In an effort to comply with governmental regulations regarding Meaningful Use our forms have been modified to capture additional data such as race, ethnicity, email address and contact information 03/13/2012

Georgia Pain Management, P.C.

Date: _____

PATIENT DEMOGRAPHICS

(Please Print)

PATIENT INFORMATION

Social Security Number _____ Referring Doctor _____

Race: (Select One)
__ American Indian or Alaska Native __Asian __African American
__Hispanic __Native Hawaiian or Other Pacific Islander __White
__Other

Ethnicity: (Select One)
___Hispanic or Latino
___Not Hispanic or Latino

Preferred Language:
__English __Spanish
__Russian __Indian
__Other

Patients Name _____ Date of Birth _____Gender: M F
Last First Middle

Marital Status: ___Married ___Single ___Widowed ___Divorced ___Separated

Address _____
Street Address City State ZIP Code

Home Phone _____
May we leave a voicemail message? **Yes No**
Preferred contact phone number **Home Cell Work**

Mobile Phone _____
May we leave a voicemail message? **Yes No**

Employer _____ Work Phone _____
May we leave a voicemail message? **Yes No**

Email address: _____ May we email medical information? **Yes No**

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION Please give your insurance card to the receptionist

PRIMARY INSURANCE

Name of Insurance Company _____ Insurance Phone _____

Policy Number _____ Group Number _____

Name of Insured _____ Insured Date of Birth _____

SECONDARY INSURANCE

Name of Insurance Company _____ Insurance Phone _____

Policy Number _____ Group Number _____

Name of Insured _____ Insured Date of Birth _____

I authorize **GEORGIA PAIN MANAGEMENT, P.C./SAMSON PAIN CENTER, P.C**. to release to my Insurance company(ies) and to other Physicians or facilities involved in my care any information required in the course of my examination or treatment. I also authorize the Center to provide details of my medical history to my insurance company in order to obtain reimbursement for medical benefits.

SIGNATURE: _____ DATE: _____

I authorize **GEORGIA PAIN MANAGEMENT, P.C/SAMSON PAIN CENTER, P.C.** to discuss my appointments, medical evaluation, treatment and results with the following people.

Authorized person 1. _____Date of Birth _____

2. _____Date of Birth _____

I hereby assign to **GEORGIA PAIN MANAGEMENT, P.C/SAMSON PAIN CENTER, P.C**. all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amounts not covered by insurance.

_____ I received a copy of the "Notice of Privacy Practices" for my records.
(Initials)

SIGNATURE: _____ DATE: _____

JAMES D. ELLNER, M.D.
GEORGIA PAIN MANAGEMENT
120 Stone Bridge Parkway, Suite 420
Woodstock, GA 30189

PAIN HISTORY AND INFORMATION

Please read the sheets carefully and answer all the questions to the best of your ability. This information will assist us in better treating your pain. Thank you for your time and corporation.

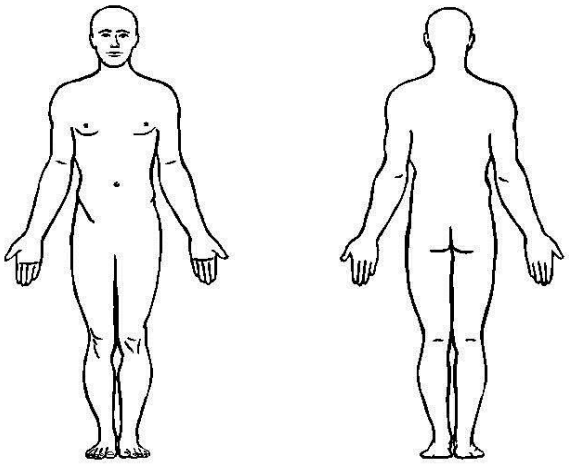
NAME: _____ _____ _____ DATE OF BIRTH: _____
LAST **FIRST** **M. I.**

Height: _____ **Weight: _____**

REFFERING PHYSICIAN(S): _____

Who is your Primary Care Physician? _____

****Please shade in the areas on the diagram where your pain is located.



1. What increases your pain? _____

_____

2. What decreases your pain? _____

_____

3. Please **CIRCLE** the appropriate words that best describe your pain:

Aching	Burning	Cold	Constant	Cramping	Dull	Electrical	Excruciating
Heavy	Hot	Numb	Intermittent	Severe	Sharp	Shooting	Sore
Stabbing	Stiff	Stinging	Throbbing	Tight	Tingling	Weak	

4. Does this problem cause you to have difficulty with (**circle all that apply**):

Completing household chores Completing tasks at work Driving a Car Exercise Sleeping

5. On a scale of **1-10** with 10 meaning the worst pain and 0 meaning no pain,

How high can your pain level go up to?: _____ How low can your pain level go down to?:_____

**Please indicate which diagnostic procedures/test you have had and the approximate date and location where the test was performed.

		DATE	LOCATION
_____	X-RAY	_____	_____
_____	CT SCAN	_____	_____
_____	MRI	_____	_____
_____	EMG	_____	_____
_____	NERVE CONDUCTION	_____	_____
_____	DISCOGRAM	_____	_____
_____	MYLOGRAM	_____	_____

Have you had any injections, procedures, or surgeries in the past year ***FOR THIS PROBLEM*? YES or NO

**If yes, what did you have done, when was it done, and by which physician? _____

_____

** Have you participated in any of the following treatments ***FOR THIS PROBLEM*** in the last two years?

Type of Treatment	Participated?	Pain Relief	Approximate Date	Still participating?
Physical Therapy	Yes No	Yes No Somewhat		Yes No
Chiropractor	Yes No	Yes No Somewhat		Yes No
Home Exercises	Yes No	Yes No Somewhat		Yes No
Traction	Yes No	Yes No Somewhat		Yes No
Tens Unit	Yes No	Yes No Somewhat		Yes No
Acupuncture/Dry Needling	Yes No	Yes No Somewhat		Yes No
Physiatrist / Psychologist	Yes No	Yes No Somewhat		Yes No
Hypnosis	Yes No	Yes No Somewhat		Yes No
Massage		Yes No Somewhat		Yes No

**How long have you had this pain?: _____

**Did this pain come on gradually or suddenly? _____

**State the reason you think caused this pain. If unknown, write unknown. _____

_____

_____

_____

MEDICAL HISTORY

List all allergies you have to medications, products, and/or foods: _____

_____

_____

Do you currently have, have had in the past, or are taking medication for the following conditions? (please circle)

***CARDIOVASCULAR*:** A-fib Anemia Aneurysm Blood Clot Cellulitis Chest pain Congestive Heart Failure Heart Attack Heart Disease Heart murmur High blood pressure High cholesterol Irregular heart beat Mitral Valve Prolapse Stroke TIA (mini stroke)

ENDOCRINE:

Diabetes Type 1 Diabetes Type 2 Goiter Hyperthyroidism Hypothyroidism Pancreatitis

GASTRO INTESTINAL: Acid Reflux (GERD) Cirrhosis Constipation Crohn's Diarrhea Diverticulitis Gallstones Hemorrhoids Hepatitis (which one?____) Hernia Irritable Bowel Liver Problems Ulcer

RESPIRATORY: Chronic Bronchitis COPD Shortness of Breath Seasonal Allergies Sleep Apnea

GENTOURINARY/REPRODUCTIVE:

Benign Prostatic Hypertrophy (BPH) Endometriosis Erectile dysfunction Kidney/Renal disease Kidney Stones Low testosterone Painful periods Polycystic ovaries Urinary Incontinence Urinary Tract Infections

MUSCULOSKELATAL:

Bursitis Degenerative Disc Disease Degenerative Joint Disease Fibromyalgia Gout Kyphosis Osteoarthritis Osteomyelitis Osteopenia Osteoporosis Rheumatoid Arthritis Scoliosis

PSYCHOLOGICAL/NEUROLOGICAL

ADD or ADHD Addiction Alcoholism Alzheimer's Disease Anxiety/Panic Attacks Bell's Palsy Bipolar Brain Injury Dementia Depression Dizziness Headaches Hearing Loss Insomnia Memory Issues Migraines Parkinson's Disease PTSD Restless Leg Syndrome Schizophrenia Seizures/Epilepsy Shingles hx. of Spinal Meningitis Substance Abuse Vertigo Suicidal Thoughts Vision Problems (cataracts, legally blind)

OTHER: hx. of MRSA HIV/AIDS Lyme's disease Malignant Hyperthermia Bleeding disorder

List any conditions you have that are not mentioned above _____

_____

FAMILY HISTORY

Do any of your immediate family (parents, children, siblings) have any of the conditions above? If so, please write them below. _____

_____

_____

SURGICAL HISTORY

Please list surgeries you have had in the past.

Surgery	Date	Surgery	Date

SOCIAL HISTORY

1. Do you currently use tobacco products? ***YES*** ***NO*** ***NEVER HAVE USED***

If yes, what products? Cigarettes Chew/Snuff/Dip Cigar Pipe

How long have you be using tobacco? _____

**If no, how long has it been since you stopped using? _____

2. Do you currently use alcohol products? ***YES*** ***NO*** ***NEVER HAVE USED***

**If yes, how often do you drink? _____

3. Do you currently use illicit or illegal drugs? (Examples: marijuana/cocaine/meth/ecstasy/heroin)

YES ***NO*** ***NEVER HAVE USED***

**If yes, which drugs do you use? _____

How long have you been using these drugs? _____

4. Do you currently exercise? ***YES*** ***NO*** ***NEVER HAVE***

**If yes, what type of exercises do you do and how often do you do them? _____

If no, were you exercising up until the point you became in pain? YES NO

5. Do you have a support system; i.e. family or friends you can rely on? YES NO

MEDICATIONS

Please list **ALL** medications you take, including over-the-counter meds, vitamins, and prescriptions from other doctors.

Medication name	***Amt (mg)***	***How Often***	***Medication name***	***Amt (mg)***	***How Often***
_____ __	_____	_____	_____ __	_____	_____
_____ __	_____	_____	_____ __	_____	_____
_____ __	_____	_____	_____ __	_____	_____
_____ __	_____	_____	_____ __	_____	_____
_____ __	_____	_____	_____ __	_____	_____
_____ __	_____	_____	_____ __	_____	_____
_____ __	_____	_____	_____ __	_____	_____

Please add any addition comments you wish to make here. _____

_____

_____

_____ _____

Patient signature **Today's Date**

PATIENT RIGHTS

1. To become informed of his/her rights as a patient in advance of the day of the procedure or when discontinuing the provision of care, patient may use an appointed representative. The patient may have a family member or representative of his/her choice involved in his/her care.
2. Exercise these rights without being subject to reprisal or discrimination with regard to race, sex, cultural, educational or religious background or the source of payment for care. To have considerate and respectful care, in a safe environment free from all forms of abuse or harassment.
3. Remain free from seclusion or restraints of any form that are not medically necessary.
4. Coordinate his/her care with physicians and receive information about illness, course of treatment and the prospects for recovery in terms that he/she can understand.
5. Receive information about any proposed treatment or procedures as needed and the expected outcome, to give informed consent or to refuse treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved.
6. Full consideration of patient privacy concerning consultation, examination, treatment and surgery.
7. Confidential treatment of all communications and records pertaining to patient care. Written permission will be obtained before medical records can be released to anyone not directly concerned with the patient care. Patient will have access to information in the medical record within a reasonable time frame (48 hours).
8. May leave the facility even against medical advice.
9. To make or file a complaint or grievance, to communicate any of his/her healthcare problems; to voice grievances regarding treatment or care that is (or file to be) furnished and receive written notice of the ASC's decision within 10 days unless otherwise notified.
10. Be informed by physician or designee of the continuing healthcare requirements after discharge.
11. Examine and receive an explanation of the bill regardless of source of payment.
12. Have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
13. All facility personnel performing patient care activities shall observe these above rights.

PATIENT RESPONSIBILITIES

1. The patient has the responsibility to provide accurate and complete information concerning present complaints, past illnesses, hospitalizations or any other health issues.
2. The patient is responsible for making it known whether the planned procedure/treatment risks, benefits and alternative treatments have been explained and understood.
3. The patient is responsible for following the treatment plan established by the physician, including instructions by nurses and other healthcare professionals, given by the physician.
4. The patient is responsible for keeping appointments or notifying the facility/physician in advance if unable to do so.
5. The patient accepts full responsibility for refusal of treatment and/or not following directions.
6. The patient is responsible for assuming that the financial obligations of his/her care are fulfilled as promptly as possible.
7. The patient is responsible for being respectful of the rights of others in the facility and is responsible for following facility policies and procedures.
8. The patient is responsible for notifying the staff if he/she has any concerns, feel his/her safety is being threatened or feel his/her privacy is being violated.
9. The patient is responsible for providing a responsible adult to transport them home from the facility and to remain with him/her for the first 24 hours.
10. The patient is responsible for informing the staff about a living will, medical power of attorney, or other advance directives that could affect his/her care.

PHYSICIAN OWNERSHIP

Samson Pain Center is exclusively owned and operated by James D. Ellner M.D.

ADVANCE DIRECTIVES

It is the policy of Samson Pain Center to ask each patient about any advance directives they may have executed and place a copy in the medical record. However, it will not be enforced as long as the patient is present and being treated at Samson Pain Center. If an emergent event occurs, the patient will be treated and stabilized, then transferred to WellStar Kennestone Hospital, where a copy of the advance directives will be sent along with other pertinent patient information. If you are interested in information regarding Advance Directives, you can contact: Georgia Division of Aging Services, 2 Peachtree St. NW, Ste 9.398, Atlanta, GA 30303-3142 or call the Division's Information and Referral Specialist at (404)657-5319. Copies of the Advance Directives form and its instructions are available at no cost to you at the following websites:

- http://aging.dhs.georgia.gov/sites/aging.dhs.georgia.gov/files/imported/DHR-DAS/DHR-DAS_Publications/ELAP-%20GEORGIA%20ADVANCE%20DIRECTIVE%20FOR%20HEALTH%20CARE-2012.pdf
- https://advocacy.gha.org/Home/Regulatory/Resources/advancedirectives.aspx

Complaints Against the Center
Healthcare Facility Regulation
2 Peachtree Street, NW
Atlanta, GA 30303-3142
(404) 657-5728

Complaints Against Physician
Composite State Board of Medical Examiners
ATTN: Ms. Gladys Henderson, Complaints Unit
2 Peachtree Street, NW, 36th Floor
Atlanta, GA 30303
(404) 657-6487

Complaints Against Nursing Staff
Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, GA
(478) 207-1640

Center Administrator
(770) 544-1000

Issues Regarding Medicare
Visit Medicare Ombudsman's Webpage at
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
or call 1-800-MEDICARE

I verify I have received and understand the information regarding physician ownership of Samson Pain Center, Patient Rights and Responsibilities, and the policy concerning Advance Directives prior to the date of my scheduled surgery.

_____	_____	_____
Patient Signature	**Printed Patient Name**	**Date and Time**