Regional Pain Care Center

MEDICATION LIST

Patient Name: _____ Doctor you are seeing: _____

Have you had any imaging studies done since last office visit? Yes or No

Date of last injection: _____

Email: _____

DID YOU BRING YOUR MEDICATION BOTTLES WITH REMAINING PILLS?

List of Medications (include over the counter) Dosage Times per day

_____
_____
_____
_____
_____
_____
_____

On the average, how severe has your pain been during the last week?

0 1 2 3 4 5 6 7 8 9 10

Not severe at all Extremely severe

In general how much is your pain interfering with day-to-day activities?

0 1 2 3 4 5 6 7 8 9 10

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to RPCC, where services were provided. I permit a copy of this authorization to be used in place of the original. I understand *I am financially responsible* to the center for charges not covered or denied by my insurance company. I further agree in the event of non-payment, to pay the cost of collection and/or court costs and reasonable fees, should this be required.

Signature: _____ Date: _____

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