New Patient Form

Your completed form helps the provider get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (346)351-2948 if you have any questions or are unsure how to complete any section of this form.

Today's Date__________

Patient Information

Your Name: ______________________________ Social Security Number: ____________________

Street Address: ______________________________ Date of Birth: __________ Age: ________

City/State/Zip: ______________________________ Height: __________ Weight: _______ lbs

Email: ______________________________ Gender : ☐ Male ☐ Female

Is Physical Address Same as Mailing? ☐Yes ☐ No If not, ______________________________

Preferred Phone: ______________________________ ☐Home ☐Mobile ☐ Work

Secondary Phone: ______________________________ ☐Home ☐Mobile ☐ Work

Email: ______________________________ Driver's License #/State: ______________

Emergency Contact Name: ______________________ Phone: ______________ Relationship: ____________

Marital Status : ☐ Married ☐ Single ☐Divorced ☐Widowed ☐ Other : ______________________________

Referral

Were you referred to our clinic by another physician? If so, whom? ______________________________

If not, how did you hear about us? ☐Insurance Company ☐Family ☐Friend ☐Pcp ☐Other ______________

Preferred pharmacy

Pharmacy Name : ______________________________ Phone Number: ______________________________

Street Address : ______________________________ City/State/Zip: ______________________________

Primary Insurance Plan

Payer(e.g.BCBS): ______________________________ Plan: ______________________________

Policy/I.D Number : ______________________________ Group Number: ______________________________

Complete this box if you are not the policy holder for your primary insurance

Insurance Policy Holder : ☐Self ☐Spouse ☐Child ☐Other: ______________________________

Policy Holder Name: ______________________________ Policy Holder Gender : ☐Female ☐Male

Date of Birth : ______________________________ Social Security Number: ______________________

Secondary Insurance Plan (If Any)

Payer(e.g.BCBS): ______________________________ Plan: ____________________________________

Policy/I.D. Number: ___________________________ Group Number: ___________________________

Complete this box if you are not the policy holder for your secondary insurance

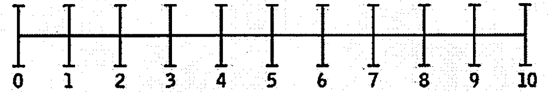
Insurance Policy Holder : ☐Self ☐Spouse ☐Child ☐Other: _______________________________________

Policy Holder Name: __________________________ Policy Holder Gender : ☐Female ☐Male

Date of Birth : _______________________________ Social Security Number: _______________________

Pain Description

<u>Use the pain scale described below to rate your pain for the questions below:</u>



0-Pain Free
1-Very minor annoyance, occasional minor twinges
2-Minor annoyance, occasional strong twinges
3-Annoying enough to be distracting
4-Can be ignored if you are really involved in your work/task, but still distracting
5-Cannot be ignored for more than 30 minutes
6-Cannot be ignored for any length of time, but you can still go to work an participate in social activities
7-Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8-Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain
9-Unable to speak, crying out or moaning uncontrollably, near delirium
10-Uncoscious, pain makes you pass out.

____ What number on the pain scale (0-10) best describes your pain right now?

____ What number on the pain scale (0-10) best describes your worst pain?

____ What number on the pain scale (0-10) best describes your least pain?

____ What number on the pain scale (0-10) best describes your average pain over the last month?

Please circle

Severity Mild Moderate Severe Other: ______________________________

Frequency of symptoms Constantly Daily Weekly Randomly Other: ____________________________

Continued Pain Description

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following that best describe your symptoms:

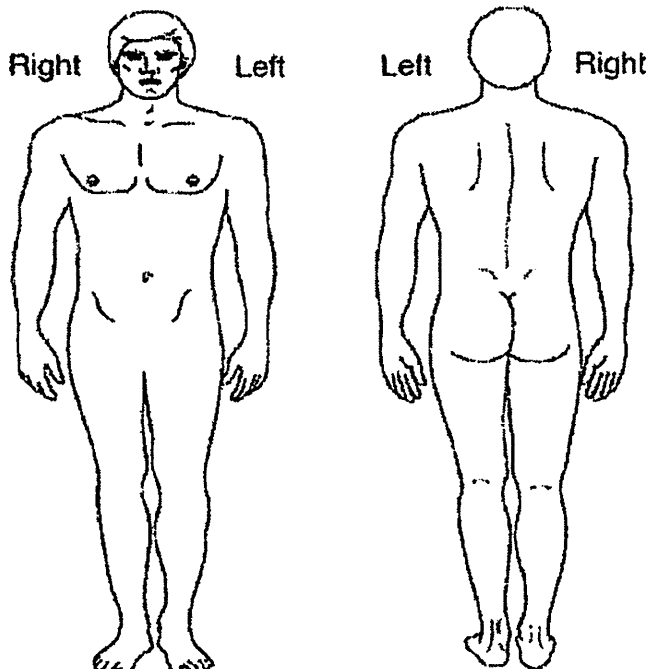
"N" = Numbness

"S" = Stabbing

"B" = Burning

"P" = Pins and Needles

"A" = Aching



Where is your worst area of pain located? ____________________

Does this pain radiate? If so,where? ____________________

Please list any additional areas of pain : ____________________

Check all of the following that describe your Pain :

☐ Aching ☐Hot/Burning ☐Shooting ☐Stabbing/Sharp

☐Cramping ☐Numbness ☐Spasming ☐Throbbing

☐Dull ☐Shock-like ☐Squeezing ☐Tiring/Exhausting

☐Tingling/Pins and Needles

What makes your pain worse: ____________________

When is your pain at its worst? ☐Morning ☐During the day ☐Evenings ☐Middle of the night

What makes your pain better? ____________________

Timing of Symptoms

Approximately when did this pain begin? ____________________

What caused your current pain episode? ____________________

Is your pain the result of a Motor Vehicle Accident or Personal Injury? (legal term describing injury sustained to your person by negligence of another) ☐ Yes ☐ No

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed ? ☐ Decreased ☐ Increased ☐Stayed the same

Current Medications

Please indicated which (if any) of the following blood-thinners you are taking :

☐Aggrenox ☐Coumadin ☐Effient ☐Eliquis ☐ lovenox ☐Plavix ☐Pletal

☐Ticlid ☐Warfarin ☐Xerelto ☐Other : ______________________________

Please list all Medications you are currently taking. Attach an additional sheet, if required.

MEDICATION NAME	DOSE	FREQUENCY

Allergies

Do you have any known drug allergies ? ☐ Yes ☐ No

If so, please list all medications you are allergic to.

MEDICATION NAME	ALLERGI REACTION TYPE

Topical Allergies: ☐Iodine ☐Latex ☐Tape ☐Are you allergic to IV contrast? ☐ Yes ☐No

Date:
Name:

Wt:
B/P:
P:
Temp:
RR:

Patient Intake Form

Please Circle if you are experiencing or have any of the following:

General:
Fatigue
Fever
Unintentional Weight Loss
Unintentional Weight Gain
Daytime Somnolence
Fogginess of Thought
Inability To Complete Tasks
Insomnia

Gastrointestinal:
Constipation
Diarrhea
Nausea
Heart Burn
Blood In Stool

Musculoskeletal:
Neck Pain
Back Pain
Muscle Aches
Joint Pain
Joint Swelling

HEENT:
Dry Mouth
Visual Changes

Genitourinary:
Difficulty Urinating
Painful Urination
Blood In Urine
Increased urinary frequency

Hematologic:
Clotting Difficulties
Easy Bleeding
Easy Bruising

Cardiovascular:
Chest Pain
Palpitations

Endocrine:
Heat Intolerance
Cold Intolerance
Increased Thirst

Psychiatric:
Depression
Anxiety
Thoughts Harming Oneself
Thoughts Harming Others
Hallucinations

Pulmonary:
Snoring
Shortness of Breath
Cough
Obstructive Sleep Apnea
Snore at night
Use CPAP machine
Smoker
Chronic Obstructive
Pulmonary Disease (COPD)

Neurological:
Glaucoma
Difficulty Walking
Headaches
Numbness
Seizures
Strokes
Weakness

Other:
Myocardial Infarction
Heart Attack
Heart Rhythm Abnormalities
Abnormal EKG's
History of Coronary Stents
Blood Thinning Medication
(Asprin, Plavix, /Clopidogrel,
Heparin/ Lovenox,
Other: ___________________)
Diabetes
Steroid Use

For Return Patients:

Current pain score(1-10) :
Lowest score this week:
Highest score this week:

What helps your pain:

What makes it worse:

Any new medications :

Any new surgeries :

Any change in health:

Past medical history

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

☐ Cancer- Type ____________________

☐ Diabetes- Type ____________________

☐ HIV /AIDS

☐Urinary Incontinence

☐Emphysema/COPD

☐ Pneumonia

☐Tuberculosis

☐Dialysis

☐Kidney Infection(s)

☐Kidney Stones

Head/Eyes/Ears/Nose/Throat

☐ Headaches

☐Migraines

☐Head Injury

☐Hyperthyroidism

☐Hypothyroidism

☐Glaucoma

Gastrointestinal

☐Bowel Incontinence

☐GERD (Acid Reflux)

☐Gastrointestinal Bleeding

☐Constipation

Hepatic

☐Hepatitis A

(Active/ inactive/ unsure)

☐Hepatitis B

(Active/ inactive/ unsure)

☐Hepatitis C

(Active/ inactive/ unsure)

Cardiovascular/Hematologic

☐Anemia

☐Bleeding disorders

☐Heart Attack

☐High Blood Pressure

☐High cholesterol

☐Mitral Valve Prolapse

☐Murmur

☐Phlebitis

☐Poor Circulation

☐Stroke

☐Coronary Artery Disease

☐Pacemaker /Defibrillator

Musculoskeletal

☐Amputation

☐Bursitis

☐Carpal Tunnel Syndrome

☐Chronic Low Back Pain

☐Chronic Neck Pain

☐Chronic Joint Pain

☐Fibromyalgia

☐Joint Injury

☐Osteoarthritis

☐Osteoporosis

☐Phantom Limb Pain

☐Rheumatoid arthritis

☐Tennis Elbow

☐Vertebral Compression Fracture

Neuropsychological

☐Alcohol Abuse

☐Alzheimer Disease

☐Bipolar Disorder

☐Depression

☐Epilepsy

☐Prescription Drug Abuse

☐Multiple Sclerosis

☐Paralysis

☐Peripheral Neuropathy

☐Schizophrenia

☐Seizures

☐Reflux Sympathetic Dystrophy /CRPS

☐Other Diagnosed Conditions:

____

Respiratory

☐Asthma

☐Bronchitis

Genitourinary/ Nephrology

☐Bladder Infection(s)

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

☐Gallbladder removal ____________________

☐Appendectomy ____________________

☐Other ____________________

Joint Surgery

☐Shoulder ____________________

☐Hip ____________________

☐Knee ____________________

Female Surgeries

☐Caesarean Section ____________________

☐Hysterectomy ____________________

☐Laparoscopy ____________________

☐Ovarian ____________________

☐ Other ____________________

Spine / Back Surgeries

☐Discectomy (Levels) ____________________

☐Laminectomy ____________________

☐Spinal fusion(Levels) ____________________

Heart Surgery

☐ Valve replacement ____________________

☐Aneurysm repair ____________________

☐Stent placement ____________________

☐Other ____________________

☐Vascular surgery ____________________

Other Common Surgeries

☐Hemorrhoid surgery ____________________

☐Hernia repair ____________________

☐Thyroidectomy ____________________

☐Tonsillectomy ____________________

Please list any other surgeries and dates (attach an additional sheet if necessary).

☐I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints :

☐MRI of the ________________ Date: __________ Facility: ____________________

☐Xray of the ________________ Date: __________ Facility: ____________________

☐CT scan of the ________________ Date: __________ Facility: ____________________

☐EMG/NCV study of the ________________ Date: __________ Facility:____________________

☐Other diagnostic testing : ____________________

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Family History

Mark all appropriate diagnoses as they pertain to your biological MOTHER and FATHER only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems: ____

☐I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ☐I AM ADOPTED (No medical history available)

Social History

Are you capable of becoming pregnant? ☐ YES ☐NO If so, are you currently pregnant? ☐YES ☐NO

Highest level of education obtained: ☐Grammar School ☐High School ☐College ☐Post-graduate

Alcohol use: ☐Daily Limited Use ☐History of Alcoholism ☐Current Alcoholism

☐Never Drink Alcohol ☐Drinks Alcohol Socially

Tobacco Use: ☐Current Tobacco User Packs per day ____ How many years smoker_____

☐Former Tobacco User ☐Has Never Used Tobacco

Illegal Drug Use: ☐Denise Any Illegal Drug Use ☐Currently Using Illegal Drugs (which: ____________________)

☐Currently Uses Marijuana ☐Currently Using Someone Else's Prescription Medications.

☐Formerly Used Illegal Drugs (not currently using) (Which: ____________________________)

Have you ever abused narcotic or prescription medications? ☐YES ☐NO (Which:__________________________)

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

☐ Chiropractic ☐ Physical Therapy ☐ Spine Surgery ☐Psychological Therapy ☐Podiatrist Treatment

☐ Discogram – (Circle all levels that apply) Cervical / Thoracic / Lumbar

☐Epidural Steroid Injection – (Circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Joint Injection – Joint(s)____

☐ Medical Branch Blocks or facet injections – (circle all levels hat apply) Cervical / Thoracic / Lumbar

☐Nerve Blocks- area/nerve(s)____

☐Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar

☐ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant

☐Trigger point Injection- Where? ____

☐ Vertebroplasty / Kyphoplasty – Level(s)____

☐ Other: ____

☐ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ☐ Yes ☐No

If so, have you ever had any adverse reaction to anesthesia? ☐ Yes ☐No

Which type of anesthesia did you react adversely to? Please check all that apply.

☐ Local Anesthesia ☐Epidural ☐General anesthesia ☐IV sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

☐ Local Anesthesia ☐Epidural ☐General anesthesia ☐IV sedation

Medical History and Consent for Treatment:

I certify that the above information is accurate, complete and true.

I Authorize Yancey Pain & Spine and any associates, assistants and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result of cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Yancey Pain & Spine to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Yancey Pain & Spine's Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed and how I may access my health records.

I authorize Yancey Pain & Spine to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Yancey Pain & Spine to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Yancey Pain & Spine will not release my Protected Health information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can b e revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan., Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may b e an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fall to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed: ______________________________ Date: ____________________

Sleep Apnea Survey

Patient: ______________________________ Date: _______________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.
Use the following scare to choose the most appropriate number for each situation.

0= Would never doze 1=Slight chance of dozing 2=Moderate chance of dozing 3= High chance of dozing

Situation Chance of dozing
Sitting and reading.. [ ]
Watching TV.. [ ]
Sitting, inactive in a public place (e.g. a theatre or a meeting)............... [ ]
As a passenger in a car for an hour without break.................................. [ ]
Lying down to rest in the afternoon when circumstances permit.......... [ ]
Sitting and talking to someone... [ ]
Sitting quietly after a lunch without alcohol.. [ ]
In a car, while stopped for a few minutes in the traffic........................... [ ]
Total... [ ]
Score1:<10 Normal range,>10 Test for OSA

STOP BANG Questionnaire

STOP

S(snore) Have you been told that you snore? Yes / No

T(tired) Are y9u often tired during the day? Yes / No

O(obtstruction) Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep? Yes /No

p(pressure) Do you have high blood pressure or on medication to control high blood pressure? Yes / No

BANG

B(BMI) Is your body mass index greater than 28? Yes / No

A(age) Are you 50 years old or older? Yes / No

N(neck) Are you a male with neck circumference greater that 17 inches, or a female with a neck circumference greater than 16 inches? Yes / No

G(gender) Are you a male? Yes / No

Score: Answered yes to three or more items, Test for OSA.

Procedure Cancelation Policy

Scheduling a procedure requires a coordinated effort of multiple people beginning with your doctor and including his nurse and administrative staff. Evaluation at the surgery center or hospital is also time consuming and expensive. Authorization by your insurance carrier must be obtained and appropriate medical supplies/ equipment for your procedure must be ordered and made available.

Cancellations can result in unused operative time. Potentially productive time by physician goes unused. Other patients who could have benefited from that time cannot do so unless the time is available.

Our office requires a 72 hour (3 Business Days) minimum notification for cancellation. This allows the physician and staff time to fill the slot with another patient.

<u>Failure to notify us of cancellation in the required time will result in a $150 charge. This will be posted to your account. No show fee must be paid prior to rescheduling a procedure.</u>

I have read the above policy and understand that the cancellation of my surgery may result in a $150.00 fee.

Patient Name ______________________________ DOB ______________

Patient Signature ___________________________ Date: ______________

DISCLOSURE TO PATIENTS

Texas law requires that, at the time of initial contact and at the time of referral, Texas physicians disclose to patients (i) any affiliation the physician has with a person or health care facility for who the patient is secured or solicitated, and (ii) that the physician may receive, directly or indirectly, remuneration of securing or soliciting the patients. This disclosure is intended to help you make a fully informed decision about your health care. William Yancey MD has a direct or indirect financial interest in one or more of the entities listed below and may receive remuneration from such entities:

Memorial Hermann Surgery Center Pinecroft
Stoneridge Surgical Center
Memorial Hermann Surgery Center Mainstreet
Surgery Center of the Woodlands

Although your physician may recommend the services of an entity listed above, you may choose to obtain services from an alternative provider or facility; you will not be treated differently by your physician or our staff if you choose an alternative provider or facility. Please let our staff know if you have any questions.

I acknowledge having received and read the above disclosure. I am aware that this disclosure is subject to change. I may request a copy of any revisions in the future by contacting a staff member of Yancey Pain & Spine.

Patient Name ______________________________ Date ______________

Patient Signature ______________________________