SPECIALTY PAIN MANAGEMENT CENTER

AJAY M. NARWANI M.D., PLLC

DIPLOMATE IN ANESTHESIA, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE IN PAIN MEDICINE, AMERICAN BOARD OF ANESTHESIOLOGY

Welcome New Patient

Thank you for your time in scheduling with us at Specialty Pain Management Center, the office of Dr. Ajay Narwani.

Please take the time to fill out the patient information and the pain assessment form included with this letter. *We make a concentrated effort to keep all of our patients waiting time to a minimum.* We look forward to seeing you at your appointment on:

Your appointment is scheduled for _____ at _____.

We ask that all new patients check in a half an hour early in order to complete the new patient paperwork. If you have already completed it, we ask that you check in 15 minutes prior to the appointment time and that you bring your paperwork with you.

At your appointment, please bring with you:

- Photo ID
- Insurance Card
- Medication List
- Any imaging paper reports (MRI, CT, X-Ray, etc.)
- Any other information that pertaining to your condition that you feel

These records are necessary in assessing your condition. It is important to fill out all forms in their entirety as it will allow us to more thoroughly address your concerns and allow more valuable examination time. *If all the forms are not filled out prior to your appointment time, it may be rescheduled.*

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NEW PATIENT PAPERWORK

Today's Date: _____

First Name: _____Last Name: _____

Date of Birth: _____ Soc. Sec. _____Gender: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____E-mail address: _____

Emergency contact: _____Emergency Phone: _____

Relationship: _____ Can we leave information with your emergency contact? Yes / No

Current work status (please circle): Retired / Disability / Student / Unemployed / Employed

Your Occupation: _____Employer: _____

Primary Care Physician: _____Phone: _____

Primary Insurance: _____Policy ID #: _____

Address: _____ Phone: _____

Subscriber Name: _____ Relationship to patient: _____

Subscriber SS #: _____ Subscriber DOB: _____

Secondary Insurance: _____Policy ID #: _____

Address: _____ Phone: _____

Subscriber Name: _____ Relationship to patient: _____

Subscriber SS #: _____ Subscriber DOB: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Worker's Compensation: Yes / No Insurance Carrier: _____

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FINANCIAL AGREEMENT & CANCELLATION POLICY

PLEASE READ THE FOLLOWING AGREEMENT. IT EXPLAINS YOUR FINANCIAL OBLIGATIONS WHILE UNDER OUR CARE AND OUR POLICIES REGARDING CANCELLATIONS.

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs the court may determine proper.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and also authorize the physician/facility to release any information required in the processing of the insurance claim. I authorize the physician/facility to release medical information to my referring physician, primary care physician, spouse, children, parents and any physician he/she may refer me to.

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT: I request that payment under the medical insurance program be made on my behalf to Specialty Pain Management Center for any services furnished me by its physician(s) and/or practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Name: _____ Signature: _____

Insurance Benefits
Arizona State Law (HB2600) requires that medical claims be paid by insurance carriers within 90 days. If your insurance carrier has not appropriately paid the submitted claim within 90 days, I understand that outstanding balances will become the responsibility of the policy holder.

Insurance Co-Payments
In accordance with my insurance contract, I understand that co-payments are due at time of service.

Deductible
If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at the time of service unless other payment arrangements have been made.

Co-insurance
I understand that co-insurance amounts may be collected at time of service, and at the time interventional procedures are scheduled.

Private Pay
If I have no insurance coverage, or insurance with which Specialty Pain Management does not participate, or Specialty Pain Management is unable to verify current insurance coverage, I understand full payment is expected at time of service. We do accept **SELF-PAY patients (i.e. Patients with *NO* insurance)**, Initial consultation is $400.00 that is due at the time of service. Follow up visits are $150.00 due at time of service, if a urinalysis is required it will be $200.00. If a procedure is scheduled- a fee schedule will be discussed with you prior to the appointment day. The amount discussed will be due at the time of service.

Notice to Medicare Patients:
If we are unable to verify from Medicare that there is automatic submission of claims to the secondary insurance carrier, you may be responsible for secondary insurance balances at the time of service and at the time interventional procedures are scheduled.

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Refund Policy
I understand that amounts collected from me (including co-payments, co-insurance and deductibles) are based on information received by Specialty Pain Management from my insurance carrier. Refunds are to be requested from your insurance company. Specialty Pain Management is not responsible for reimbursements.

Verification of Benefits and Non-Covered Services
Insurance policies are individualized per patient plan. Specialty Pain Management may provide services that my insurance plan excludes. I understand that it is my responsibility to verify coverage benefits and exclusions. I understand that all non-covered services are my responsibility.

Collections
I understand that once an account is placed in a collection status, all future services must be paid in full at time of service (no checks accepted). If my account is placed into collections, I will be responsible for all collection and interest costs.

Returned Checks
Returned checks will be subject to a $30.00 returned check fee.

NO SHOW, LATE CANCELLATIONS OR RESCHEDULING
Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations, scheduling changes, and "no-shows."

- We have a very busy practice. Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient the care they need. You must cancel or reschedule within 24 hours.
- New patient visits require our doctor to block out large time slots, making last minute cancellations and rescheduling of visits even more problematic. We provide a large amount of time and attention with each and every one of our new patients because we are committed to providing the highest quality care.

NEW PATIENT APPOINTMENTS:

- **IF YOU FAIL TO SHOW FOR YOUR APPOINTMENT, YOU WILL BE CHARGED $50.**

FOLLOW- UP VISITS:

- **IF YOU FAIL TO SHOW FOR YOUR APPOINTMENT WITHOUT NOTIFICATION YOU WILL BE CHARGED $35.**
- **IF YOU CONTINUE TO CANCEL, RESCHEDULE, OR FAIL TO SHOW FOR YOUR SCHEDULED APPOINTMENTS YOU WILL BE DISCHARGED FROM OUR PRACTICE**

PROCEDURE APPOINTMENTS:

- **IF YOU FAIL TO NO SHOW FOR YOUR PROCEDURE APPOINTMENT YOU WILL BE CHARGED $300.00,**

ADDITIONALLY, I ACKNOWLEDGE THAT IF I HAVE 2 OR MORE "NO SHOW" OR "LATE CANCELLATIONS" FOR ANY SERVICE, I MAY BE REFERRED FOR TREATMENT TO ANOTHER CLINIC.

Medical Records
We are happy to provide you with copies of your medical records upon request. However, because of time restrictions, please allow up to 30 business days to fulfill this request. Please note there is a charge for personal use, however, medical records sent to another medical provider will be done free of charge.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES. By signing this, you are indicating that you understand and agree to the terms of service explained above.

Name: _____ DOB: _____

Signature: _____ Date _____

3008 N. DOBSON RD., SUITE 2., CHANDLER, AZ 85224
PHONE: 1-480-496-2699 FAX:1-877-422-3184

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OFFICE POLICIES AND PROCEDURES

1. A cordial and cooperative tone will facilitate communication with our staff and providers. Specialty Pain Management has a very strict **ZERO** tolerance for abusive and aggressive behavior toward its staff; we do not permit patients to swear at our staff, nor be rude, aggressive, belligerent or disruptive. Thank you for remaining calm and friendly.

2). All patients with pain perceive their symptoms to be special and urgent. We acknowledge that you may be experiencing physical and emotional distress. However, all of the patients referred to this clinic feel this same urgency to obtain treatment. Extra-special consideration cannot routinely be granted in scheduling your visits and treatments due to time, space, and staff limitations. Please know that we will do everything possible to serve you in a timely and effective manner within our limitations. Occasionally, a medical emergency arises which may delay the day's schedule – we appreciate your patience in these situations.

3). Chronic pain is **NOT** considered to be a medical emergency. Therefore, emergency access to our clinic is rarely indicated. You may be referred back to your primary care physician or to an emergency facility if we cannot accommodate your urgent needs. Please do not wait until the last minute to seek care for an escalating problem.

4). Arriving late for your appointment is very disruptive and makes it nearly impossible to maintain our commitment to serve you in a timely manner. Therefore, our office has a 15-minute late policy. If you arrive 15 minutes after your scheduled appointment, we will usually not be able to see you that day. We will reschedule your appointment for the next available time. Arriving late on a routine basis for your scheduled appointments may be reason for dismissal from our clinic. THERE ARE NO EXCEPTIONS. Please keep in mind this rule does not apply for the last appointment before lunch, nor the last appointment of the day, there is NO leeway for these appointments. Out of courtesy, if you are running late please call the office to confirm we are still able to see you.

5). Missed appointments will be rescheduled at the next available time (possibly as long as 3-4 weeks). We will not refill medications in the interim so try not to miss your scheduled appointment. Missing several appointments may be reason for dismissal from our clinic.

6). When you call our clinic, you may be routed to a voice mailbox. Please leave your message. We listen to our messages daily and will return your call within 24 business hours. Multiple phone calls on the same day for the same problem are very disruptive and may cause delay in a call back. If you do this, you will be given a warning to desist. If this behavior continues, you will be dismissed from our clinic.

7). If narcotics or other potent medications to treat your pain are prescribed, you will be asked to enter into a formal narcotic agreement that outlines rules, risks, and conditions of continued access to these medications. **Please remember, it is up to the physician's discretion if opiate medications are prescribed on the first visit.**

8). Pain medication prescriptions are written for a 30-day supply. Medications are refilled once a month during a scheduled office visit. As a rule, we do not call or fax narcotic prescription refills to the pharmacy. Lost or stolen medication will **NOT** be replaced with a new prescription. Pain medication should be taken as directed as we do **NOT** provide early refills. Six months of pharmacy records may be required before a narcotic prescription can be issued. Non-urgent calls regarding medication may be returned within 72 hours. Medication changes are addressed during scheduled office visits. Before leaving the office, it is recommended that patients schedule their next appointment to avoid any last-minute requests for an appointment which we may not be able to accommodate.

9). Obtaining pain medications elsewhere without our specific written or verbal approval may be considered a sign of possible narcotic addiction and may be reason for dismissal from our clinic.

10). It is your responsibility as the patient to inquire if you are due for a urine drug screen (UDS). Please ask the front desk upon arrival if you are due for one before using the restroom. If a UDS is required, you may **NOT** leave the lobby/office once you have checked in. If you do leave the office your urine is considered a fail and you may not receive your prescription and you will be discharged from the practice. Furthermore, if we find reason you may be given a specific time limit to complete your UDS.

Following these guidelines is important for continued success in managing your pain. If our clinic guidelines are unacceptable to you, you may choose to seek care from another source more suited to your desires. Thank, you for your understanding. We consider it a privilege to serve you. We look forward to a happy and productive working relationship.

Patient Name: _____ DOB: _____

Signature: _____ DATE: _____

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AGREEMENT FOR CHRONIC PAIN MEDICATION ADMINISTRATION

PLEASE READ AND **INITIAL** ALL SECTIONS BELOW:

_____I UNDERSTAND THE PURPOSE OF THIS AGREEMENT IS TO PREVENT MISUNDERSTANDINGS ABOUT CERTAIN MEDICATIONS THAT I WILL BE TAKING FOR PAIN MANAGEMENT. THIS IS TO HELP ME AND MY DOCTOR COMPLY WITH THE LAW REGARDING CONTROLLED MEDICATIONS.

_____I UNDERSTAND THAT IF I BREAK THIS AGREEMENT, SPECIALTY PAIN MANAGEMENT WILL STOP PRESCRIBING MY PAIN MEDICATIONS.

_____I AGREE THAT I WILL NOT MIX ALCOHOL WITH PAIN MEDICATION.

_____I AGREE THAT DRIVING OR OPERATING ANY TYPE OF MACHINERY WILL NOT BE ALLOWED WHILE I AM BEING PRESCRIBED OPIOID MEDICATION AS THIS COULD BE CONSIDERED "DRIVING UNDER THE INFLUENCE" BY LAW.

_____I AGREE THAT I WILL NOT USE ANY ILLEGAL SUBSTANCES, INCLUDING MARIJUANA.

_____I WILL NOT INCREASE OR DECREASE THE DOSAGE OF MY MEDICATION WITHOUT THE CONSENT OF THE PRESCRIBING PHYSICIAN. IF I FEEL THAT ADJUSTMENTS IN THE MEDICATION DOSAGE IS REQUIRED, I AGREE TO CONTACT THE PRESCRIBING PROVIDER AT SPECIALTY PAIN MANAGEMENT FOR AN APPOINTMENT.

_____I WILL NOT SHARE MY MEDICATIONS WITH ANYONE, NOR WILL I TAKE ANOTHER PERSON'S MEDICATION.

_____I WILL NOT SELL MY PRESCRIBED MEDICATIONS, EITHER TO PATIENTS OF SPECIALTY PAIN MANAGEMENT OR TO OTHERS.

_____I WILL NOT RECEIVE ANY PAIN MEDICATIONS FROM ANY OTHER DOCTORS. IF I AM GIVEN A PRESCRIPTION FOR A CONTROLLED SUBSTANCE, I AGREE NOT TO FILL THE PRESCRIPTION UNTIL I HAVE CONTACTED THE OFFICE AND HAVE DISCUSSED IT WITH A PROVIDER AT SPECIALTY PAIN MANAGEMENT.

_____I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SAFEGUARD MY PRESCRIPTION **AND** MEDICATIONS. SHOULD MY PRESCRIPTION OR MEDICATION BE LOST, STOLEN, OR DESTROYED, UNDER NO CIRCUMSTANCES WILL IT BE REPLACED.

_____I WILL NOT CONTACT THE OFFICE TO SCHEDULE FOR AN EARLIER APPOINTMENT IF I HAVE OVER-TAKEN MY MEDICATION.

_____I UNDERSTAND THAT THERE MAY BE RISKS ASSOCIATED WITH THE USE OF PAIN MEDICATION, INCLUDING RISK OF DEATH, RESPIRATORY DEPRESSION, BOWEL AND BLADDER DYSFUNCTION, SEXUAL DYSFUNCTION, CHANGE OF APPETITE WITH POSSIBLE WEIGHT GAIN OR LOSS, CHANGE OF COORDINATION (WHICH MAY INTERFERE WITH DRIVING, OPERATING MACHINERY AND FINE MOTOR MOVEMENT) AND OTHERS.

_____I UNDERSTAND THAT THE CONTINUOUS USE OF PAIN MEDICATION MAY RESULT IN DEPENDENCE, ADDICTION, CHANGE IN PERSONALITY, AND SLEEP CHANGES.

_____I WILL REPORT ANY CHANGES IN MY MENTAL STATE, AS WELL AS POSSIBLE SIDE EFFECTS FROM MY MEDICATION.

_____I AGREE TO SUBMIT TO RANDOM URINE DRUG TESTING AND/OR PILL COUNT AT THE REQUEST OR NEED OF THE PROVIDERS ON AN AS NEEDED BASIS TO MONITOR MEDICATION COMPLIANCE WITH RECOMMENDED TREATMENT.

_____I UNDERSTAND THAT SUDDEN STOPPING OF PAIN MEDICATION CAN LEAD TO REBOUND PAIN, WITHDRAWAL SYMPTOMS, SEIZURES AND OTHER SYMPTOMS. I HAVE BEEN INFORMED NOT TO STOP ANY PAIN MEDICATION SUDDENLY UNLESS DECIDED JOINTLY BY MYSELF AND MY PAIN PROVIDER.

_____I AGREE TO ALLOW MY PAIN PROVIDER TO REVIEW ANY OF MY PAST MEDICAL OR PSYCHOLOGICAL RECORDS.

_____I AGREE THAT WHEN I HAVE ANY CONTACT WITH DR. NARWANI OR ANY STAFF MEMBER, I WILL NOT BE RUDE, AGGRESSIVE, SWEAR AND/OR BE DISRUPTIVE WITH ANY MEMBER OF THE OFFICE.

_____I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I AGREE AND UNDERSTAND THAT NON-COMPLIANCE WITH THE ABOVE WILL RESULT IN FORMAL DISCHARGE WITH NOTIFICATION TO MY PRIMARY CARE PHYSICIAN AND OTHER TREATING PHYSICIANS.

Patient Name: _____DOB: _____

Signature: _____DATE: _____

Provider Signature: _____ Witness Signature: _____

PHARMACY NAME_____PHONE: _____

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Consent for Chronic Opioid Therapy

I understand that Dr. Narwani and associates are recommending opioid medicine, sometimes called narcotic analgesics, to treat my chronic pain.

I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving – and that I will promptly advise my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family.

I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Physical dependence or tolerance to the pain relieving properties of the medication (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.)
- Addiction
- Failure to provide pain relief
- Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance.)
- Changes in hormonal levels

In addition, use of these medications poses special risks to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not understood.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications.

Having been informed of these risks and potential benefits both of such medications and possible alternative treatments, I have freely consented to taking the narcotic/opioid medication.

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I would note that I have been given the opportunity of ask any questions that I may have – and that any questions that I have raised have been discussed to my satisfaction.

I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in my running out of medications early, and early refills are not allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort.

I have been advised by my physician that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. I understand that taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I will obtain all opioids prescriptions from my physician or, during his or her absence, by the covering physician. Requests for pain medications from the on-call physician (nights and weekends) will not be honored. I will not request medications outside of normal business hours.

I will obtain all scheduled medications from one pharmacy. I will notify my physician if I change pharmacies. The pharmacy that I have selected is: _____. Its phone number is: _____

I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy.

I will submit to random pill counts and urine and/or blood drug tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day, emergency only period.

I will not share, sell or otherwise permit others to have access to these medications.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR THE TREATMENT OF MY PAIN WITH OPIOID PAIN MEDICINES.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

Patient Name: _____ DOB: _____

Signature: _____ Date _____

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HIPAA Privacy Rights Form

PATIENT INFORMATION

_____
Date

_____ _____ _____
Name (Last, first, middle initial) DOB Social Security # or Patient ID

_____ _____ ____ _____
Street address City State ZIP Code

I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED……

☐ MEDICAL RECORDS ☐ TEST RESULTS ☐ APPOINTMENTS
☐ PHONE MESSAGES ☐ MEDICATION INFORMATION ☐ ALL INFORMATION

I authorize to release one or all of the above information to the following persons……

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

Please list the following for Specialty Pain Management to leave confidential information.

_____ _____ _____
Primary phone number Other phone number E-mail address

_____ I DO NOT authorize any medical information to be released to any other individuals

Signature _____Date _____

No information will be released to any persons without the permission of the patient. All authorized persons receiving any information will need to show proper identification before any information will be released.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize:

Dr. Name or Facility: _____

Address: _____

Phone: _____ Fax: _____

To release healthcare information of the patient named above to:

Name: **Ajay Narwani**

Address: 3008 N. Dobson Rd., Suite 2

City: Chandler State: AZ Zip Code: 85224

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

DEFINITION: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.

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NAME:_____ Date of Birth: _____

LIST ALL MEDICATIONS YOU ARE TAKING (please include list, if necessary):

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY (please circle):

*Arthritis *Asthma *Bleeding Disorder *Cancer (specify) _____ *Congestive Heart Failure
*COPD *Coronary Artery Disease *Diabetes *Diabetic Neuropathy *Emphysema *Fibromyalgia *Heart Attack
*Heart Disease *Hepatitis B *Hepatitis C *High Blood Pressure *High Cholesterol *HIV/AIDS *Kidney Disease
*Liver Disease *Lupus *Neurological Disease *Neuropathy *Osteoporosis *Rheumatoid Arthritis *Seizures
*Stroke *Thyroid Disease *Vascular Disease (specify) _____
*Other medical problems: _____

LIST ANY ALLERGIES TO MEDICATIONS:

_____

_____

_____

LIST ALL OF THE SURGERIES YOU HAVE HAD (including dates):

_____

_____

_____

LIST ANY RECENT HOSPITALIZATIONS: _____

_____

_____

FAMILY HISTORY (please circle):

*Arthritis *Asthma *Bleeding Disorder *Cancer (specify) _____ *Congestive Heart Failure
*COPD *Coronary Artery Disease *Diabetes *Diabetic Neuropathy *Emphysema *Fibromyalgia *Heart Attack
*Heart Disease *Hepatitis B *Hepatitis C *High Blood Pressure *High Cholesterol *HIV/AIDS *Kidney Disease
*Liver Disease *Lupus *Neurological Disease *Neuropathy *Osteoporosis *Rheumatoid Arthritis *Seizures
*Stroke *Thyroid Disease *Vascular Disease (specify) _____
*Other medical problems: _____

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SOCIAL HISTORY

Do you smoke? Y N How much? 1-5 ½ PPD 1 PPD
Do you drink alcohol Y N How many drinks per week? 1-3 3-6 6-9 9-12 more than 12 per week?
Recreational Drug Use? Y N Do you have a medical marijuana card? Y N
Marital Status? Single Married Divorced Separated Partnered Widowed
Have you filed for disability? Y N Last date worked?

REVIEW OF SYSTEMS (please circle your answers);

CONSTITUTIONAL: significant weight gain/loss appetite loss chills fatigue fever difficulty sleeping

HEENT/NECK: dental pain double/blurred vision ringing in ears stiffness pain on rotation or movements' tenderness

RESPIRATORY: COPD/emphysema cough shortness of breath snoring wheezing

CARDIOVASCULAR: chest pain dizziness palpitations

GASTROINTESTINAL: difficulty controlling bowels abdominal pain constipation diarrhea nausea vomiting

GENITOURINARY: urination problems low sex drive pregnant/nursing (female) flank pain

MUSCULOSKELETAL: foot/ankle pain shoulder pain muscle spasms arm pain elbow pain low back pain mid back pain hip pain joint pain knee pain neck pain sciatica leg pain

SKIN/INTEGUMENTARY: rash itching tattoos

NEUROLOGICAL: numbness tingling recent falls fainting headaches memory loss weakness loss of motor skills

PSYCHOLOGICAL/PSYCHIATRIC: anxiety depression hallucinations suicidal thoughts

CIRCLE WHAT LEVEL YOUR PAIN IS TODAY:

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Please use the following scale to give us an estimate of your pain:

0: Pain Free
1: Very minor annoyance, occasional minor twinges
2: Minor annoyance, occasional strong twinges
3: Annoying enough to be distracting
4: Can be ignored if you are really involved in your work, but still distracting
5: Can't be ignored for more than 30 minutes
6: Can't be ignored for any length of time, but you can still go to work and participate in social activities
7: Makes it difficult to concentrate, interferes with sleep, you can still function with effort
8: Physical activity severely limited, you can read and converse with effort, nausea and dizziness set in as factors of pain
9: Unable to speak, crying out or moaning uncontrollably, near delirium
10: Unconscious, pain makes you pass out / Pain of amputation

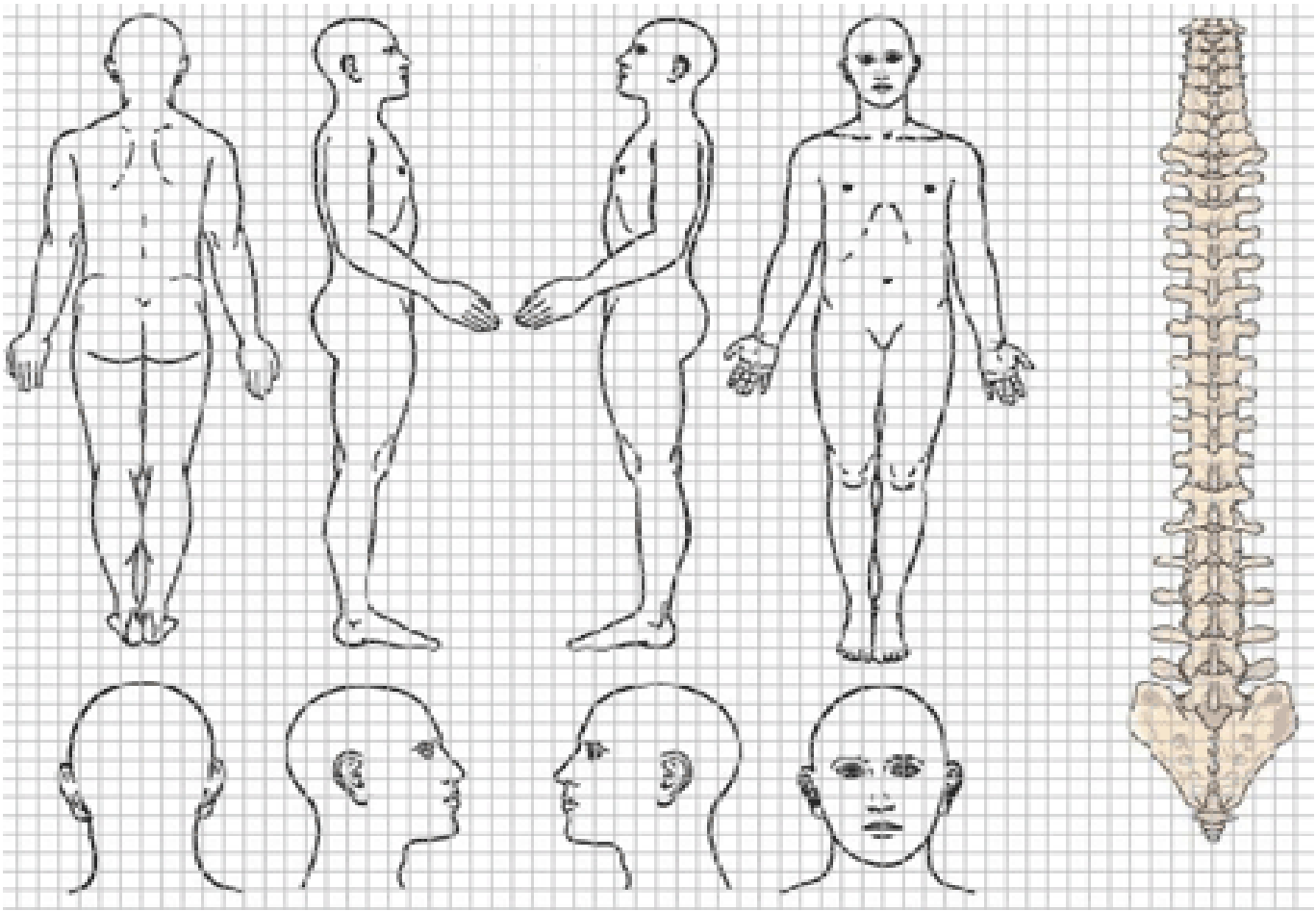
SPECIALTY PAIN MANAGEMENT CENTER

AJAY M. NARWANI M.D., PLLC

DIPLOMATE IN ANESTHESIA, AMERICAN BOARD OF ANESTHESIOLOGY
DIPLOMATE IN PAIN MEDICINE, AMERICAN BOARD OF ANESTHESIOLOGY

Use this diagram to indicate the location and type of pain. **Mark the drawing with the following letters that best indicate your symptoms.**

"N" = numbness.
"S" = stabbing pain.
"B" = burning pain.
"P" = pins and needles.
"A" = aching pain.



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