74 Regency Parkway, Mansfield, TX 76063 • Phone: (817) 419-6111 • Fax: (817) 419-9582

NEW PATIENT PACKET - WELCOME TO REGENCY

Who are you here to see today?

☐ Jason Butler, M.D.
☐ Mark Dirnberger, D.O. ☐ Other: _____

How did you hear about us? (please specify)

☐ Website/Advertisement ☐ Physician Referral: _____
☐ Friend / Family ☐ Other: _____

Patient Information

Name (First, Middle, Last) | Social Security # | Date of Birth | ☐ Male ☐ Female

Mailing Address | Apt # | City, State, Zip

Email Address | Primary Phone | ☐ Home ☐ Cell | Okay to call? Okay to text? ☐ Call ☐ Text

Occupation / Employer (or parent/guardian employer if patient is a minor) | Work Phone

Primary Care Provider (where you go for your routine medical care)

Preferred Language

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Partner

Contact Preference ☐ Home ☐ Mobile ☐ Email ☐ Portal ☐ Mail

Emergency Contact

Contact Name | Phone Number | Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last) | Social Security # | Date of Birth

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name | Policy Number/Member ID | Group Number

Policy Holder | Date of Birth | Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent

Claim# / Adjustor | Phone

Secondary Medical Insurance (if applicable)

SECONDARY Insurance Company Name | Policy Number/Member ID | Group Number

Policy Holder | Date of Birth | Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent

Claim# / Adjustor | Phone

Attorney | **Contact** | **Phone**

REGENCY
PAIN & THERAPY INSTITUTE

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FINANCIAL AGREEMENT

I hereby instruct and direct my health insurance company, personal injury protection insurance company, and/or my attorney to pay by check, made out and mailed to Regency Pain & Therapy Institute, for healthcare services allowed and otherwise payable to me, under my current insurance policy, as payment toward the total charges for the professional services rendered by this office.

I agree that I am financially responsible for all charges incurred at this office; including any insurance deductible, co-pays, or services not covered by my insurance company, workers compensation, and/or my attorney.

I hereby acknowledge and agree to the following:

- A $35.00 fee will be assessed for returned checks.
- If copies of your medical records are needed, the first copy will be free of charge. For any additional copies required, there is a $35 fee per copy.
- We require a 24-hour notification should you be unable to keep your scheduled appointment for any type of office visit or procedure. Failure to do so could result in a no-show fee of $35.
- As a courtesy, we will call, email or text to remind you of your appointment one day in advance. However, you are still responsible for the appointment, even if we are unable to contact you. We understand that unforeseen events can occur such as illness or emergencies, but kindly give us a call if you're unable to keep your appointment time.
- Payment is required prior to or at time of service.
- Failure to pay could result in cancellation of appointment until payment can be rendered.

Signature _____ Date _____

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Authorization of Release of Protected Health Information to Family Members

I authorize Regency Pain & Therapy Institute to release protected health information to my family member(s) listed below:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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MEDICAL HISTORY FORM

Name _____ DOB _____ Age _____ ☐ Male ☐ Female

Medications Currently Taking (Please include all prescription, over-the-counter, vitamins, and supplements)

NAME OF MEDICATION	DOSAGE OF MEDICATION

Allergies to any medications, x-ray dyes or other substance? ☐ Yes ☐ No
(If yes, please list name of medication and any type of reaction)

_____

_____

Surgeries/Hospitalizations

DATE	DETAILS

Severe Injuries

DATE	DETAILS

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PAST MEDICAL HISTORY

PATIENT HISTORY (No Past Conditions ☐)

(Please check any of the following disorders that you HAVE or HAVE HAD, and indicate the year it was first identified.)

AUTOIMMUNE:

☐ Yes	☐ No	Lupus
☐ Yes	☐ No	Sjogren's
☐ Yes	☐ No	Rheumatoid
☐ Yes	☐ No	Celiac

BLOOD DISORDER:

☐ Yes	☐ No	Blood Clots
☐ Yes	☐ No	Bleeding Disorders
☐ Yes	☐ No	Blood Transfusions
☐ Yes	☐ No	Sickle Cell Disease
☐ Yes	☐ No	Anemia

CANCER:

☐ Yes	☐ No	Skin
☐ Yes	☐ No	Blood
☐ Yes	☐ No	Thyroid
☐ Yes	☐ No	Bone
☐ Yes	☐ No	Lung
☐ Yes	☐ No	Prostrate
☐ Yes	☐ No	Breast
☐ Yes	☐ No	Ovarian
☐ Yes	☐ No	Kidney
☐ Yes	☐ No	Colon
☐ Yes	☐ No	Cervical
☐ Yes	☐ No	Uterine
☐ Yes	☐ No	Rectal

ENDOCRINE:

☐ Yes	☐ No	Hyperthyroid
☐ Yes	☐ No	Hypothyroid
☐ Yes	☐ No	Low Testosterone
☐ Yes	☐ No	Diabetes

GI:

☐ Yes	☐ No	Acid Reflux
☐ Yes	☐ No	IBS
☐ Yes	☐ No	Pancreatitis
☐ Yes	☐ No	Liver Disease
☐ Yes	☐ No	Ulcers
☐ Yes	☐ No	Constipation

HEART / CARDIAC:

☐ Yes	☐ No	Abnormal EKG
☐ Yes	☐ No	Heart Disease
☐ Yes	☐ No	Heart Attack
☐ Yes	☐ No	CHF
☐ Yes	☐ No	High Cholesterol
☐ Yes	☐ No	High Blood Pressure

INFECTIOUS:

☐ Yes	☐ No	Cellulitis
☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Lyme
☐ Yes	☐ No	HIV/AIDS
☐ Yes	☐ No	STD
☐ Yes	☐ No	Meningitis

PSYCHIATRIC:

☐ Yes	☐ No	Depression
☐ Yes	☐ No	Anxiety
☐ Yes	☐ No	Bipolar
☐ Yes	☐ No	Alcoholism
☐ Yes	☐ No	Panic Attacks
☐ Yes	☐ No	Insomnia
☐ Yes	☐ No	Drug Abuse
☐ Yes	☐ No	Suicide Attempt

LUNG / PULMONARY:

☐ Yes	☐ No	Allergies
☐ Yes	☐ No	Asthma
☐ Yes	☐ No	Emphysema
☐ Yes	☐ No	COPD
☐ Yes	☐ No	Home Oxygen

MUSCULOSKELETAL:

☐ Yes	☐ No	Gout
☐ Yes	☐ No	Arthritis
☐ Yes	☐ No	Muscle Disease
☐ Yes	☐ No	Osteoporosis

NEUROLOGIC:

☐ Yes	☐ No	Headaches
☐ Yes	☐ No	Seizures
☐ Yes	☐ No	Multiple Sclerosis
☐ Yes	☐ No	Migraines
☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Concussion

SKIN:

☐ Yes	☐ No	Eczema
☐ Yes	☐ No	Shingles
☐ Yes	☐ No	Psoriasis
☐ Yes	☐ No	Keloid
☐ Yes	☐ No	Herpes
☐ Yes	☐ No	Concussion

UROLOGICAL:

☐ Yes	☐ No	Infections
☐ Yes	☐ No	Kidney Stones
☐ Yes	☐ No	Dialysis
☐ Yes	☐ No	Kidney Disease

OTHER CONDITIONS NOT LISTED (Please provide us with any past disorders or diseases outside of those listed above)

_____

_____

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PAST MEDICAL HISTORY (CONTINUED)

Condition	Father	Mother	Sibling	Condition	Father	Mother	Sibling
Heart disease				Thyroid disease			
Hypertension				Arthritis			
High cholesterol				Osteoporosis			
Heart attack				Depression/Anxiety			
Diabetes				Suicide			
Bleeding/clotting disorder				Drug/alcohol addiction			
Anemia				Infectious disease			
Asthma				HIV/AIDS			
COPD				Skin Disease			
Colon/Bowel problems				Cancer			
Kidney disease				Other			

Social History

Do you smoke or use other tobacco products? ☐ Yes ☐ No If yes, how much?_____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much?_____
Do you use illegal or recreational drugs? ☐ Yes ☐ No If yes, how much? _____

Current Symptoms (Please describe any current body symptoms or pains with regard to the following areas)

Head / Face _____
Neck _____
Shoulders _____
Arms _____
Chest _____
Abdomen _____
Low back _____
Pelvis _____
Hips _____
Legs _____
Knees _____
Feet _____

Please provide any other details you would like to add: _____

_____

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PERSONAL INJURY INTAKE FORM

PLEASE DESCRIBE DETAILS OF THE ACCIDENT

NAME: _____ **DATE OF ACCIDENT:** _____

1. Position in car: ☐ Driver ☐ Passenger ☐ Front ☐ Middle ☐ Back Seat

2. Location: ☐ City Street ☐ Highway ☐ Interstate ☐ Other: _____

3. Were you wearing a seat belt at the time of the accident? ☐ Yes ☐ No

4. Make & Model of the vehicles involved:

Your Car: _____

Other Car: _____

5. Type of accident: ☐ Head-On ☐ Rear-End ☐ T-Boned ☐ Other: _____

Was your car: ☐ Stopped ☐ Moving

6. Please describe the damage to your car: _____

_____

7. Were airbags deployed? ☐ Yes ☐ No If yes: ☐ Front ☐ Side

8. Did you see it coming? ☐ Yes ☐ No

9. Did you brace for impact? ☐ Yes ☐ No

10. Was the vehicle... ☐ Drivable or ☐ Towed

11. Describe body position at moment of impact:

☐ Twisted Left or Right ☐ Faced Forward ☐ Asleep ☐ Laying Down

☐ Other: _____

12. Lose Consciousness? ☐ Yes ☐ No

13. Dazed or shaken up? ☐ Yes ☐ No

14. Police, Fire or Ambulance? ☐ Yes ☐ No

15. Did you go to the ER? ☐ Yes ☐ No

16. How did you get out?

☐ Had to be extracted ☐ With help ☐ On your own

17. Were you in a neck brace and on a backboard? ☐ Yes ☐ No

18. Please describe any pains or other symptoms you felt immediately after the accident: _____

_____

19. Did you go to the ER or Urgent Care on your own? ☐ Yes ☐ No

Date: _____ **Name:** _____ **Location:** _____

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PERSONAL INJURY INTAKE FORM (CONTINUED)

20. Did you have any: ☐ Labs ☐ X-Rays ☐ CT Scan ☐ MRI

21. Any Prescriptions? ☐ Yes ☐ No

22. What was your diagnosis? _____

23. Have you seen any other doctors for this accident? ☐ Yes ☐ No

Dates: _____ **Name:** _____ **Phone #:** _____

Dates: _____ **Name:** _____ **Phone #:** _____

Dates: _____ **Name:** _____ **Phone #:** _____

24. Did you have any more: ☐ Labs ☐ X-Rays ☐ CT Scan ☐ MRI

☐ Other: _____

25. Had Any Chiropractic or Physical Therapy? ☐ Yes ☐ No

Dates: _____ **Name:** _____ **Phone #:** _____

26. Have you had any pain injections? ☐ Yes ☐ No

Type: _____ **Doctor Who Performed:** _____

27. Please provide any other details about the accident not already listed above:

_____

WORK HISTORY

Occupation: _____ **Employer:** _____

Describe your normal job functions: _____

Are you able to perform your normal job duties? ☐ Yes ☐ No

Does your employer have light duty? ☐ Yes ☐ No

PAST HISTORY

Have you had any prior accidents? ☐ Yes ☐ No

Date: _____ **Brief Details:** _____

Date: _____ **Brief Details:** _____

Did you sustain injuries? ☐ Yes ☐ No

Were you treated? ☐ Yes ☐ No

Have you had any other prior injuries, pains, or symptoms similar to those sustained in this accident?

_____

Do you have a Primary Care Physician? ☐ Yes ☐ No

Name: _____ **Phone Number:** _____

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CURRENT SYMPTOMS & PAIN

Using the symbols below, mark the area on your body where you feel the described sensation.

ΔΔΔΔ	= = = =	OOOO	XXXX	///////	.....
Aching	Numbness	Pins & Needles	Burning	Stabbing	Other