Camelback INTERVENTIONAL & PAIN

NAVMED

Please Print As Legibly As Possible or Circle if Applicable:

Today's Date: ____ /_____/_____ DOB: ____/____/_____

Last Name:_______________First Name:________________Middle Name:____________Nickname:__________

Age:_____ Sex:_______ Gender:______ Height: ______ Weight: ______

Address:____City:______________State:_____Zip:___________

Mobile Phone:____________Home Phone:_____________Cell Phone:____________Email:___________________

Preferred Form of Contact:____________ Social Security # _________-_____-_________

Who referred you:____

In case of emergency, notify:
Emergency Contact Name:_____________________Relationship:_________Cell Phone Number:____________

Primary and Secondary Insurance Information:

Name of Primary Insurance Company | Primary Insurance Member ID Number:

____

Name of policy holder of Primary Policy | Relationship to patient

____

Date of Birth of policy holder (if not patient) | Employer of the Primary Insurance Holder?

____

Name of Secondary Insurance Company | Secondary Insurance Member ID Number:

____

Name of policy holder of Secondary Insurance | Relationship to patient

____

Date of birth of policy holder (if not patient) | Employer of the Secondary Insurance Holder?

____

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Current Symptoms

Chief Complaint:____

How did your current episode begin? Suddenly ____________ Gradually______________

When did your current pain episode begin? ________________________________

What caused your current pain episode? __________________________________

Has the pain lessened, worsened or stayed the same? __________________________

How often is your pain? [ ] Occasional [ ] Frequent [ ] Constant

Does your pain radiate? If so, where to? ___________________________________

On a scale of 1-10, what is your pain on average?_______at its worst?_______at it's best?_______

Describe your pain:
Continuous--Intermittent--Throbbing--Shooting--Pins and Needles--Numbness
Stabbing--Sharp--Aching--Tingling--Hot--Burning
Other:____

What makes your pain better?
Sitting--Standing--Rising from sitting--Bending forward--Bending backward--Walking--Climbing Stairs--Lying on your back--Lying on your stomach--NSAIDs--Ointments/Creams--Massage--Stretching
Other:____

What makes your pain worse?
Sitting--Standing--Rising from sitting--Bending forward--Bending backward--Walking--Climbing Stairs--Lying on your back--Lying on your stomach--Lifting--Exercise/Exertion--Massage--Stretching
Other:____

Please circle all the following physicians or specialists you have consulted ONLY for pain relief for the current problem, not for other problems

Chiropractor--Endocrinologist--Neurologist--Neurosurgeon--Orthopedic Surgeon
Physical Therapist--Psychiatrist--Rheumatologist--Pain Physician--Podiatrist--Internal/Family Medicine
Other:______________________________Name:______________________

Is there anything else you would like to tell us about your current symptoms?

____

____

____

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CIRCLE ALL THAT APPLY TO YOU TODAY

General: None--Fever/Chills/Nausea/Vomiting/Fatigue/Difficulty Sleeping /Weight Gain/Loss

Skin: None--Rash/Itching/Redness

HEENT: None--Headaches/Double/Blurred Vision/Ringing in Ears

Blood: None--Bleeding Problem/Use of Anticoagulants? Yes /No

Cardiovascular: None--Chest Pain/Myocardial Infarction/Congestive Heart Failure/Pacemaker/Defibrillator Abnormal Rhythm/High Blood Pressure

Genitourinary/ Nephrology: None--Urination Pain/Low Sex Drive/Loss of control

Gastrointestinal: None--Diarrhea/Loss of bowel control/Abdominal Pain/Change in Bowel Habits

Musculoskeletal: None--Neck Pain/Low Back Pain/Mid Back Pain/Muscle Spasms/Joint Pain/Knee Pain Shoulder Pain/Hip Pain

Neurological: None--Weakness/Fainting/Dizziness/Numbness/Tingling/Instability When Walking

Psychiatric: None--Anxiety/Increased Stress/Depressed Mood/Suicidal Thoughts/Hallucinations

Other Issues Not Listed:____

Females:Is there a chance you may be or are pregnant? Yes/No Last Menstrual Cycle:______________

Past Medical History

Heart Disease--Coronary Artery Disease--Heart Attack--Congestive Heart Failure--Stroke--Diabetes

High Blood Pressure--Increased Cholesterol--Vascular Disease--Osteoarthritis--Rheumatoid Arthritis

Kidney Disease--Chest Pain--Bleeding Disorder--Asthma/COPD/Emphysema--Fibromyalgia

Shortness of Breath--Thyroid Disease--Cancer--Neuropathy--Autoimmune Disorder--Bleeding Disorder

Other:____

Family History

Anxiety/Depression--Arthritis--Cancer--Diabetes--Headaches--Heart Disease/Stroke--Back Pain
High Blood Pressure--Liver Problems--Seizures--Substance Abuse--Back Pain--Bleeding Disorder
Other:____

Social History

Are you? Married or living with significant other--Divorced--Widowed--Single
Do you have children? ____________If yes, how many?___________________________________
Alcohol use? ___________Former?_________Frequency: Socially ___ Daily ____ Weekly________
Tobacco use? _____Former? _______ How many per day? ___________How many years? _______________
Recreational drug use? _____________ What drugs? ____
Have you ever abused narcotics or prescription medications? _______________________________________
Disabled? If yes starting what date? ____

Allergies Reaction

- __________________________ ______________________________
- __________________________ ______________________________
- __________________________ ______________________________
- __________________________ ______________________________

Current medications and doses, including over the counter:

Do you take any of the following blood thinning medications?
Aspirin--Coumadin/Warfarin--Plavix--Lovenox--Ticlid--Pradaxa--Heparin--Eliquis--Other:__________________
_
When was your last dose? _________________________

Medication Dosage

- __________________________ ________________________________
- __________________________ ________________________________
- __________________________ ________________________________
- __________________________ ________________________________
- __________________________ ________________________________
- __________________________ ________________________________

List all surgeries you have had
Surgeries Year

- __________________________ ________________________________
- __________________________ ________________________________
- __________________________ ________________________________
- __________________________ ________________________________

Have you had any imaging performed:

MRI/CT/X-Ray/Ultrasound ________________ Where ___________________________
Facility ____
Contact Number ____

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Pharmacy Information

Today's Date: ____________________ Patient Name: ______________________________
Name of Preferred Pharmacy: ____
Pharmacy Address: ____
Street City State Zip Code
Pharmacy Cross Streets: _____________________________ & ___________________________________
Pharmacy Phone #: ________________________________ Pharmacy Fax #: ________________________

Patient Authorization to Obtain Summary Plan Description & 5500 Form

I hereby direct you to forward to Camelback Interventional & Pain the following governing plan documents for the purpose of applicability of compliance with PPACA.

1. Summary plan description
2. 5500 Form (Plan Annual Report)
3. Certified Copy of Certificate for PPACA Grandfathered Plan

Please forward to the below address immediately:

Camelback Interventional & Pain, LLC
6910 E. Fifth Avenue
Scottsdale, Arizona, 85251

Thank you!

____

Patient Name (Please Print)

____

Patient Signature

____

Date

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Release of Records Authorization

Today's Date: ___________

Patient: _______________________________ DOB: __________________

I authorize you, your agent, or legal representative to release and disclose as requested all the medical information, including but not limited to records of examinations, treatments, consultations, diagnostics and laboratory findings, admissions and discharge reports, treatment and prognosis records, nurses and doctors notes and other non-medical information in my file.

If you are being treated by Multiple Medical Providers, and you would like Camelback Interventional & Pain to review records from or attempt to coordinate Your Health Care with, please ask our front desk for a secondary Medical Release Form.

Doctor: ____

Name of Medical Practice: ____

Address: ____

Phone: ____

Contact Person (If known): __________________________________

Patients Name (Printed): ____

Patients Signature: ____

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