Precision Pain Management
23521 Paseo de Valencia, Suite 204
Laguna Hills, CA 92653

PRECISION PAIN MANAGEMENT

New Patient Information

Name: _____ _____ _____
First Middle Last

DOB:_____SSN: _____-_____-_____ **Gender:** ☐Female☐ Male

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Cell Phone #: _____ Home Phone #: _____

Work Phone #: _____ Occupation: _____ E-Mail: _____

Emergency Contact: _____ Relation: _____Phone: _____

Ethnicity: ☐African American ☐Caucasian ☐Hispanic ☐Asian Other: _____
Primary Language: _____

Primary Care Provider (PCP): _____ Phone: _____

Referring Provider: _____ Phone: _____

Referral Source: _____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Date of Birth: _ _____

Relationship to Patient: _____

SSN: _____

Insurance Name: _____

Subscriber ID: _____

Group # _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Date of Birth: _ _____

Relationship to Patient: _____

SSN: _____

Insurance Name:_____

Subscriber ID:_____

Group#:_____

Insurance Coverage Declarations

1. Are you involved in any litigation or lawsuit regarding your pain? ☐Yes ☐ No

2. Are you seeking Workers' Compensation as a result of your pain? ☐Yes ☐ No

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Today's Date:_____

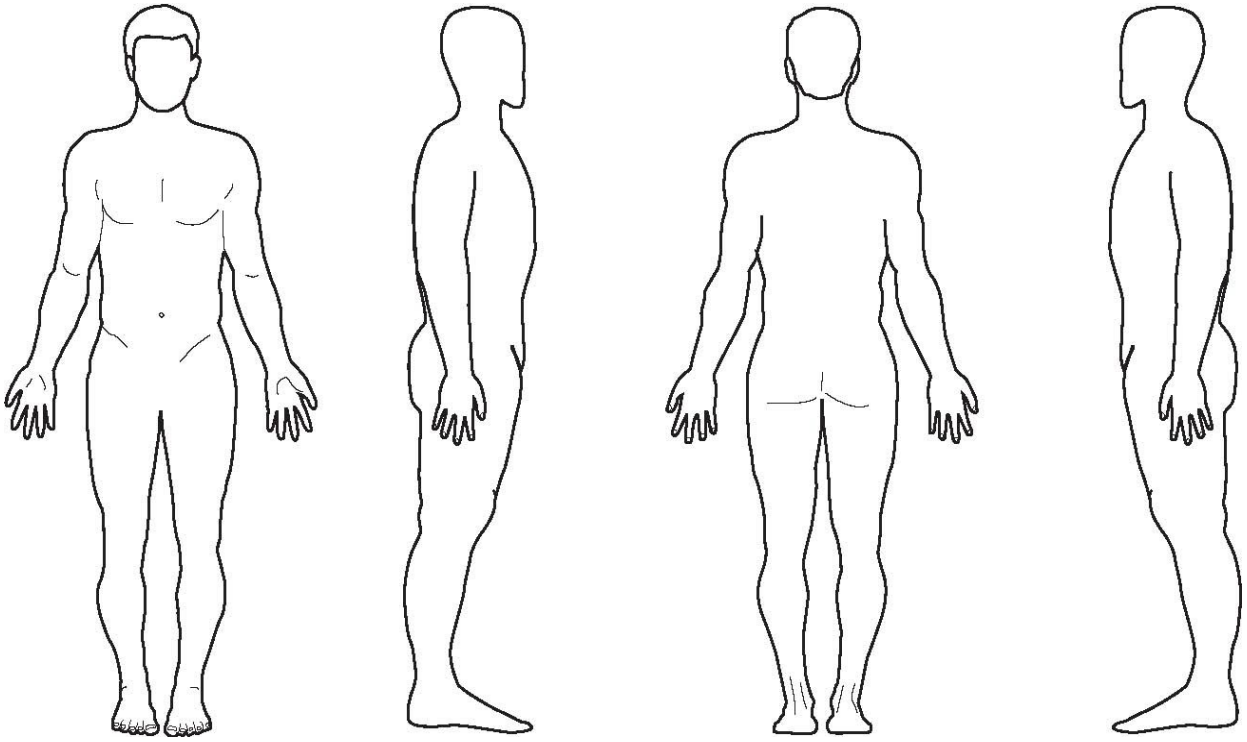
New Patient Intake Form

Full Name: _____ Age: _____ Occupation: _____

1. Chief complaint (pain): _____
2. Onset of symptoms (date/description):_____
3. Are you experiencing radiating pain? (description): _____

Shade areas of pain or discomfort on the images below:

Front Right Side Back Left Side



1. Please rate your pain on a scale of 0-10, with 0 being no pain and 10 being the worst pain imaginable:
   At its best: _____ At its worst:_____ At this moment: _____
2. Select the frequency at which your pain occurs (check):
   ☐ Continuously ☐ Several times a day ☐ Intermittently ☐ Occasionally ☐ Less than daily
3. When is your pain worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ All the Time ☐ No Usual Pattern
4. Describe any changes in pain intensity since its onset: ☐ Better ☐ Worse ☐ No Change

5. Select one or more items below to describe your pain (check all that apply):
☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Electric Shock ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Deep ☐ Numb ☐ Tingling ☐ Other: _____

6. Please check the ones your pain interferes with (check all that apply):
☐ General Activity ☐ Mood ☐ Walking Ability ☐ Normal Work
☐ Sleep ☐ Enjoyment of Life ☐ Intimacy

7. What makes the pain worse? (check all that apply):
☐ Standing ☐ Sitting ☐ Walking ☐ Movement ☐ Lying down ☐ Bending forward
☐ Arching backward ☐ Coughing ☐ Sneezing ☐ Using the restroom ☐ Other: _____

8. What makes the pain better? (check all that apply):
☐ Standing ☐ Sitting ☐ Walking ☐ Movement ☐ Lying down ☐ Coughing ☐ Sneezing
☐ Bending forward ☐ Arching backward ☐ Using the restroom ☐ Other: _____

9. What tests have been done and when? (check all that apply & give dates and location of imaging):
X-ray: _____ MRI: _____ CT: _____ EMG: _____ Bone Scan: _____
Other: _____

10. Do you have any of the following symptoms associated with your pain?
Numbness/Tingling If yes, where?_____
Weakness If yes, where? _____
Bowel/Bladder Incontinence If yes, when did it start? _____

11. List the names of other doctors or specialists you have seen for your pain or who have treated your pain:
_____
_____

12. Please check all procedures or modalities you have tried to manage or treat your pain: Did it help?
Acupuncture_____ Massage _____
Biofeedback_____ Meditation_____
Chiropractor_____ Nerve Blocks _____
Epidural_____ Physical Therapy _____
Facet Block_____ Psychotherapy_____
Ice/Heat_____ Surgery_____
Medications_____ TENS_____
Other _____

13. Medical Illnesses (please check all that apply):
☐ Arthritis ☐ Cancer: _____ ☐ Diabetes ☐ Headaches ☐ Hepatitis ☐ Asthma ☐ COPD ☐ Stroke
☐ Hypertension ☐ Kidney Disease ☐ Thyroid Disease ☐ Seizure Disorder ☐ GERD ☐ Other: _____

14. Prior Surgeries (please list type & date, or provide a list):
_____
_____

15. Allergies: _____

16. Current Non-Pain Medications (name and current dose, or please provide list):

17. Do you take any of the following blood thinners? (check all that apply):

☐ Aspirin ☐ Coumadin ☐ Plavix ☐ Heparin ☐ Brilinta ☐ Eliquis ☐ Xarelto ☐ Lovenox

18. Current Pain Medications (name and current dose, or please provide list):

19. Previous Pain Medications (name and previous dose):

20. Social History check: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Use tobacco? Amount_____ Use alcohol? Amount_____

Use illegal drugs? ☐ YES or ☐ NO Been treated for alcohol or drug addiction ☐ YES or ☐ NO

Type_____

21. **Family History (check all that apply):**

- ☐ **Cancer** Who:_____
- ☐ **Diabetes** Who?_____
- ☐ **Heart Disease** Who?_____
- ☐ **Stroke** Who?_____
- ☐ **Depression/Suicide Alcohol/Drug Abuse** Who?_____

I, the undersigned, have completed this form. The information that I have provided is true and accurate to the best of my knowledge.

X_____ _____
Patient/Legal Guardian Signature Date

X_____ _____
Person signing on patient's Behalf/Relationship Reason patient is unable to sign

Today's Date

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of medication to treat your pain?	☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5. How often is there tension in the home?	☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8. How often do you feel bored?	☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10. How often have you worried about being left alone?	☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐

Patient Name: _____ Date of Birth: _____

Today's Date

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
16. How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21. How often have you been sexually abused?	☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
24. How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

Please include any additional information you wish about the above answers.
Thank you.

Patient Name: _____ Date of Birth: _____

Precision Pain Management

23521 Paseo de Valencia, Suite
204 Laguna Hills, CA 92653

P) 949-458-2026 F) 949-273-8053

Financial Policy

We would like to share our financial policies, billing procedures, and required notices with you. We hope you find this information helpful. If you have any questions or concerns, please contact our billing manager.

1. **Insurance Claim Filing:** As a courtesy, we are happy to file insurance claims for your primary insurance. If you have Medicare and a secondary insurance, please confirm with Medicare that you are set up for a crossover which will allow Medicare to send their Explanation of Benefit (EOB) directly to your secondary insurance for payment.
   *****You as a Medicare beneficiary are the only person who can contact Medicare and give Medicare permission to send the EOB (Explanation of Benefit) directly to your secondary insurance.
   *****If Medicare does not crossover, you will be responsible for billing your secondary insurance and paying for the balance as well.

2. **Time of Service:** As a patient, you are responsible for co-payment/co-insurance amount, plus any deductible at the time of service.

3. **Insurance Verification:** If our office cannot verify your insurance benefits or if you have no insurance, payment in full is expected at the time of the service. We accept most forms of payment.

4. **If your insurance carrier sends payment directly to you, then payment is due in full at your visit. In the event that your insurance does not cover all services, you will be billed for services that are not covered.**

5. **Statements:** Our statements are sent out on a monthly basis. All charges are due and payable within 30 days of receipt. We will make every effort to work with you, so please contact our billing manager if there is a need for a payment plan.

6. **Account Balances:** If your insurance has not paid your account in full within a reasonable amount of time and after reasonable effort has been made, you will be billed the entire balance. If you are unable to keep your account current, we will not be able to provide additional medical services to you unless an agreed upon reasonable payment as been made and the remainder is pending. We may require that you pre-pay for all future services.

7. **Non-Payment:** In the event that payment is not made on your account, and it is placed in collection, you are required to pay the balance so that medical service can be continued.

8. **Returned Checks:** There will be a $30.00 service fee on all returned checks in addition to the amount of the original check and the bank penalty. Please understand that we can only accept a cash payment to settle this issue. If there is a repeat incident, we will no longer be able to accept your check.

9. **LATE CANCELLATION/"NO SHOW POLICY":** Please notify us with at least 24 hours' notice if you must cancel your appointment so that we may let another patient have your appointment time. If you do not provide at least 24 hours' cancellation notice or do not show up for your appointment, there will be a "no-show" fee of $50.00 for missed office visits and $150.00 for missed facility procedures that will be due prior to rescheduling.

SB 1061 Notice: "A holder of this medical debt contract is prohibited by **Section 1785.27** of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

Attestation: By signing below, I am attesting that I have read and understood the foregoing Financial Policy and agree to abide by the terms of the policy and notice.

_____ _____ _____

Print Name Signature Date

Date of Birth:_____

Precision Pain Management

Pharmacy Authorization Form

Name of Patient: _____ Date: _____

I, _____, give permission to the office of Dr. Andrew Messiha to assess my current medication lists through my pharmacy.

My Current pharmacy is _____.

The Pharmacy address is:

_____
Street Name

_____
City, State, Zip Code

_____ _____
Patient Signature Date

Precision Pain Management

23521 Paseo de Valencia, Suite 204 Laguna Hills, CA 92653
Tel: 949-458-2026 Fax: 949-273-8053

Permission for Written & Verbal Communications

_____ _____
Patient's Name **Date of Birth**

I permit Precision Pain Management (AHM, Inc.), their physicians, nurses, and other personnel to contact, in person, via messaging, text, or by telephone, myself, other healthcare providers invoved in my care, and with the following family members or friends involved in my medical care regarding my medical care.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____

☐ I **do not** authorize anyone, outside of my healthcare providers, to have access to my health information.

This authorization is limited to discussions regarding the following medical condition(s):

_____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following time frame from _____ to _____
If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the office.

_____ _____
Patient's Signature **Date**

If this Release is signed by a representative on behalf of the patient, complete the following:

_____ _____
Representative's Name Representative's Signature

_____
Relationship to Patient

Date of Birth:_____