PAIN MANAGEMENT CENTER OF WISCONSIN, S.C.

PATIENT REGISTRATION/ REGISTRO DEL PACIENTE

Name: _____ DOB: _____ Date: _____
Nombre Fecha de Nacimiento Fecha

Address: _____ City: _____ State: _____ Zip _____
Direccion Ciudad Estado Codigo Postal

Social Security: _____ Sex _____ Marital Status _____
Seguro Social Sexo Estado Civil

Name of Spouse: _____ Spouse's Telephone ( ) _____
Nombre del Cónyuge Telefono del Cónyuge

Home Telephone: ( ) _____ Work ( ) _____ Cell ( ) _____
Telefono de Domicilio Trabajo Celular

Employer: _____ Employer Address: _____
Empleador Direccion

Referring physician's name and phone: _____ ( ) _____
Nombre y telefono del doctor que lo refiere

Health Insurance: _____ ID: _____ Group: _____
Seguro de Salud # Identificacion Grupo

Parent/ Guardian Name (if patient is under 18): _____
Nombre del padre/madre/ tutor (sí el paciente es menor de 18 años)

Were you injured at work? _____ Yes _____ No Date of Injury: _____
¿Se lastimó en el trabajo? Sí No Fecha del accidente

Worker's Comp Insurance: _____ Claim# _____
Nombre de la compañia de seguro del trabajo Numero del Reclamo

Were you injured in an auto accident? _____Yes _____No Date of Injury: _____
¿Se lastimó en un accidente de auto? Fecha del Accidente

State Accident Occurred in: _____ Wisconsin _____ Illinois Other _____
Estado donde ocurrio

Auto Insurance: _____ Policy: _____
Seguro del Automovil Numero de Póliza

If you are represented, name of your Attorney: _____
Sí esta representado, anote el nombre de su abogado

Current Medications Medicinas que toma actualmente	Dosage Dosis	How many daily? Cuantas por día?	Name of prescribing doctor Nombre del doctor que le prescribió

Allergies/ Alergia a Alguna Medicina:	What happens when you take it?/¿Que le pasa si la toma?

Family Member Miembro de Familia	Age Edad	Alive or Deceased? ¿Vivo O Fallecido?	Medical History/ Cause of Death Historia Medica/ Causa de Muerte
Father/Padre			
Mother/Madre			

Past Medical History: Please circle if you have had any of the following:
Historia Medica: Por favor haga un círculo si usted sufre o ha sufrido de alguna de estas condiciones:

1. Lung Disease, Bronchitis, Asthma, Emphysema, Pneumonia.
   Entermedad del Pulmon, Bronquitis Asma, Enfisema, Neumonía.
2. Heart disease, Bypass surgery, Heart attack, High blood pressure Irregular hearbeat
   Entermedad del Corazón Cirugía de Bypass Ataque Cardiaco Alta Presión Arterial Latidos Irregularer
3. Stroke, Siezure, Neuropathy, Headaches
   Derrame Cerebral Convulsiones Neuropatias Dolores de Cabeza.
4. Kidney disease, Blood in urine, Stones
   Enfermad de los Riñones Sangre en la Orina Calculos o Piedras en los Riñones
5. Arthritis, Lupus, Gout
   Artritis Lupus Gota
6. Esophageal Reflux
   Reflujo Esofágico
7. Thyroid Condition, Diabetes
   Condicion de la Tiroides Diabetes
8. Cancer, Lymphoma, Leukemia, HIV/AIDS
   Cancer Limfoma Leucemia Sida
9. Depression, Schizophrenia, other psychiatric disease
   Depresión Esquizofrenia Otra enfermedad mental.
10. Polio
    Polio

Have you ever had a problem with drug or alcohol abuse? ¿Ha tenido problemas de abuso de drogas o alcohol?
☐ Yes/ Si ☐ No

Do you use any recreational drugs?
Utiliza alguna **droga recreacional?**

_____

Social History/ Historia Social

Occupation/ Ocupacion:

Working Status Estado de Trabajo CHECK ONE Marque Uno	FullTime Tiempo Completo ☐	Part time Tiempo Parcial ☐	With Restrictions Con Restricciones ☐	Unemployed Desemplead ☐	Ret Ret ☐

If you are not working, how long have you been off?
¿ Cuanto Tiempo está sin trabajar? _____

Do you use tobacco? ¿Consume tabaco? ☐No ☐Yes/ Sí
How many per day? ¿Cuanto fuma al dia? _____

Check One Marque Uno	Cigars Puros ☐	Tobacco Tabaco Snuff ☐	Cigarettes Cigarrillos ☐		

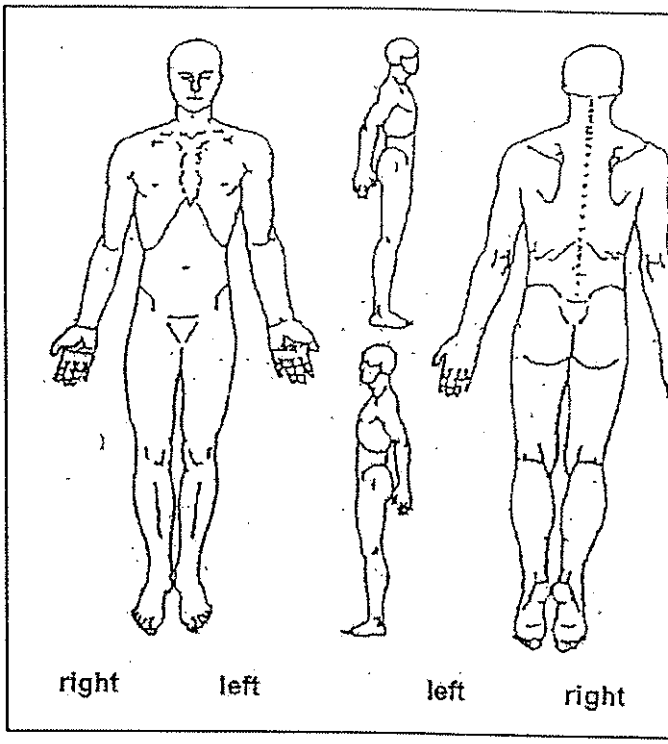
Do you use Alcohol? ¿ConsumeAlcohol? ☐ No ☐ Yes/ Sí
If yes how many per day ? ¿Cuanto por Dia? _____

Check One Marque Uno	Wine Vino ☐	Alcohol Licor ☐	Beer Cerveza ☐	Other Otro ☐	

Please draw in the location of your symptoms
Por favor haga un círculo en el dibujo adjunto:

XXX=Pain 000= Numbness Tingling

XXX=Dolor **000=Adormecimiento/Hormigueo**



Check which apply
Marque lo que sea aplicable

☐ Sharp/ Intenso ☐ Dull/ Tenue
☐ Achy/ Sensacíon de dolor ☐ Throbbing/ Punzante
☐ Pulling/ Desgarrante ☐ Stiff/ Rígido
☐ Burning/Ardor ☐ Pressure/ Oprimente
☐ Sore/ Adolorido ☐ Spasms/ Espasmos

Please check (√) what you have had recently:
por favor, que ha tenido recientemente

Fevers or Chills fiebre o escalofríos		**Shortness of Breath** Falta de aliento		**Rashes** la erupción	
Double Vision doble visión; diplopía		**Difficulty Controlling Bowels** Dificultad para controlando su esfinter		**Numbness/Tingling in Hands/Feet** Entumecimiento/Hormigueo en Manos/Pies	
Dizziness tener *or* sufrir un mareo		**Difficulty Controlling Bladder** Dificultad para controlar vejiga		**Depression** depresión	
Swelling in Feet hinchazón de pies		**Joint Swelling** Inflamación de las articulaciones		**Problems Sleeping** Problemas para dormir	

What makes the pain worse? ☐ Sitting ☐ Standing ☐ Walking ☐Lying down ☐Bending ☐ Lifting ☐ Coughing
¿Que hace que empeore el dolor? Sentadose Parándose Caminando Acostándose Agachándose Cargando Tosiendo

What makes your pain better? ☐ Sitting ☐ Standing ☐ Walking ☐Lying down ☐Medication ☐Ice ☐Heat
¿Que hace que mejore el dolor? Sentadose Parándose Caminando Acostándose Agachándose Hielo Aplicando Calo

On a 1-10 scale, rate your worse pain: 1 2 3 4 5 6 7 8 9 10
En escala del 1 al 10 evalúe el nivel de su dolor (mild) (moderate) (severe)
Leve moderado severo

NEW PATIENT FINANCIAL AGREEMENT

PAIN MANAGEMENT CENTER OF WI 4710 W. LOOMIS ROAD GRNFLD WI 53220 414-433-1000

1. I understand that all current medical insurance information must be provided by me so that **it may be utilized to pay for treatment rendered regardless of causation**. This includes coverage through a spouse or other source i.e.: auto med pay. **I agree to provide updated cards as they are issued for all.**

2. I understand it is my responsibility to **know my covered benefits** and to **provide all proof of coverage as well as obtain authorization and/or appropriate referrals** for any and all treatment or procedures requiring them in accordance with my particular plan.

3. I understand **it is my responsibility to pay for co-payments,** deductible and non- covered services out of my own pocket **at the time of service with cash or personal check only**.

4. I understand that although Pain Management Center of WI will file all necessary paperwork on my behalf and assist me as much as possible: **it is my responsibility to personally follow up with my insurance company to expedite payment** of any and all unpaid claims.

5. I understand that Pain Management Center of WI reserves the right to immediately terminate treatment due to non-compliance with any part of this agreement.

6. I understand that I am ultimately liable for all unpaid bills and if I am unable to meet my financial obligation, I will contact the billing office immediately to negotiate acceptable payment arrangements.

7. I understand that non-payment will result in my account being forwarded to the credit bureau.

I have read and understand this document.

Authorized
Signature:_____ Date:_____

HENRY ROSLER, M.D.
JORDAN MANDEL, M.D.
HENRY ALBA, M.D.

PERSONAL HEALTH INFORMATION (PHI) PATIENT CONFIRMATION AGREEMENT/ RECEIPT OF NOTICE OF PRIVACY AND DISCLOSURE PRACTICES

Name:_____ Date:_____
Please print clearly, first and last name

I received and reviewed on this day, a legible copy of Pain management Center of Wisconsin S.C. Notice of Privacy Practices. I understand my rights and responsibilities regarding my Personal health Information uses and disclosures and agree to all therein.

Signed_____ Date:_____

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Though I received and reviewed on this day a legible copy of Pain Management Center of Wisconsin S.C. Notice of Privacy Practices, I decline to sign this agreement. Pain Management Center will not retaliate in any way as a result of my refusal to sign.

Signed:_____ Date:_____

Privacy Officer Signed:_____ Date:_____

Witness signed:_____ Date:_____