

# Advanced Pain Management Center Cedar Hills Surgery Center

10305 SW Park Way  
Tel: 503-295-0730 ~ Fax: 503-295-0731

Thank you for your interest in establishing care with Advanced Pain Management Center and/or Cedar Hills Surgery Center. For your convenience we have attached a new patient packet for you to complete. Once we receive your completed packet we can move forward with scheduling your appointment. You may fax it to the above fax number or email it to [info@apmconline.org](mailto:info@apmconline.org).

Sincerely,

Our New Patient Coordinators

**PATIENT REGISTRATION FORM**

**Personal**

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Name \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Date of birth \_\_\_\_\_ Email address \_\_\_\_\_

I consent to be contacted by email     I prefer to be contacted by phone

Preferred phone number \_\_\_\_\_

Emergency contact name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

**Employer:** \_\_\_\_\_

Employer's phone number: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Race:**     American Indian/Alaskan Native     Asian/Pacific Islander

Black     White

**Ethnicity:**     Hispanic     Non-Hispanic

I refuse to report any information regarding my ethnicity or race

**Primary language:**     English     Spanish     Other \_\_\_\_\_

Primary care provider \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

How did you hear about us?

Physician     Friend/relative     Internet search

Insurance carrier     Workers comp carrier     Attorney

Is there someone special you would like us to thank? \_\_\_\_\_

**Insurance Information**

Primary personal insurance\_\_\_\_\_

ID #\_\_\_\_\_ Policy holder's name\_\_\_\_\_

Policy holder's employer\_\_\_\_\_

Telephone #\_\_\_\_\_

Secondary personal insurance\_\_\_\_\_

ID #\_\_\_\_\_ Policy holder's name\_\_\_\_\_

Policy holder's employer\_\_\_\_\_

Telephone #\_\_\_\_\_

**Workers compensation information**

I do not have an open workers compensation claim

I do have an open workers compensation claim

Accepted condition(s)\_\_\_\_\_

W/C Claim #\_\_\_\_\_ W/C Carrier\_\_\_\_\_

Adjuster's name\_\_\_\_\_ Phone\_\_\_\_\_

**MVA information**

I do not have an open MVA claim

I do have an open MVA claim

Accepted condition(s)\_\_\_\_\_

Claim #\_\_\_\_\_ Carrier\_\_\_\_\_

Adjuster's name\_\_\_\_\_ Phone\_\_\_\_\_

**Attorney information:** If you have an attorney involved in your case please provide that information below.

Name: \_\_\_\_\_ Phone \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I authorize Advanced Pain Management Center and/or Cedar Hills Surgery Center to furnish my insurance company all information requested concerning my present illness or injury. I assign Advanced Pain Management Center and/or Cedar Hills Surgery Center all benefits for services rendered.

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any services rendered by practitioners of Advanced Pain Management Center and/or Cedar Hills Surgery Center.

The assignment will remain in effect until revoked by me in writing. An electronic version of this assignment is to be considered as valid as the original.

Print insured/authorized person's name\_\_\_\_\_

Signature\_\_\_\_\_Date\_\_\_\_\_

## FINANCIAL POLICY

Patient name (please print) \_\_\_\_\_ Date \_\_\_\_\_

**Payment for services:** Per our financial policy, payment is due at the time of service. This includes payment in full for patients who are self-pay and payment in full of all appropriate co-pays for patients with insurance.

We are not contracted with any Medicaid plan.

\_\_\_\_\_ **(initial) I HAVE active Medicaid (OMAP, DMAP, OHP, Care Oregon etc.)**

\_\_\_\_\_ **(initial) I do not have an active Medicaid (OMAP, DMAP, OHP, Care Oregon etc.)**

\_\_\_\_\_ **(initial) Billing your insurance:** As a courtesy, we will bill your insurance for services. If you have a commercial insurance policy that does not reimburse us for services, financial responsibility may default to you.

\_\_\_\_\_ **(initial) Insurance co-pays, co-insurance and deductibles:** Should your insurance assign you a copay, co-insurance payment or deductible, we cannot waive this for you. We must collect this from you at each visit as appropriate. Physicians are penalized if they do not hold patients accountable for patient responsibility. As such, if you do not present with appropriate payments, your visit will be rescheduled.

\_\_\_\_\_ **(initial) Self-pay status:** Payment is due at the time service is rendered. If you present and are not able to pay without making prior arrangements, your visit will be rescheduled.

\_\_\_\_\_ **(initial) ANESTHESIA FEES:** Your anesthesia will be provided by Onsite Anesthesia and you will be billed separately through that company. Questions regarding your anesthesia bill should be directed to (503) 372-2794.

\_\_\_\_\_ **(initial) NEUROPHYSIOLOGICAL MONITORING FEES:** If your physician believes that this type of monitoring is in your best interest during your procedure, services will be provided by a certified technologist from Willamette Neuromonitoring. You will be billed separately for these services through that company. Questions regarding your monitoring fees should be directed to at 469-619-0529.

\_\_\_\_\_ **(initial) RETURNED CHECK CHARGE**  
You will be charged a \$35 returned check fee when you write a check that does not clear your bank. We do not redeposit returned checks regardless of the reason. If a check from you is returned for any reason, you will be required to pay for all future services with cash, money order or credit card.

**\_\_\_\_\_ (initial) No show fees**

Should it be necessary for you to cancel your appointment, we require 24 hour notice to help us facilitate continuity of care in our clinic. No show fees cannot be billed to your insurance. If your condition is covered under a workers' compensation claim, this does not apply. Failure to call to cancel an appointment will result in the following fees:

1. \$50 for follow up appointments
2. \$150 for procedure appointments

**\_\_\_\_\_ (initial) Check acceptance policy: CHECK ACCEPTANCE POLICY**

The Front Desk is not authorized to accept checks:

1. Over the amount of \$300 however payments mailed to our office can be paid with a check even if the amount is over \$300.
2. Checks written by a third party (i.e., friend, relative, etc.)
3. Checks that are not imprinted with the name, address of the account holder.

**\_\_\_\_\_ (initial)** We can hold a payment for 72 hours and not beyond this time frame.

Signature of Patient or Responsible Party \_\_\_\_\_

**HEALTH HISTORY**

Pharmacy name \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_

**Medication Allergies**

Medication

Reaction


**Non-medication Allergies (other) Please mark all boxes that apply**

Seafood    Iodine    Latex    Tape    Contrast agents

**Current Medications – pain medications, blood thinners (ibuprofen, Motrin, aspirin), diabetic medications, diuretics, heart medications, blood pressure medications**

Name	Strength	How Taken Daily, twice a day	Prescriber

**PAST HEALTH HISTORY**

If you have ever been diagnosed with one of the problems listed below, please check the box.

Never diagnosed with a significant problem

**Cancer**    Negative

Type: \_\_\_\_\_



**Ears**  Negative

- Hearing loss  Meniere's disease

**Nose and sinuses**  Negative

- Recurrent sinusitis  Chronic sinusitis  Nose bleeds

**Mouth/throat**  Negative

- Sleep apnea  TMJ disease

**Heart/blood vessels**  Negative

- Aneurysm  Angina  Atrial fibrillation  Atrial flutter  
 Blocked carotid artery  Cardiomyopathy  CVA (stroke)  
 Congenital heart disease  Congestive heart failure  Coronary artery disease (CAD)  
 Deep vein thrombosis (DVT)  Heart attack  Heart disease  Heart block  
 Heart valve defect  High blood pressure  Irregular heart beat requires TX  
 Mitral valve prolapse  Pericarditis  Peripheral vascular disease  
 Pulmonary hypertension  Raynaud's disease  Rheumatic fever  
 Thrombophlebitis  Transient ischemic attack (TIA)

**Lungs/respiratory**  Negative

- ARDS (adult respiratory distress syndrome)  Asthma  Bronchiectasis  
 Chronic interstitial fibrosis  COPD/emphysema  Cystic fibrosis  GERD  
 Phrenic nerve paralysis  Pneumothorax  Pulmonary embolus  Sarcoidosis  
 Silicosis  Tuberculosis

**Stomach/Digestive**  Negative

- Achalasia  Barrett's esophagus  Cirrhosis  Crohn's disease  
 Diverticulitis/diverticulosis  Diverticulum (Meckel's)  
 Duodenal ulcer  GERD  H. pylori  Hepatitis B  Hepatitis A  
 Hepatitis C  Irritable bowel syndrome  Pancreatitis  
 Portal hypertension  Pyloric stenosis  Ulcerative colitis

**Genitourinary** Is it possible you may be pregnant?  Yes  No

**Kidneys/urinary tract**  Negative

- Glomerulonephritis  Incontinence (type undetermined)  Renal failure  
 Renal insufficiency

**Bones, joints, and muscles**  Negative

- Ankylosing spondylitis  Arthritis (osteo)  
 Arthritis (rheumatoid)  Congenital dislocated hip  Degenerative bone disease  
 Disc disorder in back  Disc disorder in neck  Fibromyalgia  Gout  
 Muscular dystrophy  Myasthenia gravis  Osteopenia  Osteoporosis  
 Recurring bursitis  Spinal stenosis

**Skin**  Negative

- Dermatitis unspecified  Eczema  Exfoliative dermatitis  MRSA  
 Extensive/severe burn  Fungal infection  Herpes simplex dermatitis

- Lyme disease       Lupus (involving the skin only)       Neurofibromatosis  
 Porphyria       Psoriasis       Scleroderma       Shingles

**Brain and nervous system**       Negative

- Alzheimer's disease       Amyotrophic lateral sclerosis  
 Aneurysm of blood vessel in the brain       AV malformation       Carpal tunnel syndrome  
 Complex regional pain syndrome       Dementia       Encephalopathy  
 Entrapped nerve       Epilepsy       Guillain-Barre syndrome  
 Hydrocephalus       Mononeuropathy       Multiple sclerosis  
 Neuralgia       Neuritis       Paralysis  
 Parkinson's disease       Polyneuropathy       Progressive neurologic disorder  
 Restless leg syndrome       Radiculitis       Ruptured cervical disc  
 Ruptured lumbar disc       Sleep disorder       Spinal cord infarction  
 Stroke       Subarachnoid hemorrhage  
 Transient ischemic attack (TIA)       Tumor of the brain, unspecified  
 Tumor of the spinal cord, unspecified       Tumor of the brain, benign  
 Vertebral basilar occlusion

**Mental and emotional health**       Negative

- Alcohol or drug treatment       Alcoholism       Bipolar disorder  
 Depression       Drug dependency       General psychiatric illness  
 IV drug abuse       Posttraumatic stress syndrome  
 Schizophrenia

**Endocrine, hormones, and metabolic problems**       Negative

- Diabetes, type uncertain       Diabetes, Type I       Diabetes, Type II  
 Glycogen storage syndrome       Graves' disease       Hyperthyroidism, high  
 Thyroid dysfunction

**Blood and lymph node problems**       Negative

- Anemia, type not stated elsewhere       Clotting disorder       Hemophilia  
 Sickle cell disease       Von Willebrand's disease

**Immune/Autoimmune and infectious problems**       Negative

- Anaphylaxis       AIDS       Autoimmune disorder       HIV positive  
 Lupus, systemic       MRSA

**Surgeries and hospitalizations**

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**Mouth**       Negative

- Jaw surgery

**Neck**       Negative

- Neck surgery, type unspecified \_\_\_\_\_

**Heart and blood vessels**       Negative

- Angioplasty of heart arteries       Bypass of heart arteries (coronary artery)  
 Carotid endarterectomy       Heart implantable defibrillator       Heart pacemaker  
 Heart transplant       Repair aortic aneurysm, abdominal

Repair aortic aneurysm, thoracic

Surgery not listed above \_\_\_\_\_

**Thoracic (lungs)**  Negative

Thoracic surgery, type unspecified \_\_\_\_\_

Lung surgery, type unspecified \_\_\_\_\_

Pneumonectomy (removal of lung)  Resection of lung tumor

**Abdominal and gastrointestinal**  Negative

Liver surgery, unspecified  Liver transplant  Pancreas surgery, unspecified

Pancreas resection, partial  Pancreas resection, total

Pancreas resection, radical  Spleen surgery, unspecified

Spleen resection, splenectomy

**Small intestine, colon, and rectal**  Negative

Colectomy  Colon resection  Colostomy  Gastrectomy, unspecified

Bariatric (weight loss) surgery  Bariatric surgery, gastric banding

**Bones, joints and muscles**  Negative

Bone, joint or muscle surgery \_\_\_\_\_

Bone surgery, amputation  Bone surgery, fracture reductions

Joint surgery, arthroscopic procedures  Joint surgery, open

Spine surgery (disc removal, laminectomy, kyphoplasty, vertebroplasty) / Please list below

**Brain, spinal cord and nervous system**  Negative

Brain surgery, unspecified  Nerve surgery, unspecified

Spinal cord surgery, unspecified  Carpal tunnel release  Craniotomy, unspecified

**Interventional pain management**

Negative

Celiac plexus block  Epidural steroid injection  Facet injection

Ganglion impar injections  Hypogastric plexus block  Intrathecal pump

Medial branch block  Peripheral stimulator implant  Peripheral stimulator trial

SI joint injection  Spinal cord stimulator implant  Spinal cord stimulator trial

Splanchnic block  Sympathetic nerve block

Transforaminal epidural steroid injection  Trigeminal nerve block

**SOCIAL HISTORY**

Select if patient is retired

**Employment status**  Currently employed  Disabled and unable to work

Unemployed

**Marital status**     Single     Divorced     Married     Other

**Current use of tobacco products**     None  
 Yes, currently uses tobacco     Current every day smoker

**Current use of alcoholic beverages**     None  
 When did you last consume alcohol and how much \_\_\_\_\_

**Recreational drug use**     No  
 Yes    If yes, please list which drugs below

\_\_\_\_\_  
**Home living situation**     Lives with spouse     Lives with spouse and children  
 Lives with partner     Lives in assisted living residence     Lives in nursing home

### **REVIEW OF SYSTEMS**

This section tells us what you are currently being treated for and/or problems, signs or symptoms that you may currently be experiencing.

No problems now or in the recent past

**CONSTITUTIONAL SYMPTOMS (general health)**     **Negative**  
 Dizziness     Feeling bad all over (malaise)     Fever     Fever and chills  
 Generalized aching     Heals poorly

**EYES**     **Negative**  
 Dry eyes     Spots or specks     Wears corrective glasses or contacts

**EARS, NOSE, MOUTH AND THROAT**     **Negative**  
**Ears:**

Dizziness     Hearing loss     Ringing in ears

**Nose and sinuses:**     **Negative**  
 Facial pressure sensation     Nasal congestion     Nasal obstruction  
 Mouth breathing

**Mouth and throat:**     **Negative**  
 Dry mouth     Hoarseness     Popping sound in the jaw when chewing  
 Snoring     Partials, dentures or loose teeth

**Cardiovascular**     **Negative**  
 Blacking out or fainting     Bluish discoloration of lips and/or fingernails  
 Chest pain at rest     Chest pain with exercise     Cold hands or feet  
 Enlarged veins in legs     Heart murmur     Irregular heart beat

- Leg cramps when walking
- Lightheadedness or near fainting on standing up
- Palpitations
- Shortness of breath when lying down
- Shortness of breath when sitting or standing
- Suddenly waking up short of breath at night
- Swelling including ankles or legs

**Respiratory**

**Negative**

- Coughing up blood
- Pain or tightness in chest
- Shortness of breath or difficulty breathing
- Sleep disturbance due to breathing
- Snoring (excessive)
- Wheezing

**Gastrointestinal (upper and lower digestive system)**

**Negative**

- Abdominal pain
- Abdominal swelling
- Abdominal tenderness
- Black stools
- Bleeding (rectal)
- Blood in stools
- Blood in vomitus
- Constipation
- Constipation and diarrhea
- Diarrhea
- Gas (excessive)
- Heartburn/indigestion
- Nausea
- Rectal pain
- Difficulty swallowing (general)
- Vomiting

**Musculoskeletal (bones, joints, and muscles)**

**Negative**

- Cramping
- Decrease in size of muscles
- Limitation of joint including back
- Loss of muscle strength
- Muscle pain
- Muscle tenderness
- Pain in back
- Pain in neck
- Painful joints
- Pain when using muscles
- Redness of skin over joints
- Stiffness in joints
- Stiffness in neck
- Swelling of joints
- Weakness

**Integumentary (skin, breasts, hair, nails)**

**Negative**

- Bruises easily
- Hair changes
- Nail changes
- Poor wound healing
- Skin lesions (suspicious)
- Skin rash

**Neurological (brain and nervous system)**

**Negative**

- Change in alertness
- Difficulty remembering
- Difficulty speaking
- Difficulty thinking
- Difficulty walking
- Difficulty with balance
- Difficulty with coordination
- Drooping on one side of the face
- Excessive daytime sleepiness
- Falling down
- Headache
- Loss of bladder control
- Loss of bowel control
- Loss of consciousness
- Numbness
- Pain, facial, severe
- Seizures ( ) with abnormal body movements ( ) without abnormal body movements
- Spinning sensation
- Tingling / pins and needles sensation
- Tremor
- Paralysis
- Weakness

**Endocrine (glands, hormones, blood sugar control)**

**Negative**

- Lightheadedness or near fainting on standing up

**Hematologic/lymphatic (blood and lymph nodes)**

**Negative**

- Bleeding into a joint
- Bleeds excessively after injury or minor surgery
- Bruises easily
- Uses aspirin

**Allergic, infectious, immunologic**

Hives

Infections (recurring)

Low blood pressure

**Negative**

Mouth breathing