RUSH PAIN CENTER – NEW PATIENT EVALUATION

Date ___/___/_____ Nurse: _____ Secretary: _____

Patient Name: _____ _____ _____
LAST FIRST MI

Patient SS Number: _____-_____-_____ ☐ Male ☐ Female DOB: ___/___/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____/_____-_____ Work/Cell Phone: _____/_____-_____

Chief Complaint: _____

Treatment requested MD only: _____

Referring Physician: _____ Phone: _____/_____-_____

Address: _____ City: _____ State _____ Zip_____

Called by: ☐ Patient ☐ Workers Compensation ☐ Lawyer ☐ Referring Physician ☐ Other

Primary insurance: _____ ☐ HMO ☐ PPO ☐ POS ☐ Commercial

Telephone: _____ ID: _____ Group: _____

Effective date:_____ Verified by: _____ Date: _____

Owner of insurance policy: _____ Relation: DOB: ID:

Secondary insurance: _____ ☐ HMO ☐ PPO ☐ POS ☐ Commercial

Telephone: _____ ID: _____ Group: _____

Effective date:_____ Verified by: _____ Date: _____

Work-Related Injury / Personal injury or accident: ☐ Yes ☐ No

Date of injury: _____/_____/_____ Claim # _____;

Claim Adjustor: _____ Phone: _____/_____-_____

Address: _____ Fax: _____/_____-_____

Rehabilitation Nurse: _____ Phone: _____/_____-_____

Address: _____ Fax: _____/_____-_____

Case in litigation: ☐ Yes ☐ No Attorney: _____

Address: _____ City: _____

State _____ Zip _____ Phone: _____/_____-_____ Fax: _____/_____-_____

Have you ever been treated in a Pain Center before: ☐ Yes ☐ No Requested Letter ☐ Records ☐

Do you have any history of substance abuse: ☐ Yes ☐ No

Do You take any narcotics: ☐ Yes If yes what?_____ Prescribed by

_____MD ☐ No

Emergency contact: _____ Relation: _____ Phone: ____/____-_____

Available records? ☐ MRI ☐ CT SCAN ☐ X-RAY ☐ EMG Other: _____

Prior Surgeries: ☐ Yes ☐ No Diabetic taking insulin/pills: ☐ Yes ☐ No

Any bleeding disorder: ☐ Yes ☐ No Taking: ☐ Coumadin ☐ Plavix ☐ Ticlid ☐ No

Any allergies to medication: ☐ Yes ☐ No If yes which: _____

Fasting 6-8 hours before appointment ☐ Driver accompanying patient ☐ by: _____

Appointment Date: _____/_____/_____ Time: _____Am / Pm DR: _____