narcotic Agreement:

- 1.) This is a contract between you and your doctor in which you need to review and sign. The purpose of the contract is not to convey mistrust, intimidate or make us appear inflexible. It is used by our office to help us efficiently monitor and treat your pain.
- 2.) Patients are not to increase their medications on their own. Any increase or decrease has to be done with the consent of the Doctor/PA. Patients are not allowed to obtain any pain medications from other Doctors, ER, etc. once they are under our care.

### Clinic Policies:

- 1.) We have designed a program that requires input from different specialties like Psychological Services and Physical Therapy. We rely on these services to aid in our assessment and treatment of your pain. We understand that some of you may come to us having already attempted some of these services and may have had less than desirable outcomes. However, we are confident in our referral and ask that you comply with our recommendations. **NOTE:** Matters discussed with Psychological Services are confidential. We are provided a report from them that addresses only your pain issues.
- 2.) There are certain behaviors and/or actions that will not be tolerated at our office:
  - a. Do not use any threatening or curse words. Our “zero tolerance” policy states these are grounds for immediate dismissal from this practice.
  - b. We can understand that problems, concerns and question come up which require our attention. **We ask that if you call the office, you leave only one message and allow up to 24 hours for a return call, multiple telephone calls within one day will not change our response time.** Messages are answered as quickly as possible and in order of severity.
  - c. Please, do not stop in to speak with a staff member without an appointment, as this will delay our interactions with patients scheduled for that day.
  - d. Paperwork is to be brought to scheduled office visits, this way the doctor may discuss any pertinent information needed to fill out the paperwork. Some paperwork does require a fee and will not be filled out until the fee is collected. Please allow enough time for completion of all paperwork.

### Primary Care Physician (PCP) Requirement:

- 1.) DOC is a referral based service only; therefore, it is mandatory that you have a primary care physician (PCP) or other specialist prior to your first appointment at our clinic. We



will inform your referring physician of our treatment recommendations after your initial evaluation and of your progress thereafter.

- 2.) At the time of your discharge from our service, your care will be referred back to your PCP or referring doctor.

**Medication Management Policy:**

- 1.) The number of telephone calls received daily regarding medications can be overwhelming. Please read the following before calling the office. The main goal of treatment with narcotic medications is to improve your ability to function and/or work.
- a. You must help yourself by following a healthy way of life including exercise, weight control, and limiting/ceasing the use of alcohol and tobacco.
  - b. It is important to take your medication exactly as prescribed. If you have any questions about medications, please discuss these with your physician at your next scheduled office visit. If your medications are taken other than as directed and you run out early, we will not be able to honor early refills.
  - c. Medications will not be refilled if you “no show,” cancel, or do not schedule a follow up appointment. Refills of narcotic medications will not be made as an “emergency” because you suddenly realize you will run out of medications before your next appointment. Please plan accordingly, taking holidays and weekends into consideration.
  - d. **NARCOTIC PRESCRIPTIONS ARE NOT FAXED, MAILED, “CALLED IN”, OR OTHERWISE DELIVERED TO YOUR PHARMACY.**
  - e. Medication changes (switching from one to another) will not be made over the telephone except in a dire emergency. Please wait until your next appointment to discuss these changes.
  - f. You should allow up to 2 weeks if your doctor prescribed a new medication for you to see maximum affect.
  - g. Violation of the above conditions can lead to termination of your association with our clinic. If the violation includes obtaining controlled substances from another practitioner, we may also report this action to other healthcare providers or authorities.

I have thoroughly read, understand, and accept all of the above. Any questions I had regarding this information has been answered to my satisfaction by a DOC staff member. I understand that I will be held accountable as I progress through my pain management treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
DOC staff member

\_\_\_\_\_  
Date



DAYTON OUTPATIENT CENTER

**Pain Management**

**PATIENT HISTORY FORM**

(Must be filled out by new patients before seen by Physician)

<b>PATIENT INFORMATION</b>	PATIENT NAME (LAST, FIRST)		M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DOMESTIC PARTNER			
	EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED <input type="checkbox"/> FULL-TIME STUDENT			JOB TITLE / DATE LAST WORKED		
	PRIMARY CARE PHYSICIAN <input type="checkbox"/> NONE			PHONE NUMBER		
	PREVIOUS PAIN DOCTOR <input type="checkbox"/> NONE			PHONE NUMBER		
<b>CAUSE OF PAIN</b>	DATE PAIN STARTED	LOCATION OF PAIN		PAIN LEVEL /10	CONSTANT <input type="checkbox"/> YES <input type="checkbox"/> NO	PAIN WORSE <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> None
	WORK INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	BWC <input type="checkbox"/> YES <input type="checkbox"/> NO	CLAIM #	ACTIVE <input type="checkbox"/> YES <input type="checkbox"/> NO	ATTORNEY NAME / PHONE NUMBER	
	AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF ACCIDENT	ATTORNEY NAME / PHONE NUMBER			
	OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE	ATTORNEY NAME / PHONE NUMBER			
Any previous testing? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MRI <input type="checkbox"/> CT scan <input type="checkbox"/> Xray <input type="checkbox"/> EMG/NCV <input type="checkbox"/> OTHER Where was your testing? _____ Date of testing: _____ Are you having trouble sleeping due to pain? <input type="checkbox"/> YES <input type="checkbox"/> NO Trouble staying asleep? <input type="checkbox"/> YES <input type="checkbox"/> NO Activities that worsen pain <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Other _____ Does stress affect your pain? <input type="checkbox"/> YES <input type="checkbox"/> NO Source of stress: _____ Anything help your pain? <input type="checkbox"/> YES <input type="checkbox"/> NO What helps? _____						

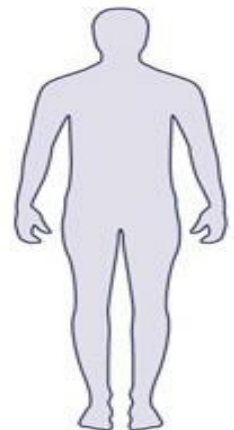
MARK DRAWING BELOW ACCORDING TO WHERE YOU HURT

PART OF THE BODY

- STABBING \_\_\_\_\_
- BURNING \_\_\_\_\_
- ACHING \_\_\_\_\_
- NUMBNESS \_\_\_\_\_
- PINS & NEEDLES \_\_\_\_\_
- JOINT PAIN \_\_\_\_\_



FRONT



BACK



DAYTON OUTPATIENT CENTER

**Pain Management**

**MEDICAL HISTORY**

PATIENT NAME (LAST, FIRST)		M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HEIGHT	WEIGHT	TOBACCO USE <input type="checkbox"/> YES <input type="checkbox"/> NO How much? PPD YRS.	ALCOHOL USE <input type="checkbox"/> YES <input type="checkbox"/> NO How much?	

Please list your past surgeries with dates or provide list \_\_\_\_\_

Have you ever been diagnosed with any of these? (check any that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Angina          | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Kidney stones    |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Liver Disease    |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> CHF             | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Thyroid Disease  |
| <input type="checkbox"/> COPD/Emphysema  | <input type="checkbox"/> Intestinal Issues      | <input type="checkbox"/> Ulcers/Gastritis |

Have you ever had any of the following happen to you? (check any that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Head (history of trauma) | <input type="checkbox"/> Passing out          | <input type="checkbox"/> Diarrhea/Constipation     |
| <input type="checkbox"/> Bloody stool             | <input type="checkbox"/> Bloody Urine         | <input type="checkbox"/> Shortness of breath       |
| <input type="checkbox"/> Skin rash                | <input type="checkbox"/> Upset stomach/nausea | <input type="checkbox"/> Weakness/Loss of strength |
| <input type="checkbox"/> Painful joints           | <input type="checkbox"/> Swelling             | <input type="checkbox"/> Dizziness                 |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Depression/Anxiety   | <input type="checkbox"/> Eyesight changes          |
| <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Hearing loss         | <input type="checkbox"/> Alcohol/Substance abuse   |

Have you ever had any pain treatments? (check any that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Trigger point injections | <input type="checkbox"/> Epidural steroid injections | <input type="checkbox"/> Facet joint injections    |
| <input type="checkbox"/> SI joint injections      | <input type="checkbox"/> Spinal Cord Stimulator      | <input type="checkbox"/> Morphine/Intrathecal pump |
| <input type="checkbox"/> Accupuncture             | <input type="checkbox"/> Chiropractor                | <input type="checkbox"/> Physical therapy          |
| <input type="checkbox"/> Aquatic/Pool Therapy     | <input type="checkbox"/> Addiction Counseling        | <input type="checkbox"/> Psychological counseling  |

Circle a number the best describes how your pain interferes with the following activities  
(0 is the lowest with no interference and 10 indicates complete interference)

FAMILY (Chores, Yardwork, Driving)

0 1 2 3 4 5 6 7 8 9 10

RECREATION (Hobbies, Sports)

0 1 2 3 4 5 6 7 8 9 10

SOCIAL ACTIVITY (Parties, Theater, Dining Out, Social Functions)

0 1 2 3 4 5 6 7 8 9 10

OCCUPATION

0 1 2 3 4 5 6 7 8 9 10

SEXUAL BEHAVIOR

0 1 2 3 4 5 6 7 8 9 10

LIFE SUPPORT ACTIVITIES

0 1 2 3 4 5 6 7 8 9 10



DAYTON OUTPATIENT CENTER

**Pain Management**

**MEDICAL HISTORY  
MEDICATIONS**

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER
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Please list all your Allergies \_\_\_\_\_  
\_\_\_\_\_

Please list your current PAIN medications \_\_\_\_\_  
\_\_\_\_\_

Have you tried other pain medications in the past? If so, what? \_\_\_\_\_  
\_\_\_\_\_

Please list any other medications you take currently or provide a list \_\_\_\_\_  
\_\_\_\_\_

Do you have any side effects from current medications? If so, what? \_\_\_\_\_

Are you concerned about your use of pain medications?      YES     NO

Have you ever used marijuana, cocaine or any other illegal drugs in the past?      YES     NO

Do you have any history of substance abuse?     YES     NO    (check any that apply)  
 Alcohol                       Illegal Drugs                       Prescription Drugs

Any family history of substance abuse?  YES     NO    (check any that apply)  
 Alcohol                       Illegal Drugs                       Prescription Drugs

Any history of psychological disorders in the past or present?  YES     NO    (check any that apply)  
 Attention Deficit Disorder     Bipolar  
 Depression                       Anxiety                       Schizophrenia

Any history of preadolescent sexual abuse?                       YES                       NO

I certify all my answers are true and are answered to the best of my knowledge.

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



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

I, \_\_\_\_\_, do hereby authorize the release of my protected health information (PHI), as indicated herein; between the following parties:

FROM: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

TO: **DOC Pain Management**  
**1010 Woodman Drive**  
**Dayton, Ohio 45432**  
**Fax:937-252-3700**  
**Phone:937-252-2000**

I authorize the use or disclosure of the following PHI: (Please list dates of service, condition or event for releases)

I request these records to be released for the following purpose:

**Pain Management Treatment**

I authorize this release effective for 180 days from the date of my signature below. If not specified, this authorization shall be effective for one (1) year. I understand, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing a any time. I understand revocation is not effective to the extent the provider has relied on this authorized release.

I also make the following qualification: If the information specified above contains information related to treatment for drug and/or alcohol abuse or HIV test results; I understand I have the right to inspect or copy my PHI and I have the right to refuse to sign this authorization

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Patient Signature or Guardian, or Durable Power of Attorney \_\_\_\_\_ Date \_\_\_\_\_

Patient unable to sign due to: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**OFFICE USE ONLY\*\*DO NOT WRITE BELOW THIS LINE**

FOR OFFICE USE ONLY: (Make sure only minimum necessary information is released)

**Surgery Records**  **Pain Clinic Records**  **Imaging Records**  **Testing Records**

Indicate PHI released by checking boxes below

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Face Sheet           | <input type="checkbox"/> Operative Reports        | <input type="checkbox"/> Physician Orders    |
| <input type="checkbox"/> H&P                  | <input type="checkbox"/> Radiology Reports        | <input type="checkbox"/> Therapy Reports     |
| <input type="checkbox"/> Discharge Summary    | <input type="checkbox"/> Office Notes             | <input type="checkbox"/> Emergency treatment |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Pathology Reports        | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Laboratory Reports   | <input type="checkbox"/> Physician Progress Notes |  |

Medical Record Clerk Signature \_\_\_\_\_ Date \_\_\_\_\_