Bianco Brain and Spine, LLCP

Today's Date: _____

Name: _____

Date of Birth: _____

Name of Doctor who referred you today: _____

List of Physicians:

Primary Care Physician_____

Pain Management Physician_____

Neurologist_____

Cardiologist_____

Chief Complaints

Are You? □ Left Handed □ Right Handed

□ Headaches
□ Balance problems
□ Dizziness
□ Seizures
□ Visual Disturbances
□ Right facial pain
□ Left facial pain
□ Hearing Loss
□ Memory Loss
□ Nausea/Vomiting

□ Drop things (grip decrease)
□ Bowel or Bladder Incontinence
□ Difficulty Walking
□ Left arm pain
□ Left numbness and tingling
□ Left arm weakness
□ Right arm pain
□ Right numbness and tingling
□ Right arm weakness
□ Shoulder pain

□ Neck pain
□ mid back pain
□ Low back pain
□ Left leg pain
□ Right leg pain
□ Left leg numbness/tingling
□ Right leg numbness/tingling
□ Left leg weakness
□ Right leg weakness

Any other complaint(s) not listed above _____

History and Physical

Date of onset: _____

Pain Frequency: □ Constant □ Daily □ Weekly □ Monthly □ only with activity

Pain Level: **Choose one option** □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

Briefly describe how your injury/ illness started or how it occurred: _____
_____
_____

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Previous Conservative Treatment/Testing

Please list any treatments you received below and what type of relief it provided, no relief, slight relief, moderate relief, complete relief

Rest _____ Medication_____ Weight Loss_____

Epidural Steroid Inj. _____ Oral Steroids_____ Physical/Water Therapy _____

Brace _____ Chiropractor_____ Massage Therapy_____

Current Allergies and Medications

Are you allergic to any medications? (Please List):_____

Medication Name:	Dosage:	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History

□ Alcoholism	□ Anemia	□ Anesthetic Comp	□ Anxiety
□ Arthritis	□ Asthma	□ Autoimmune Problem	□ Birth Defects
□ Bleeding Disease	□ Blood Clots/DVT	□ Bowel Disease	□ Cancer
□ COPD	□ Depression	□ Diabetes	□ Gout
□ Heart Attack	□ Heart Disease	□ Hepatitis	□ High BP
□ High Cholesterol	□ HIV	□ Kidney/Bladder Disease	□ Liver Disease
□ Lung/Respiratory Disease	□ Mental Illness	□ Migraines	□ Osteoporosis
□Parkinson's	□ Reflux/GERD	□ Seizures	□STD
□ Stroke/TIA	□ Seasonal Allergies	□ Suicide Attempt	□ Thyroid Problems
□ Ulcers			

□ **Other Disease**_____ □ **Type of Cancer**_____

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Past Surgical History

Starting with the most recent, please list in date order any surgeries you have had:

Date: _____ Operation: _____ Date: _____ Operation: _____

Date: _____ Operation: _____Date: _____ Operation: _____

Family History-(Please list family member with the condition)

□ Alcoholism	□ Anemia	□ Arthritis
□ Asthma	□ Bleeding Disease	□ Depression
□ Diabetes	□ Heart Disease	□ Hypertension
□ High Cholesterol	□ Kidney/Bladder Disease	□ Lung/Respiratory Disease
□ Migraines	□ Osteoporosis	□ Seizures
□ Severe Allergies	□ Stroke	□ Thyroid Problems
□ **Other**_____	□ **Type of Cancer**_____	

Social History

Marital Status: □ Single □ Married □ Divorced □ Widowed

Do you live alone? □ Yes □ No If not, who do you live with? Spouse_____Children_____Other_____

Do you have children? □ Yes □ No If yes, how many? _____

Occupation: _____

Job Status: □ **Unemployed** □ **Employed** full-time □ **Employed** part-time □ **Retired** □ **Disabled**

Risk Factors

Do you smoke? □ Never □ Currently □ Previously Yr started _____ Yr. Quit _____

Cigarette pks/per day _____ Cigarette/ pipes per wk _____ Chewing/ per week _____

Do you drink alcohol? □ Yes □ No

If yes, type of alcohol consumed_____ how many drinks? _____ How often? _____

Are you at risk for HIV? □ Yes □ No

Do you use IV or elicit street drugs? □ Never □ currently □ previously Drug of choice? _____

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Review of Symptoms-(Please check all that apply, to the right of the word)

General Symptoms: Fever_____ Sweats____Fatigue____Chills____ Weight Loss_____

Eyes: Blurring_____Double Vision_____Discharge_____Vision Loss_____Eye Pain_____
Light Sensitivity_____ Halos_____

Ears/Nose/Throat: Earache_____ Ear Discharge____Ringing in the Ears_____ Nosebleeds_____
Nasal Congestion_____

Cardiovascular: Difficulty Breathing at Night_____Shortness of Breath with Exertion____Swelling of the Hands or feet___Lightheadedness with Exertion___Tachycardia/Fast heart rate___ Chest Pain/Discomfort ___Near Fainting/Fainting Spells___

Respiratory: Sleep Disturbances____Cough____Shortness of Breath____Coughing up blood____Wheezing___
Excessive snoring____

Genitourinary: Urinary Incontinence_____Urinary Urgency_____Urinary Frequency____Nighttime Urination____Blood in Urine_____Unusual urine color____Painful Urination____Foul Urine odor____Inability to empty bladder____ Trouble starting urinary stream____

Musculoskeletal: Back Pain___Joint Pain____Neck Pain____Muscle cramps____Muscle weakness____Muscle aches____ Arthritis____Gout____Loss of Strength____Stiffness____

Skin: Night sweats____Excessive Perspiration____ Rash____Itching/Dry Skin____Flushing____Suspicious Lesions____Skin Cancer_____Poor wound healing____

Neurologic: Headaches____Difficulty Concentrating____Inability to speak____Frequent Falls____Unbalanced coordination____Numbness____Tingling____Weakness____Seizures____Tremors____Memory Loss____Excessive daytime sleeping____Dizziness____

Psychiatric: Depression____Anxiety____Schizophrenia____Bipolar____Mental Problems____Thoughts of Suicide or Violence____Sense of great danger____Frightening thoughts or sounds____

Endocrine: Cold Intolerance____Heat Intolerance____Excessive Hunger____ Excessive Thirst____Excessive Urination____Weight Change____

Heme/Lymphatic: Abnormal Bruising____Bleeding_____Skin Discoloration____Fevers____Allergies (Please List)_____

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Cancellation Policy

Please note the following two policies:

Bianco Brain and Spine has now instituted a new policy that all cancellations made less than 24 hours of your appointment time will now accrue a $25 cancellation fee.

By signing below you acknowledge that you have been notified of this policy.

_____

Signature

_____

Printed Signature

_____

Date

*After three (3) Consecutive cancellations without advanced notice you may be discharged as a patient from Bianco Brain and Spine.

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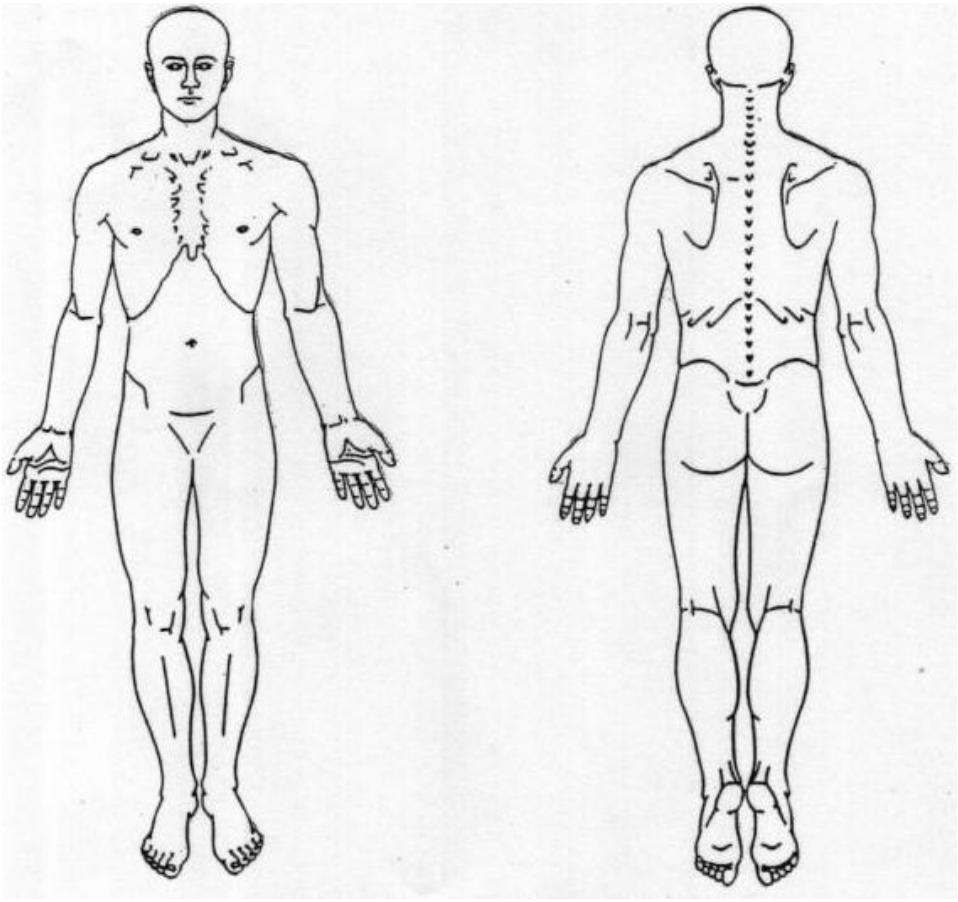
Pain Diagram

Instructions: Mark the location of Your symptoms using these symbols:

Sharp Pain	XXXXX	Numb/Tingling	++++++
Dull Pain	0000000	Other _____	



Pain Scale

Instructions: Indicate your level of pain by choosing the appropriate number on the scale below:

_____

0 1 2 3 4 5 6 7 8 9 10

No Pain | Moderate Pain | Very Severe Pain

Print Name_____ Date _____

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Office Policies

I hereby authorize my medical insurance companies to make payments directly to Bianco Brain and Spine.

Additionally, I understand **any charges not paid by my insurance companies are ultimately my responsibility.**

I understand that it is my responsibility to know what my co-pay is, my co-insurance is, as well what my deductible is.

If I have **no medical insurance**, I understand payment is **due in full at the time of visit.** If you do not have the co-pay amount you will not be seen by the physician and your appointment will be rescheduled.

If my **injury occurred at school**, I'm aware I need a claim form filled out by an appropriate school official.

If my **injury occurred because of a motor vehicle accident** or other personal injury I will be considered a self-pay patient. I understand Bianco Brain and Spine does not accept third party insurance or letters of protection from attorneys. We also do not accept Worker's Comp at any time.

I am aware I will be asked for any outstanding balances, co-pays, co-insurances, or deductibles at the time of my visit. If I do not have these payments, I may be asked to reschedule my appointment with the physician.

I understand I will be charged $30 for any returned checks.

I am aware if I need surgery I will be asked for a **pre-payment** prior to my procedure and will need to make arrangements for the rest of the balance.

I am aware that I am responsible for knowing which of my insurance primary, secondary, tertiary is and so on. I understand that Bianco Brain and Spine will not contact my insurance companies to request this information.

_____ _____

Printed Name Relationship to Patient

_____

Signature

_____

Date

Bianco Brain and Spine, LLCP

HIPAA POLICIES

- I'm aware it is the office policy to restrict protected patient health information.
- I may refer to the office's Notice of Privacy Practices for detailed information.
- I understand Bianco Brain and Spine may provide information to caregivers and physicians currently involved in my care and to my insurance company for payment of claims.
- I authorize the following additional individuals to have access to my protected patient health information. I understand that if they are written on this list Bianco Brain and Spine will release information to them if they request as such.
- It is my responsibility to remove anyone from this list if they are no longer to receive information about my health status.

Name (Print)	Date of Birth	List any Restrictions (specific)	Relation to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Restrictions might include: Sexually Transmitted Diseases, Pregnancy, and Terminal/Mental/Behavioral Illness

May we leave confidential clinical information on your answering machine? ☐ Yes ☐ No

I have read and understand the above policies of the practice and agree to be bound by their terms.

SIGNATURE: _____ DATE: _____

Patient/Legally Authorized Representative

_____ _____

Printed Name Relationship to Patient

Bianco Brain and Spine, LLCP

Please note the following change:

Effective on October 1, 2014, all FMLA paperwork will require a $25 charge **each time** it is completed or filled out. This also includes any paperwork filled out for short-term disability, long-term disability, and any forms filled out for personal reasons.

All FMLA paperwork, at this time, will only be completed once surgery is performed unless the physician deems it is necessary for you to be off of work beforehand.

Thank you,

Bianco Brain and Spine

Bianco Brain and Spine, LLCP

Prescription and Medication Policy

A reminder to our patients…

- Unless surgery is performed by Dr. Bianco and Dr. Patel no narcotic prescriptions will be given. Dr. Bianco and Dr. Patel do not prescribe Class II Medications.
- If you are a patient that has a surgical procedure by Dr. Bianco or Dr. Patel please read our policy regarding narcotics.
- Refill requests for medications prescribed by our office will be accepted **only from your selected pharmacy** during regular business hours. Business hours are Monday through Friday from 8:00am to 5:00pm. It is **your** responsibility to let us know if your pharmacy changes.
- If you need a refill on your medication**, please contact your selected pharmacy** for a refill request to be sent to our office. Please do not contact our office directly for refills as this will only delay the process.
- After discharge from the hospital please have the refills sent to our office instead of the discharging physician at the hospital. They will be unable to prescribe your medication.
- If your request is received after 3:30pm Monday through Thursday, or after 12:00pm on Friday, it will be processed the next business day. Please plan accordingly, **as no refills will be authorized on Saturday or Sunday.**
- **If you receive a prescription for pain medication from this office, you agree not to seek additional pain medications from any other physicians office unless you are referred by our office to that specific physician to take over management of you pain medications.**
- If you seek pain medications from other physicians while we are prescribing you narcotics you may be discharged as a patient from Bianco Brain and Spine. This policy is in place to provide you with the safest care possible.

Selected Pharmacy Information:

Pharmacy name: _____

Pharmacy address: _____

Pharmacy phone number: _____

I have read and understand the above policy.

Patients Printed Name: _____

Patients Signature: _____ Date_____

Bianco Brain and Spine, LLCP

Pain Contract

This is an agreement between _____(the patient) and the medical providers of Bianco Brain and Spine, LLC, concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition in the majority of people.

   I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.

3. Overdose on this medication may cause death by stopping my breathing. This can sometimes be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.

4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication. The most common one is constipation. Most need to adhere to a bowel regimen to prevent. Other side effects include, but are not limited to: depression, anxiety, sexual dysfunction, and difficulty urinating.

6. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.

7. I agree that the opioids will be prescribed by only <u>one</u> doctor and I agree to fill my prescriptions at only <u>one</u> pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.

8. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced without a police report.

9. I agree not to sell, lend, or in any way give my medication to any other person. Any of these scenarios is illegal and considered drug trafficking.

10. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my

permission for it to be tested for alcohol and drugs.

11. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor and to manage my overall health as it pertains to effective pain management.

12. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with a past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued, and I will be referred to a drug treatment program for help with this problem.

I have read the questions asked above and I understand the agreement. If I violate the agreement the doctor may discontinue this form of treatment.

Patient signature

Doctor signature