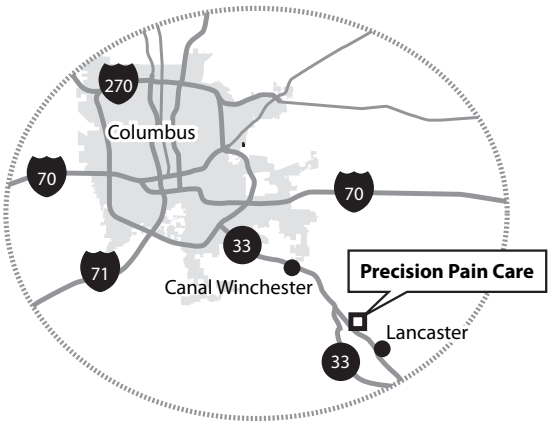
PRECISION PAIN CARE

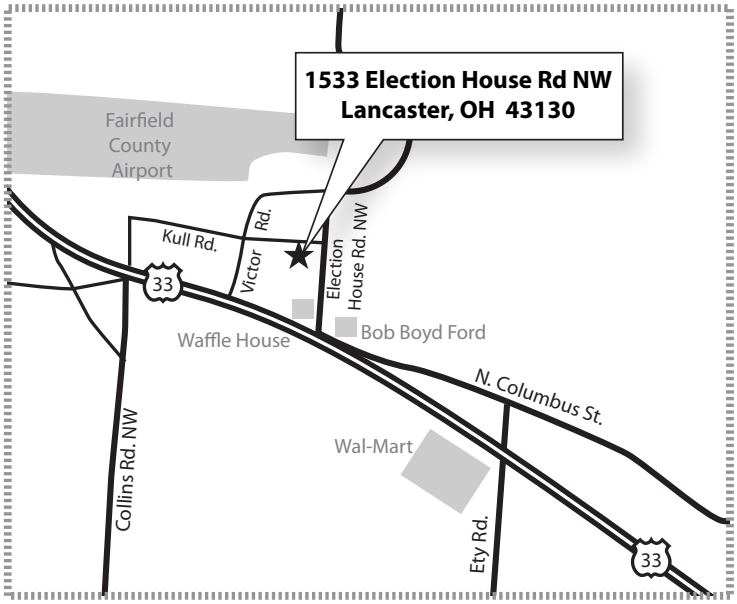
Tel: 740.689.9500

Ronald P. Linehan MD
Board certified in Pain Management and Anesthesiology

Initial Visit Package

- PLEASE FILL OUT ATTACHED PAPERWORK AND BRING TO APPOINTMENT
- HAVE A CURRENT INSURANCE CARD AND COPAY
- IF INJECTIONS ARE INDICATED, YOU WILL NEED A DRIVER





Your Appointment is at:

Phone: 740-689-9500

Date: _____

Time:_____

- Should you need to reschedule, a 24 hour notice is appreciated. You should expect a reminder call one day before your appointment
- Please fill out all patient information sheets prior to your appointment. If you are unable to do this, please show up 15 minutes before your appointment to complete them.

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Patient Information

Patient Information

Patient Name: _____ (Last / First / Middle Initial) Date of Birth:_____ Sex (Circle One) M F

Phone: (_____)_____ Cell Phone: _____SS#_____

Address:_____ City: _____ State _____ Zip_____

Employer: _____ Phone: (_____)_____

Occupation:_____ Work Status: ☐Full: ☐Part-time ☐Disabled ☐Retired ☐Unemployed

E-mail address _____

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

Name of Spouse: _____ Date of Birth:_____

Employer: _____

Is your visit due to a work related injury? Yes ☐ No ☐

Emergency Information

Name: _____ Relationship:_____

Home Phone: (_____)_____ Work Phone:(_____)_____

Workers Compensation Information

MCO: _____ Physician of Record: _____ Date of Injury: _____

Claim Number: _____

Employer at time of injury _____

Attorney Name:_____ Phone:(_____)_____

Please Note: We do NOT accept Motor Vehicle Insurance.

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Signature and Authorization

1. Consent to Medical Procedures:

The undersigned consents to the treatment that may be performed during the initial office visit or on a follow up visit to this office. Care may include emergency treatment or services that may include, but are not limited to laboratory procedures, medical or surgical treatment or procedures, local anesthesia. Surgical procedures rendered to the patient, other than emergency, will have a separate consent.

2. Authorization, Consent, and Waiver for Releases of Information:

Precision Pain Care physicians are hereby authorized to release any information necessary, including copies of my medical records, to collect benefits. Such records may include those with information of psychological or psychiatric nature, pertaining to my medical condition or treatment for such a condition, my condition or treatment relating to the use of alcohol, my condition or treatment relating to the use of drugs, and emergency treatment and services. I hereby release Precision Pain Care physicians from and waive all liability that may rise from the release of such information.

3. Assignment of Benefits:

In consideration of services received or to be received, I, the undersigned, hereby assign Precision Pain Care physicians participating in service the amount due me or that which becomes due to me up to an amount not exceeding the physician charges for the period of treatment and I hereby authorize and direct that payments be made directly to the said physician. I further recognize that if payment is made directly to me by said insurance company or HMO, the amount received up to the amount of the physician bill is the property of Precision Pain Care physicians and should be paid over to said physicians immediately.

4. Financial Agreement:

I hereby promise to pay Precision Pain Care physicians participating in my treatment and care, for any and all services rendered to the named patient. I hereby acknowledge financial responsibility of any and all services rendered which my insurance plan or HMO may exclude from payment, either because the plan deems such services not medically necessary, or for any other reason, including pre-certification requirements, second opinions, or pre-existing conditions. I shall hereby be responsible for payment in the event my insurance plan or HMO does not pay within the payment terms.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Signature:_____

Patient Name:_____

Date:_____

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Patient History Form

Please fill out both sides of form

*Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date:_____ / _____ /_____ / Date of Last Physical Exam: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Height: _____ Weight: _____ Age _____

Referring Physician: Name _____

Family Physician: Name _____

Chief Complaint

What is the main reason for your visit today? Give a brief description of your problem.

_____

_____

_____

_____

_____

Past Medical &Social History

Please List All Serious Illness In Your Past. (Example: Diabetes, Tuberculosis, Cancer, Heart Disease, Hepatitis, ect.,)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List Any Past Surgeries and Year Occured:

_____

_____

_____

Do You Smoke? ☐ Yes ☐ No How Much? _____

Do You Drink? ☐ Yes ☐ No How Much? _____

Any Drug Allergies? ☐ Yes ☐ No Please List _____

_____

Medications

List all current medication, dosages and doctor writing

_____

_____

_____

_____

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Patient Survey

Could you please fill out the following survey which will help us better serve you and all our new patients. Your input is important to us at Precision PainCare. We value your comments and any suggestions on how to improve our service is greatly appreciated.

How did you hear about Precision Pain Care: ☐ Referred by physician _____ (Name of physician) ☐ Yellow pages

☐ Direct mail ☐ Referred by family/friend ☐ Located on internet search ☐ Internet Yellow Pages

Other:_____

How would you rate our staff on making your appointment:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Comments:_____

_____

Did you have any trouble finding our office?

☐ Yes ☐ No

If yes, how could we have helped?:_____

_____

Did you look at our website and review our procedures before coming In for your appointment?

☐ Yes ☐ No If yes, was this helpful to you? ☐ Yes ☐ No

Your e-mail address_____

Are there any suggestions you might have about our service?_____

_____

_____