

NEW PATIENT INFORMATION RECORD**FULL LEGAL NAME:**

Last: _____ First: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: _____ Sex: _____ SSN: _____ Ethnicity: _____

Primary Language: _____ Marital Status: S M D W O**PATIENT EMPLOYER'S INFORMATION:** Currently employed Unemployed Legally Disabled Retired-Retirement date: _____

Company Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Work phone: (____) _____

IF MARRIED, PLEASE LIST SPOUSE'S EMPLOYMENT INFORMATION:

Spouse's Name: _____ Employer: _____ (Retirement Date: _____)

Address: _____

City: _____ State: _____ Zip: _____ Work phone: (____) _____

EMERGENCY CONTACTS:

1. Name: _____ Relationship: _____ Phone #: (____) _____

2. Name: _____ Relationship: _____ Phone #: (____) _____

PRIMARY CARDHOLDER INFORMATION (IF DIFFERENT FROM PATIENT):

Name: _____ DOB: _____ SS#: _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home phone: (____) _____

Cardholder's employer: _____ Work Phone: (____) _____

Cardholder's work address: _____

Primary Insurance Company: _____

Cardholder's Name: _____

Secondary Insurance Company: _____

Cardholder's Name: _____

Tertiary Insurance Company: _____

Cardholder's Name: _____

BAYLOR UNIVERSITY MEDICAL CENTER
DALLAS, TEXAS

52332 (Rev. 03/10)

NEW PATIENT INFORMATION RECORD

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PHYSICIAN INFORMATION:

Referring Physician: _____ Phone: (____) _____

Address: _____ City: _____ State: ____ Zip Code: _____

Primary Care Physician (PCP): _____ Phone: (____) _____

Address: _____ City: _____ State: ____ Zip Code: _____



If your pain is a result of an injury at work, please fill out the following section:

WORKERS' COMPENSATION INFORMATION:

Date of Injury: _____ Claim #: _____ Insurance Carrier: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Adjuster: _____

Employer at time of injury: _____ Brief description of accident: _____



Employer's address at time of injury: _____

Treating MD: _____ Street Address: _____

City: _____ State: ____ Zip: _____ Phone: (____) _____



For all patients:

Circle one

(Y) (N) **INSURANCE AUTHORIZATION**

I hereby authorize physician: Vera / Ravula to furnish information to my insurance carriers concerning my illness and treatment.

(Y) (N) **ASSIGNMENT OF BENEFITS**

I hereby assign to physician: Vera / Ravula all payments for medical services rendered to my dependents or Myself. I understand that I am responsible for any amount not covered by insurance.

(Y) (N) **TREATMENT AUTHORIZATION**

I hereby authorize physician: Vera / Ravula to render health care to me during this visit.

SIGNATURE: _____

DATE: _____

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NEW PATIENT INFORMATION RECORD

NEW PATIENT QUESTIONNAIRE

Patient Name: _____

Date: _____

1. Where is your pain located? _____

2. How long have you had pain?

- Less than 6 months
- 6-12 months
- More than a year
- More than 2 years

3. How did your pain start?

- After a work related injury. Date: _____
- After an auto accident. Date: _____
- After an injury. Date: _____
- Developed slowly over time
- Other: _____

4. Check the one(s) that describe your pain:

- Constant pain always present
- Periodic pain not present all the time
- Pain that occurs with standing or sitting only
- A sharp "knife like" pain
- Pain that occurs only with activity
- Other: _____

5. Please check the kinds of doctors or specialists you have seen ABOUT THIS PAIN:

- | | | |
|---|--|--|
| <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Neurosurgeon |
| <input type="checkbox"/> Physical Medicine | <input type="checkbox"/> Gynecologist | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Dermatologist | <input type="checkbox"/> Endocrinologist |
| <input type="checkbox"/> Gastroenterologist | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> General Surgeon |
| <input type="checkbox"/> Oncologist | <input type="checkbox"/> Hand Surgeon | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Plastic Surgeon | <input type="checkbox"/> Urologist | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Other: _____ | | |

6. Please rate your pain according to the following:

MILD-----MODERATE-----SEVERE

1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This is how my pain felt during the past week:

7. What tests have been done to try to diagnose your pain?

- X-rays
- MRI scan
- CT scan
- Myelogram
- Bone Scan
- Blood work
- Ultrasound
- Other: _____

Findings: (if known): _____

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8. What other treatments have you tried to help this pain?

- | | | |
|--|--|---|
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> TENS unit | <input type="checkbox"/> Home exercises |
| <input type="checkbox"/> Injections or nerve blocks | <input type="checkbox"/> Stress management | <input type="checkbox"/> Pain programs |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Other: _____ | | |
| <input type="checkbox"/> Medications you have taken for pain (please list any medicines you can remember trying for this pain) | | |
| _____ | | |
| _____ | | |

Did any of these treatments or medications seem to help your pain?

- No Yes If so, which ones? _____

9. Please circle any FAMILY medical problems:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Artery or Vein problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers | <input type="checkbox"/> GI bleeding |
| <input type="checkbox"/> Cholesterol problems | <input type="checkbox"/> COPD | <input type="checkbox"/> Other: _____ |

10. Please check either Yes or No to any of these which apply to you:

- | | Yes | No |
|---|--------------------------|--------------------------|
| Married? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink daily? | <input type="checkbox"/> | <input type="checkbox"/> |
| History of alcohol or drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you seen a psychologist or psychiatrist? | <input type="checkbox"/> | <input type="checkbox"/> |
| Currently under high stress? | <input type="checkbox"/> | <input type="checkbox"/> |
| Currently employed ? | <input type="checkbox"/> | <input type="checkbox"/> |
| Disabled? | <input type="checkbox"/> | <input type="checkbox"/> |
| Lawsuit pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| Family problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent Crisis? | <input type="checkbox"/> | <input type="checkbox"/> |
| Current depression? | <input type="checkbox"/> | <input type="checkbox"/> |

11. Please check any of these which apply to you:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Lung Pain | <input type="checkbox"/> Trouble Urinating |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Sedation | <input type="checkbox"/> Trouble Working | <input type="checkbox"/> Abnormal Heartbeats | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Bowel/Bladder Problems |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Bowel/Bladder Incontinence |
| <input type="checkbox"/> Difficulty Driving | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Rash | <input type="checkbox"/> Numbness | <input type="checkbox"/> Decreased Sexual Interest |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Other: _____ |

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NEW PATIENT QUESTIONNAIRE

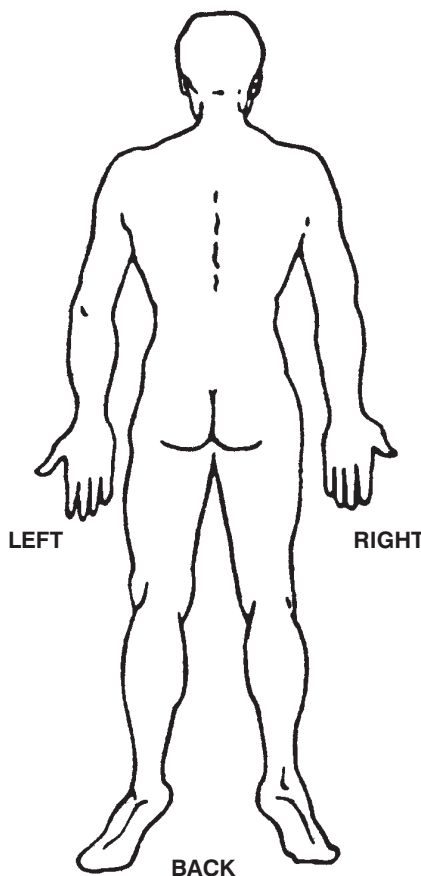
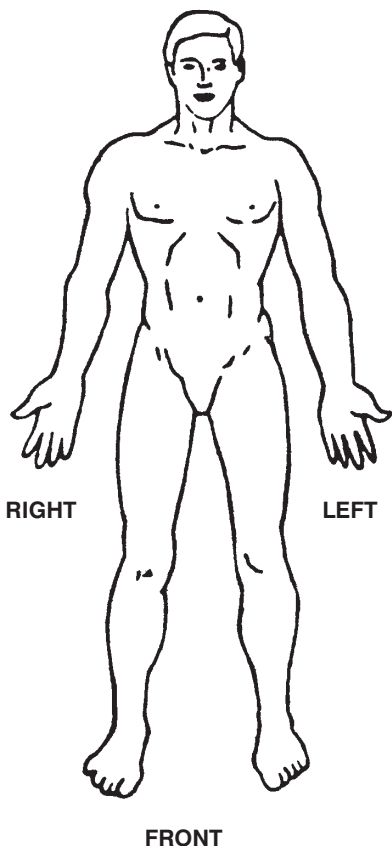
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BAYLOR CENTER FOR PAIN MANAGEMENT

Patient's Name: _____ Date: _____

Mark the area on your body where you feel the described sensations.

<u>Ache</u>	<u>Numbness</u>	<u>Pins & Needles</u>	<u>Burning</u>	<u>Stabbing</u>
^^^	00000	_____	XXXXX	/////
^^^	00000	_____	XXXXX	/////
^^^	00000	_____	XXXXX	/////



On a scale of 0 to 10 how is your pain now?

1 2 3 4 5 6 7 8 9 10

MILD-----MODERATE-----SEVERE

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BAYLOR CENTER FOR PAIN MANAGEMENT

MEDICATION AGREEMENT

This agreement was developed to try to decrease the risk of problems or side effects occurring with medication prescribed through this office. Please read through each statement and initial where requested. If there are any questions, please do not hesitate to ask.

I understand that all medications have potential risks. Although any major risks will be discussed with you, it is impossible to talk about each potential side effect or risk of each medication. If you want detailed information, ask us and we will give you a copy of the PHYSICIAN'S DESK REFERENCE information on each medication. Your pharmacist can also give you detailed information if you ask.

Initials: _____

I will not exceed the prescribed medication amount or receive similar medication from other sources.

Initials: _____

If I begin to have a side effect that concerns me, I will stop the medication and notify my physician.

Initials: _____

Our policy is to prescribe medication during office visits and not over the telephone. Your medication should last until your next scheduled appointment.

Initials: _____

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MEDICATION AGREEMENT