

Integrated Pain Specialists of Southern California, Inc.

Kevin S. Smith, M.D. / Nicole Wright, PA-C / Steven Lebowitz, PA-C

Main Office: 7910 Frost Street, Suite 280, San Diego, CA 92123

East County Office: 5525 Grossmont Center Drive, Suite 609, La Mesa, CA 91942

Phone: (619) 398-2988 Fax 1: (619) 398-2987 Fax 2: (858) 300-1156

Appointment Location: _____ 5525 Grossmont Center Drive, Suite 609, La Mesa, CA 91942

Appointment Date: _____

Check-in Time: _____ **Appointment Time:** _____

To avoid being rescheduled, please be on time for your appointment.

Please allow yourself an extra 20 minutes for parking.

New patients need to have their paperwork completed prior to your appointment.

Directions:

I-8 East towards El Centro. Exit La Mesa Blvd toward Grossmont Center Dr.

Turn left onto La Mesa Blvd. La Mesa Blvd becomes Grossmont Center Dr. Turn right onto Healthcare Dr. At the stop sign, turn right onto Healthcare Dr. Make your first right turn into the parking structure.

I-8 West towards San Diego. Exit Grossmont Center Dr. toward La Mesa Blvd. Turn right onto Grossmont Center Dr.

Turn right onto Healthcare Dr. At the stop sign, turn right onto Healthcare Dr. Make your first right turn into the parking structure.

CA-125 North. Take the Grossmont Blvd exit. Turn left onto Grossmont Blvd. Turn right onto La Mesa Blvd. La Mesa Blvd becomes Grossmont Center Dr. Turn right onto Healthcare Dr. At the stop sign, turn right onto Healthcare Dr.

Make your first right turn into the parking structure.

CA-125 South. Take the Grossmont Blvd exit. Turn right onto Grossmont Blvd. Take the 2nd right onto La Mesa Blvd.

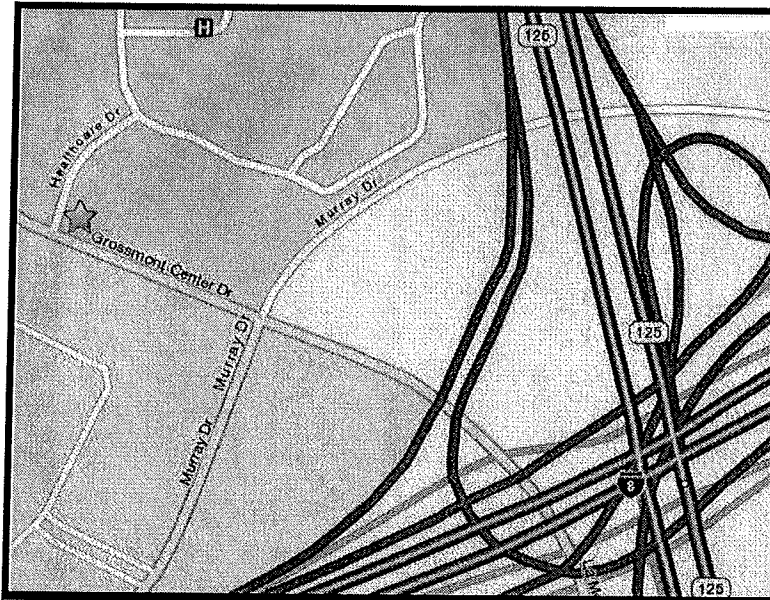
La Mesa Blvd becomes Grossmont Center Dr. Turn right onto Healthcare Dr. At the stop sign, turn right onto Healthcare Dr. Make your first right turn into the parking structure.

I-805 South. Go to 163 South and follow I-8 East directions.

I-15 and Hwy 163 North and South, use I-8 East directions.

Please note, there is no charge for the 1st hour of parking in the structure.

After the 1st hour, there is a \$3.00 fee for parking with validation.



Dear Sir/Madam:

Enclosed you will find several forms; which we ask that you complete and bring with you to our office prior to your consultation. Please arrive thirty (30) minutes prior to your appointment; this will help expedite the process of setting up your account. If your paperwork is not completed prior to your appointment time you will need to be rescheduled.

Our office will obtain records from your referring physician prior to scheduling your appointment. If you have any additional records or radiology studies you would like to have reviewed, bring them to your appointment, please arrive a few minutes early so that we can get them into your chart for the doctor's review.

Upon check-in with the receptionist, please provide your identification and insurance card(s) to copy for your chart and pay any co-pays that apply. **If your co-pay is not paid at the time of service there will be a twenty (\$20) charge to bill for a co-payment.**

Our Practice focuses on one on one personalized service, quality care and attention to detail. To do so, we must ensure that we allow enough time for each patient's appointment. With this in mind, for all appointments longer than one hour, we require indication of commitment by payment at the time of scheduling.

In the event that you must cancel your appointment, the following is our cancellation policy.

Appointments – 48 hour notice or \$45 charge

Procedures Scheduled 1 hour or less – 48 hour notice or \$100 charge

Procedures Scheduled longer than 1 hour and less than 2 hours – 72 hour notice or \$175 charge.

Procedures Scheduled 2 hours or more – 7 day notice or \$500.00 charge

We look forward to meeting you at your consultation with Dr. Smith.

Sincerely,

Medical Office Staff
Integrated Pain Specialists

Integrated Pain Specialists
(619) 398-2988 – Phone
(619) 398-2987 – Fax
(858) 300-1156 – Alt Fax
(619) 270-4951 – Answering Service

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Integrated Pain Specialists of Southern California

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name		Today's Date		Date of Birth		Sex		Age	
Social Security Number		Marital Status (circle): S M W D		Primary Language		Race		Ethnicity <input type="checkbox"/> Refuse to report	
Home Address		City		State		Zip			
Mailing Address if Different		City		State		Zip			
E-mail				<input type="checkbox"/> I would like to be web-enabled so I may update my information, view reports & appointment info, receive confirmation calls, send & receive e-messages through the Patient Portal.					
Home Telephone Number			Work Telephone Number			Cell Telephone Number			
Permission to leave telephone message(s) at:				Home: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Primary Phone #		Message: <input type="checkbox"/> Brief <input type="checkbox"/> Detailed			
				Work: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Primary Phone #		Message: <input type="checkbox"/> Brief <input type="checkbox"/> Detailed			
				Cell: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Primary Phone #		Message: <input type="checkbox"/> Brief <input type="checkbox"/> Detailed			
Occupation				Employer's Name					
Employer's Address		City		State		Zip			
Spouse Name				Employer					
Primary Physician's Name									
Whom May We Thank for Referring You to Our Practice?									
NOTIFY IN CASE OF EMERGENCY									
Name					Relationship				
Address		City		State		Zip			
Home Telephone Number			Work Telephone Number			Cell Telephone Number			
Nearest Relative (not living with you)					Relationship				
Home Telephone Number			Work Telephone Number			Cell Telephone Number			
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES									
Name					Telephone				
Address		City		State		Zip			
Insurance Company				Claim Address					
Subscriber/Primary Insured's Name				Subscriber's Date of Birth			Subscriber's SSN#.		
Insurance ID No.:									
Secondary Insurance				Claim Address					
Subscriber/Primary Insured's Name				Subscriber's Date of Birth			Subscriber's SSN#.		
Were You Injured on the Job?		YES NO		Have you Informed Your Employer?				YES NO	
Original Date of Injury:		Name of Claims Adjuster:			Adjuster Phone:			Adjuster Fax:	
Attorney Name:				Attorney Phone:			Attorney Fax:		

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Kevin S. Smith M.D. I understand that I am financially responsible for any balance. I authorize Integrated Pain Specialists or my insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____

Date: _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION:

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

The medical information/records will be used for the following purpose:

This authorization is:

Unlimited (all records, excluding Substance Abuse, Mental Health, HIV, Diagnosis/Treatment)

Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)

HIV Diagnosis/Treatment _____(initial)

Psychiatric/Mental Health _____(initial)

Genetic Information _____(initial)

Tests for Antibodies to HIV _____(initial)

DURATION: This authorization shall be effective immediately and remain in effect until _____(date)

RESTRICTIONS:

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

Signature of Patient (or legal/personal representative)

Relationship (if other than patient)

Patient's Name (please print)

Today's Date

Patient's Social Security Number

Patient's Date of Birth

Witness Name

Witness Signature

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Notice of Privacy Practices

Consent to the Use and Disclosure of Health Information
for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and laboratory results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis of planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third-party payers can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as accessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to view and or request a Notice of Privacy Practices that provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and; prior to implementation will post and make available, the revised notice at physical practice site(s). I also understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my healthcare operations; and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing; except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

I request the following to be allowed to discuss my medical care with the Clinic.

I have read and understand the Notice of Privacy Practices.

Signature of Patient or Legal Representative

Witness

Today's Date

Notice of Effective Date

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Financial Agreement for Services Provided

I have chosen **Integrated Pain Specialists, Kevin S. Smith, M.D.** to provide medical services. I agree to be financially responsible for all of the fees charged for medical services provided that are not covered by my health insurance.

I understand that I am responsible for the co-payment or deductible requirements of my insurance and for payment for any services that are not covered or are ineligible for payment by my insurance. If it is determined that I am not eligible for insurance coverage, I agree to pay the fee charged by IPS.

I acknowledge that if I present for medical services without the proper authorization or referral which is required by my insurance company, I will be responsible for paying the fee charged by IPS. I also understand that if a service is provided that is not included as a benefit under my insurance coverage, that I will be responsible for paying the fee charged by IPS.

I understand I may be personally responsible for payment of services that I am electing to proceed with. I agree to pay for all services at the time of service or within 30 days of receipt of a bill as well as pay for any outstanding fees owed to IPS. I also agree that if my account is transferred to any outside entity for collection, I will pay for the collection agency and any attorney's fee and costs in connection with obtaining payment.

If my appointment has been scheduled at a facility, I understand that I will receive bills for services rendered by the facility separate and apart from the physicians' charges.

I understand if I have an HMO with POS option and wish to use my PPO benefits without using HMO benefits, I cannot switch once treatment has been initiated.

I have asked and had answered to my satisfaction, all questions I have regarding my responsibility for payment of services. I understand and agree to proceed with medical services.

Signature of Patient/Responsible Party

Patient Name (Please Print)

Date

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No Show / Cancellation Policy

- **Appointments** – 48 hours business notice or \$45 fee
- **Procedures Scheduled 1 hour or less** – 48 business hours notice or \$100 fee
- **Procedures Scheduled longer than 1 hour and less than 2 hours** – 72 business hours notice or \$175 fee
- **Procedures Scheduled 2 hours or more** – 7 business day notice or \$500.00 fee

Unfortunately, when a patient No Shows or Cancels last minute it is too late to fill that appointment time with another patient who may have been in need of an urgent appointment.

Please be informed that consistent non-compliance to this policy may result in the termination of our physician/patient relationship and discharge from the practice.

I have read and understand the above policy.

Patient Signature

Name (please print)

Date

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Effective: March 8, 2011

I acknowledge that I have been informed that Integrated Pain Specialists **does not have a contract with Medi-Cal as a Primary or Secondary insurance coverage.** I have agreed to continue my care with Integrated Pain Specialists. I am aware that I will be financially responsible for all charges accrued that are not covered by my insurance.

Patient Signature: _____ Date: _____

Print Patient Name: _____

Witness: _____ Date: _____

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Patient's Name: _____ Date of Appt: _____

Patient's Date of Birth: _____ Age: _____ Sex: Male Female

Referring Physician: _____ Primary Care Physician: _____

Reason for Referral: _____

Diagnosis: _____

When did your pain start/Date of injury? _____

If you were injured, please describe the injury: _____

Name of Employer (if work related): _____

Are you involved in litigation: Yes No

Attorney's Name and Address: _____

If your pain is due to an accident at work:

- a. Are you still working? Yes No
- b. If you are still working, are your activities or hours restricted because of pain? Yes No
- c. Are you receiving disability benefits? Yes No

Have you ever had nerve blocks or injections to relieve the pain? Yes No
If yes, did they relieve the pain? Yes No

If yes, how long did the pain relief last? _____

What type of injection did you have? _____

Have you used any of the following to relieve the pain?

- Acupuncture Bed Rest
- TENS Unit Psychotherapy
- IDET, other disc procedures Trigger Point Injections
- Chiropractor Steroid Injections
- Biofeedback/Relaxation Training Physical Therapy
- Massage Others: (Describe) _____

Studies:

Please circle all diagnostic tests for your pain.

Tests	Of what body part	Results(+/-)	Date	Location	Requesting Physician
MRI Scan					
CT Scan					
X-ray					
Bone Scan					
Thermography					
EMG/NCS					

For office use only:

B/P _____ P _____ T _____ O₂ _____ Rm # _____ MA: _____

Please have this form completed prior to your visit and bring along with you to your appointment. Thank you.

Patient Name: _____

Circle any drugs you have used in the past for relief of your pain.

Non-Steroidal Anti-inflammatories:

Aspirin
Motrin (Ibuprofen)
Vioxx
Orudis
Naprosyn
Relafen

Lodine
Feldene
Toradol
Bextra
Celebrex
Indocin

Anti-epileptics:

Depakote
Neurontin
Topamax
Tegretol
Dilantin
Lyrica

Opioids:

Morphine
MS Contin
Roxanol
Duragesic (Fentanyl)
Actiq
Levo-Dromoran
Methadone
Percodan
Percocet
Codeine
Vicodin-Hydrocodone
Norco
Dilaudid
Oxycodone (OxyFast)
Demerol
Darvocet/Darvicet-N
Darvon
Lortab
Non-opioids:
Tylenol

Muscle Relaxants:

Flexeril
Robaxin
Valium

Soma
Baclofen

Stimulant

Dexedrine
Ritalin
Provigil

Anti-depressants:

Nortriptyline
Elavil (Amitriptyline)
Zoloft
Paxil

Trazadone
Cymbalta
Effexor
Remeron

Anti-migraine

Inderal
Fiorinal
Cafergot/Ergotamines
Imitrex

Anti-anxiety:

Ativan (Lorazepam)
Xanax

Anti-hypertensive:

Clonidine (Catapres)

Other: _____

List all **PAIN MEDICATIONS** you are currently taking:

Medicine

Dose (amount)

Times each day

List all **OTHER MEDICATIONS** you are currently taking:

Medicine

Dose (amount)

Times each day

List all **MEDICATION ALLERGIES:**

Patient Name: _____

Describe the pain:

Is there a **constant** (continuous, non-stop, all of the time) component to your pain? If yes, circle any words that best describe your pain.

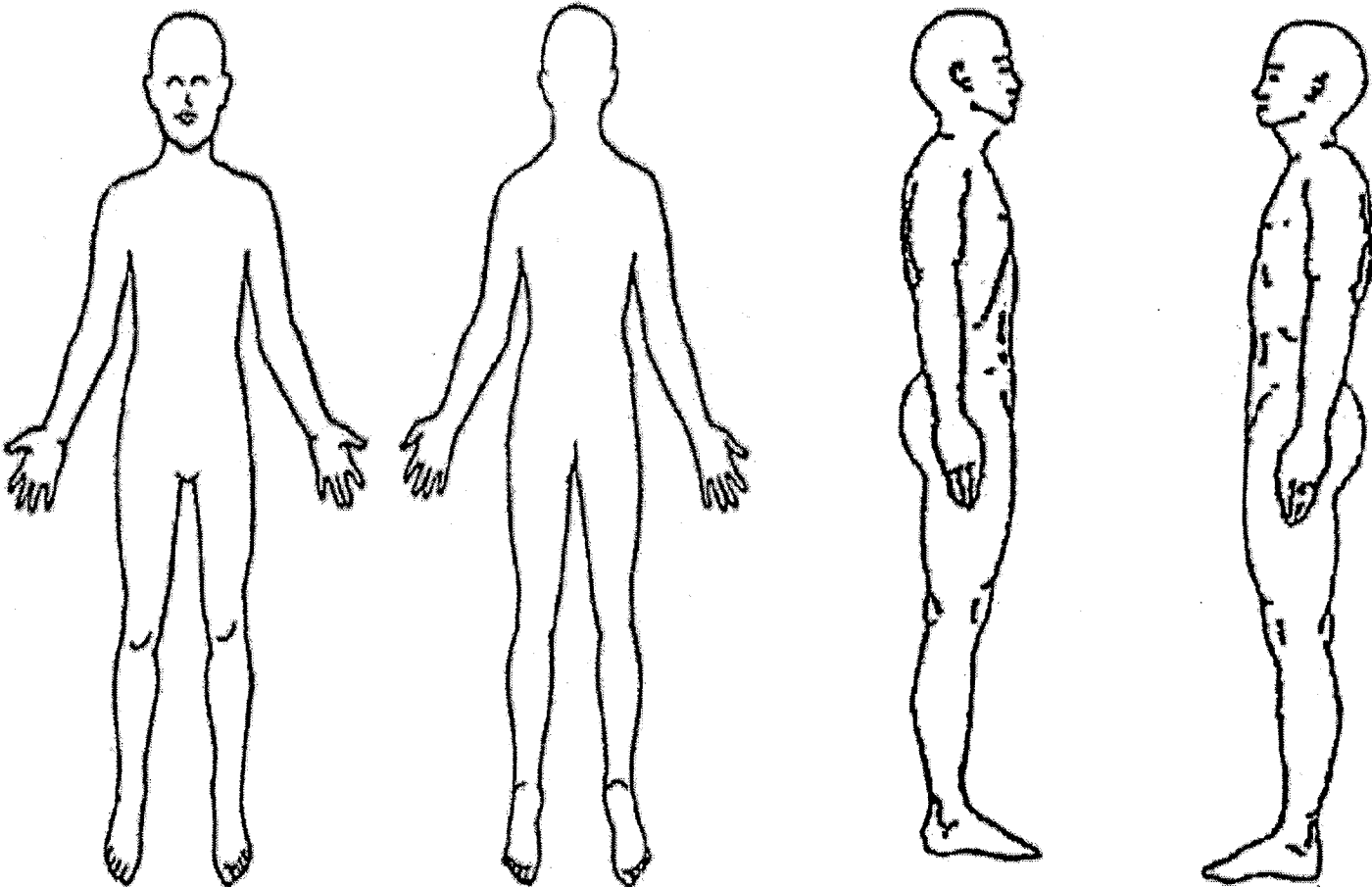
Pulsing, throbbing, pounding, dull, sore, aching, radiating, penetrating, shooting, tender, taut, tight, numb, squeezing, tearing, pricking, stabbing, tiring, cold, sharp, pinching, gnawing, cramping, pulling, hot, burning, scalding, tingling, itchy, stinging, intense, unbearable, or _____

Is there an **intermittent** (occasional, periodic, at intervals) component to your pain? If yes, circle any words that best describe your pain.

Pulsing, throbbing, pounding, dull, sore, aching, radiating, penetrating, shooting, tender, taut, tight, numb, squeezing, tearing, pricking, stabbing, tiring, cold, sharp, pinching, gnawing, cramping, pulling, hot, burning, scalding, tingling, itchy, stinging, intense, unbearable, or _____

Location:

Please mark on the drawings below with a "C" the areas where you feel constant pain and with a "T" the areas you feel intermittent pain.



Patient Name: _____

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Balance/Fall Assessment Self-Test

(PLEASE CIRCLE ALL THAT APPLY)

- | | | |
|--|-------|----|
| 1. Have you fallen in the past year? | YES | NO |
| 2. How many times | _____ | |
| 3. Were you injured with this fall? | YES | NO |
| 4. Do you have balance problems when you are walking? | YES | NO |
| 5. Do you have any migraines, hearing loss, or ringing in your ears? | YES | NO |

Medicare and other Insurance companies ask us to help identify patients that may be at risk for falls

For Office Use Only:

Documented in Report

Entered in by: _____
Initials

This section has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realize you may consider that two of the statements in anyone section relate to you, but please **mark the box which closely describes your problem.**

I Pain Intensity

- I can tolerate the pain I have without having to use pain killers.
- The pain is bad but I manage without having to take pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain and I do not use them.

II. Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

III. Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights of the floor, but I can manage if they are conveniently positioned, eg on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

IV. Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than a 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk using a cane or crutches.
- I am in bed most of the time and have to crawl to the toilet.

V. Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.

VI. Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 30 min.
- Pain prevents me from standing for more than 10 min.
- Pain prevents me from standing at all.

VII. Sleeping

- Pain does not prevent me from sleeping well
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hrs sleep
- Even when I take tablets I have less than 4 hrs sleep.
- Even when I take tablets I have less than 2 hrs sleep.
- Pain prevents me from sleeping at all.

VIII. Sex Life

- My sex life is normal and causes no extra pain.
- My sex life is normal but it causes some extra pain.
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

IX. Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, eg dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- I have no social life because of pain.

X. Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys less than thirty minutes.
- Pain prevents me from traveling except to the doctor or hosp.

What makes the pain better? _____

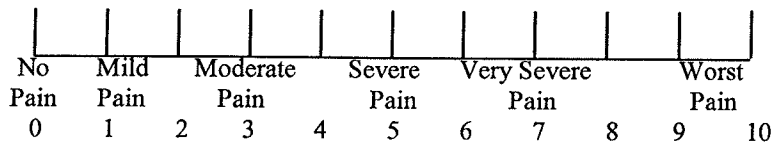
What makes the pain worse? _____

Numbness or tingling? Yes No If yes, describe: _____

Weakness? Yes No If yes, describe: _____

Bowel or bladder problem? Yes No If yes, describe: _____

How severe is your pain?



If YES please describe:

Has the Pain affected your:

Mood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Sleep	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Social Life	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Habits (circle all that apply) Currently Use Previously Used How much? How long? When Stopped?

Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Recreation/Street Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Have you been in a chemical dependency program? Yes No

Have you ever been to a pain doctor or pain clinic? Yes No

If YES, please list: _____
 Location: City _____ State: _____

Have you ever been dismissed from a physician's office due to a disagreement over medications? Yes No

Enter Medical condition and ages for all family members:

<u>Relative</u>	<u>Current Age (or age at death)</u>	<u>Current Medical Condition</u>	<u>(or cause of death)</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Brother	_____	_____	_____
Sister	_____	_____	_____
Children	_____	_____	_____
Spouse/Partner	_____	_____	_____

Please list your exercise program by activity and frequency (example – run 20 minutes, 4 times a week)

Please list any hobbies. (Example – sewing, painting, gardening, carpentry, auto repair)

Current Physical Activity Level: Little Moderate Very Active

Height: _____ **Weight:** _____

Patient Name: _____

Past Medical History:

Have you ever had

<u>Yes</u>	<u>No</u>	<u>Condition</u>	<u>When</u>	<u>If YES, please explain</u>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Wheezing	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Jaundice)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising/bleeding	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nerve Paralysis	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (seizures)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Nervous System issues	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Complicated pregnancy	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Smoking History	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Gastro intestinal	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	MRSA/VRE	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____	_____

Please list all surgeries and dates:

Have you had surgery specifically for your present pain? Yes No

If yes, please list:

<u>Operation</u>	<u>Hospital</u>	<u>Date</u>	<u>Surgeon</u>	<u>Results</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Patient Name: _____

Have you had any unusual reactions to anesthesia? If so, please describe:

Please list all hospitalizations and dates:

For your convenience, the area below can be used by you to write down any questions you might have for your doctor.

Disclaimer

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Smith will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Integrated Pain Specialists of Southern California, Inc.

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Disclosure of Beneficial Interest

“California Business and Professions Code Section 654.2 requires your physician to notify you when your physician, or someone in his or her immediate family, has a “significant beneficial interest,” as that term is defined under Section 654.2, in any organization to which your physician refers you for services.” We are providing this notice to inform you that Dr. Kevin Smith has a significant beneficial interest in Mission Valley Heights Surgery Center. Please be advised that you may choose any organization for the purpose of obtaining the services ordered or requested by your physician, and a list of such organizations can be obtained by the San Diego County Medical Society.