Patient Name: _____ Patient DOB: ____ /____ /____

HPI
INTEGRIS HEALTH
Nevin Sam, D.O.
Board Certified Interventional Pain Management
10001 S. Western, Suite 101 | Oklahoma City, OK 73139
9800 Broadway Ext, Suite 201 | Oklahoma City, OK 73114
OFFICE 405.286.2725 **FAX** 405.286.2724

NEW PATIENT HISTORY

Today's Date: ____ /____ /_____

REASON FOR VISIT

_____

_____

_____

_____

PAIN ASSESSMENT

Pain Score

1. **Rate your pain level with a number from 1 to 10 for each situation listed below**:
   (0= no pain. 10 = worst pain imaginable)

   _____ My WORST pain in the last month _____ My AVERAGE pain in the last month

   _____ My LEAST pain in the last month _____ My pain TODAY

Pain Type

2. **Describe your pain**

☐ Acute	☐ Deep	☐ Superficial
☐ Chronic	☐ Intractable	☐ Visceral
☐ Surgical	☐ Phantom	☐ Other
☐ Neuropathic	☐ Referred	

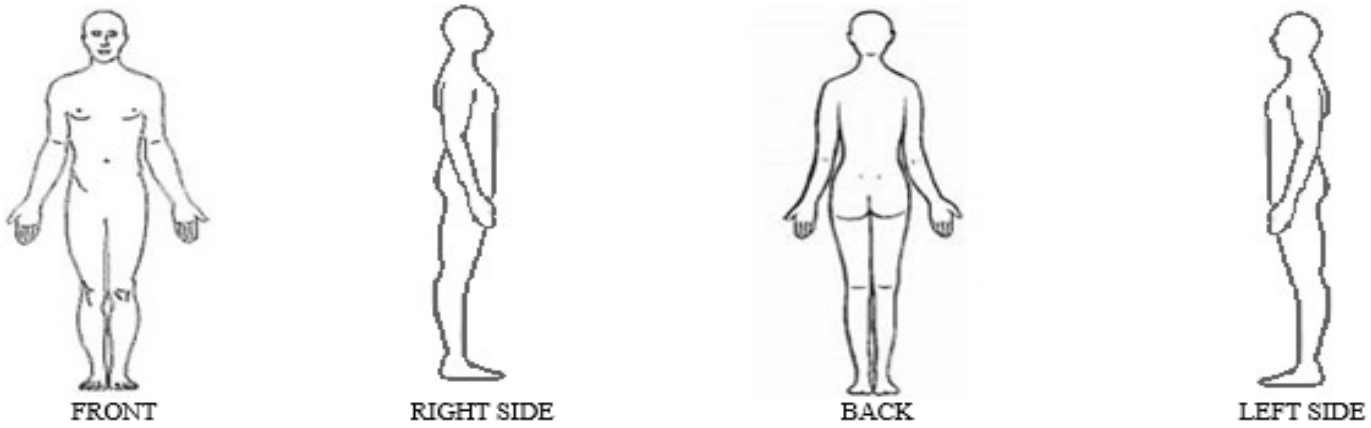
Pain Location

3. Where is your pain located? (Check all that apply, including R or L)

Place #1 next to the worst pain, #2 next the second worst etc….

- ☐ Head
- ☐ Neck
- ☐ Shoulder
  - ☐ Right
  - ☐ Left
- ☐ Arm
  - ☐ Right
  - ☐ Left
- ☐ Back
  - ☐ Upper
  - ☐ Mid
  - ☐ Lower
  - ☐ Radiates
  - ☐ to Leg
- ☐ Hand/Wrist
  - ☐ Right
  - ☐ Left
- ☐ Hip
  - ☐ Right
  - ☐ Left
- ☐ Buttocks
- ☐ Leg
  - ☐ Right
  - ☐ Left
- ☐ Foot/Ankle
  - ☐ Right
  - ☐ Left
- ☐ Chest
- ☐ Ribs
- ☐ Abdomen
- ☐ Pelvis
- ☐ Groins

***4.* Shade in the areas where you feel pain.** Place and "X" where the pain is greatest.



Pain Radiating Towards

***5.* Does your pain radiate to other areas of your body?**

☐ Yes ☐ No If yes, where? _____

Pain Descriptors

6. Circle all that apply in describing your pain…

☐Aching ☐ Burning ☐ Cramping ☐ Crushing ☐ Discomfort ☐ Headache ☐ Heaviness ☐ Itching

☐ Jabbing ☐ Nagging ☐Numbness ☐ Penetrating ☐ Pins & Needles ☐ Pounding ☐ Pressure

☐ Radiating ☐ Sharp ☐ Shooting ☐ Sore Spasm ☐ Squeezing ☐ Stabbing ☐ Tender ☐ Throbbing

☐ Tightness ☐ Tiring ☐ Unable to describe ☐ Other_____

Pain Frequency

7. Is your pain constant (always there) or intermittent (comes and goes)?

- ☐ Constant and always present, about the same intensity
- ☐ Constant and always present, but intensity varies
- ☐ Usually present, but some periods of time without pain
- ☐ Often present, but have pain-free periods of 1 or more hours
- ☐ Occasionally present for brief periods, usually less than 30 minutes
- ☐ Rarely present, but have pain every few days or weeks

Pain Onset

8. How did your pain begin? (Check one below)

◯ Gradual ◯ Ongoing ◯ Progressive ◯ Sudden ◯ Unable to tell ◯ Other: _____

Approximately, when did your pain begin? _____

Clinical Progression

9. How has your pain level change? (Check one below)

◯ Not changed ◯ Gradually Worsening ◯ Gradually Improving ◯ Rapidly Worsening ◯ Resolved ◯ Other

Aggravating Factors

10.Pain is aggravated / worsened by…. (Check all that apply)

☐ Bending ☐ Stretching ☐ Straightening ☐ Exercise ☐ Kneeling ☐ Squatting ☐ Standing
☐ Walking ☐ Stairs ☐ Relaxation ☐ Alcoholic Drinks ☐ Sexual Activity ☐ Massage
☐ Medications ☐ Sitting ☐ Lying Down ☐ Hot ☐ Cold ☐ Hot Tub-Pool

Result of Injury

11. Is your pain the result of an injury? ☐ Yes ☐ No

If yes, was this a work related injury? ☐ Yes ☐ No

Patient's Stated Pain Goal

12. What level of pain do you feel you could function on a daily basis and enjoy life? _____

Pain Interventions

13. What other forms of treatment have you received for pain? (Check all that apply)

☐ Epidural Steroid Injections-Blocks ☐ Trigger Point Injections ☐ IDET ☐ Intrathecal Pump (Morphine)
☐ Spinal Cord Stimulator (Dorsal Column Stimulator) ☐ Botox ☐ Pain Counseling ☐ Hypnosis
☐ Psychotherapy ☐ Medication ☐ Surgery ☐ Ablation-Rhizotomy Therapy ☐ Physical Therapy ☐ TENS
☐ Acupuncture ☐ Message Therapy ☐ Chiropractic ☐ Nerve Root Blocks
Marijuana (If so, do you have a Medical Marijuana Card?) ☐ Yes ☐ No

14. Pain is improved by… (Check all that apply)

☐ Relaxation ☐ Alcoholic Drinks ☐ Sexual Activity ☐ Exercise ☐ Massage ☐ Medications

☐ Marijuana ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Heat ☐ Cold ☐ Hot Tub-Pool

ALLERGIES / CONTRAINDICATIONS

15. Are you allergic or have intolerances to any medications? Yes No

Medication	Your Reaction / What Happens?

MEDICATIONS

16. What medications are you <u>currently</u> taking?

Medication	Dosage	Frequency	Date Started	Does it help your pain?

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

Address: _____ (Please include cross streets)

HISTORY

Medical History

17. List all past / present conditions for which you have received medical treatment

☐ ADD / ADHD	☐ Emphysema	☐ Never / muscle disease
☐ Allergic rhinitis	☐ Failure to thrive	☐ Obesity
☐ Allergies	☐ GERD	☐ Osteoporosis
☐ Anemia	☐ Glaucoma	☐ Pneumonia
☐ Anxiety	☐ Headache	☐ Scoliosis
☐ Arthritis	☐ Hearing loss	☐ Seizures
☐ Asthma	☐ Heart murmur	☐ Sickle cell anemia
☐ Cancer	☐ Hepatitis	☐ Stoke
☐ Cataracts	☐ HIV / AIDS	☐ Substance abuse
☐ CHF	☐ Hypertension	☐ Thyroid Disease
☐ Clotting disorder	☐ Inflammatory bowel disease	☐ Tuberculosis
☐ COPD	☐ Jaundice	☐ Ulcers (GI)
☐ Depression	☐ Kidney disease	☐ UTI
☐ Diabetes Mellitus	☐ Meningitis	☐ Varicella
☐ Eating Disorder	☐ Myocardial infarction	☐ Vision problems
☐ Eczema		

Surgical History

18. Starting with the most recent, please list every surgical procedure you have undergone <u>for pain</u>

Approximate Date	Procedure	Surgeon	Write: 'H' if it helped 'W' if it worsened 'NC' if no change in your pain

19. Starting with the most recent, please list every surgical procedure you have undergone <u>other than those listed above for pain</u>

Approximate Date	Procedure	Surgeon

Family History

20. Place an X in the box for all that apply

	Father	Mother	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Failure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐

Alcohol

21. Do you use alcohol? (Please check one) … ☐ Yes ☐ Not Currently ☐ Never

If yes, drinks per week
Wine _____
Beer _____
Liquor _____

Tobacco / Smokeless Tobacco / E-cigarette –Vaping

22. Are you a current smoker? ☐ Yes ☐ No

If no, have you previously smoked? ☐ Yes ☐ No

If yes, how many packs did you smoke per day? _____ How many years? _____

If yes, how many packs do you smoke per day? _____ How many years? _____

23. Do you currently use other forms of tobacco? ☐ Yes ☐ No

If no, have you previously used other forms tobacco? ☐ Yes ☐ No

24. Do you currently use an E-cigarette / Vaping Device? ☐ Yes ☐ No

If no, have you previously used an E-cigarette / Vaping Device? ☐ Yes ☐ No

Drug Details / Drug Use

25. Have you ever used illicit or illegal drugs or substance? ☐ Yes ☐ No

If yes, check all that apply and note when last used _____

☐ Marijuana ☐ Uppers ☐ Downers ☐ Cocaine ☐ Heroin ☐ Amphetamines

☐ Methamphetamines ☐ Other _____

26. In your opinion, have you ever been addicted to…

Alcohol? ☐ Yes ☐ No

Drugs? ☐ Yes ☐ No

Prescription Medication? ☐ Yes ☐ No

27. Are there any substance abuse issues in the household? ☐ Yes ☐ No

28. Have you participated in a recovery treatment program? ☐ Yes ☐ No

Other

29. With whom do you live? _____

30. Are you able to take care of yourself? ☐ Yes ☐ No

If no, please enter the name of your caregiver: _____

REVIEW OF SYSTEMS

Mark the following symptoms that you currently suffer from:

Constitutional:
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Diaphoresis
- ☐ Fatigue
- ☐ Unexpected weight change

HENT:
- ☐ Congestion
- ☐ Dental problem
- ☐ Drooling
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Facial swelling
- ☐ Hearing loss
- ☐ Mouth sores
- ☐ Nosebleeds
- ☐ Postnasal drip
- ☐ Rhinorrhea
- ☐ Sinus pain
- ☐ Sinus pressure
- ☐ Sneezing
- ☐ Sore throat
- ☐ Tinnitus
- ☐ Trouble swallowing
- ☐ Voice change

Eyes:
- ☐ Eye discharge
- ☐ Eye Itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Photophobia
- ☐ Visual disturbance

Respiratory:
- ☐ Apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stridor
- ☐ Wheezing

Cardiology:
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations

GI:
- ☐ Abdominal distention
- ☐ Abdominal pain
- ☐ Anal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea

Musculoskeletal:
- ☐ Arthralgia
- ☐ Back pain
- ☐ Gait problem
- ☐ Joint swelling
- ☐ Myalgia
- ☐ Neck pain
- ☐ Neck stiffness

Neurological:
- ☐ Dizziness
- ☐ Facial asymmetry
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Syncope
- ☐ Tremors
- ☐ Weakness

Psychiatric:
- ☐ Agitation
- ☐ Behavior problem
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Dysphoric mood
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous/anxious
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal ideas
- ☐ Are you under psychiatric care?

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NEW PATIENT INFORMATION

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST	FIRST	MIDDLE INITIAL	SEX:	BIRTH DATE:	AGE

SOCIAL SECURITY NO.:	MARITAL STATUS: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated	SPOUSES NAME:	RACE:

PATIENT'S ADDRESS:			REFERRING PHYSICIAN:	ETHNICITY:
CITY:	**STATE:**	**ZIP CODE:**	Are You: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired	**PREFERRED LANGUAGE:**

HOME PHONE:	WORK PHONE:	CELL PHONE:
( )	( )	( )

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Company_____

Name of the Person who carries the Insurance Policy _____ Relationship to Patient _____

Carriers DOB _____ Carriers SS#_____

Carriers Employer _____

Secondary Insurance _____

Carrier Name _____ Relationship to Patient_____

Not Applicable ❑ Carriers DOB _____ Carriers SS#_____

Carriers Employer _____

EMPLOYMENT INFORMATION

Patient's Employer_____ Ph#_____

Insured Employer_____ Ph#_____

If the patient is a minor, please list both parents names and employer

Mother_____ Employer_____ Ph#_____

Father_____ Employer_____ Ph#_____

NEXT-OF-KIN INFORMATION

NEAREST RELATIVE (OR FRIEND, NOT SPOUSE) NOT LIVING WITH YOU:	
HOME PHONE: ( )	**RELATIONSHIP TO THE PATIENT:**

THIRD PARTY BILLING

Is Your Injury Work Related?	☐ Yes	☐ No
Is This Injury Due To An Accident?	☐ Yes	☐ No
If Your Injury Is MVA Related Have You Obtained an Accident Report?	☐ Yes	☐ No

I Authorize the RELEASE of any MEDICAL INFORMATION if necessary to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I, acknowledge and agree that I have received a copy of the HPI Privacy Notice.

Signature Date

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Chart No. _____

HPI Physicians, LLC

Authorization to Release Information via Phone/Family/Friends

Patient Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of HPI regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

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

Email Address: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

I understand this authorization will remain in effect until I revoke the authorization in writing.

_____ _____
Patient Signature Date

HPI STAFF ONLY:

Documented by:

_____ _____
Initials Date

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HPI Physicians, LLC

Financial Policy

Thank you for choosing "HPI Physicians, LLC" as your healthcare provider.

In additional to accepting traditional insurance plans and Medicare we are contracted with numerous, Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different and constantly updating providers participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referrals, prior-authorization and pre-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up to date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring to each appointment your current insurance card, or any other information that is required by your insurance carrier. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing yourclaim.

Payment for all co-insurance, deductible, and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover Card, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at (405) 286-2725 to make payment arrangements. **Please be aware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services will be billed separately.**

If your injury was due to a Motor Vehicle Accident you will be set up on a self-pay account for any charges incurred up to $500.00. If charges exceed $500.00, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the Physician. **Please note that not all HPI Physicians will accept third party/MVA patients.**

There is a $35.00 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital South or North, Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing HPI Physicians to participate in your care.
Sincerely, HPI Physicians & Staff

My signature below acknowledges receipt of this Financial Policy:

Signed:_____Date_____

(Signature of person financially responsible for payment)

Relationship if other than patient: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how HPI Physicians, LLC, as applicable (the "Practice"), will use protected health information for the purposes of treatment, payment for treatment and healthcare operations.
- The Notice explains in more detail how the Practice may use and share protected health information other than treatment, payment and healthcare operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient Name (print): _____

Patient Date of Birth: _____

This form must be signed by either the patient or by the patient's personal representative.

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient:

_____

_____

_____ Date:_____
Signature of Patient or Patient's Personal Representative

Current contact information for patient or personal representative signing this form:

Name (print): _____

Address: _____

Telephone: _____

E-mail: _____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or the patient's personal representative on this Acknowledgement but did not because:

☐ It was emergency treatment
☐ I could not communicate with the patient
☐ The patient refused to sign
☐ The patient was unable to sign because _____
☐ Other: _____

_____ _____ _____
Signature Practice Staff Member | Name (please print) and title | Date

This form should be placed in patient's medical record.

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AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of HPI Physicians (HPI-P) to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of HPI-P to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of HPI-P charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers' compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. **I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release HPI Physicians, LLC. agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at HPI-P. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release HPI-P from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand a photocopy of this document is as valid as the original.

SIGNED _____ DATE _____

(Patient)

OR _____ WITNESS TO _____
(Nearest relative or responsible party) SIGNATURE

_____ Policyholder's Signature _____
(Relationship to patient)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Dept. of Health, or by law.

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Appointment No Show and Late Policy

Appointment No Shows

A NO SHOW appointment is a missed appointment without notifying our office 24 hours prior to scheduled appointment. If your appointment is scheduled for a Monday, we require notification no later than the Friday prior to your appointment.

- **The first no show will result in a call or email reminding you that you have missed your appointment and will need to reschedule for another day.**
- **The second no show will result in a call or email and a $50.00 charge to the patient, not your insurance company. This must be paid prior to scheduling your next appointment.**
- **The third no show will result in a dismissal from the practice.**

Late Policy

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment for another day. If you are late to your appointment, but do not call us prior to your appointment time, we will give your time away to another patient.

- Patients arriving early or on time will be seen in the order they were scheduled.
- Post-operative patients arriving 10-30 minutes late will be seen, but will have to wait while we see patients who arrived to their scheduled appointment on time.
- Non Post-operative patients arriving 10-30 minutes late will be asked to reschedule.
- Any patient arriving more than 30 minutes late will be asked to reschedule.

_____

Signature of Patient | Signature of Parent or Guardian (if applicable)

_____

Print Name of Patient | Print Name of Parent or Guardian

Dated:_____