ST. LUKE'S MEDICAL GROUP

PATIENT DATA SHEET

Referred by _____ Primary Care Physician _____

Patient _____
(Last Name) *(First Name)* *(Middle Initial)*

Address _____ _____ _____
(City/State) *(Zip Code)*

Home Phone No. _____ Cell Phone No. _____ Work Phone No. _____
May we leave a message? Y N ***May we leave a message? Y N*** ***May we leave a message? Y N***

Date of Birth _____ Sex: M F Marital Status: Single Married Widowed Divorced Separated

SSN _____ Patient's Employer _____

Employment Status: Full Time Part Time Retired Unemployed Student Status: Full Time Part Time N/A

Emergency Contact Person _____ Phone No. _____ Rel. To Patient _____

Person Responsible for Balance _____ Responsible Party's Date of Birth _____

Responsible Party's Address _____ SSN: _____
(If different from patient's address)

Email Address _____

We are collecting email addresses for those patients that would like to use Patient Portal for our office to communicate with you via the Web. For more information, please ask at Check In/Out. This feature will be available in the near future.

Race: *(Please Circle)*

American Indian or Alaska Native
Asian
Native Hawaiian
Black or African America
White
Hispanic
Other Race
Other Pacific Islander
Unreported/Refused to Report

Ethnicity: Hispanic Non-Hispanic Refused to Report **Preferred Language:** _____

Pharmacy: ❑ St. Luke's Retail Pharmacy 314-205-6023

❑ Primary Pharmacy Name _____ Primary Pharmacy Telephone No. _____

INSURANCE INFORMATION (COPIES OF INSURANCE CARDS REQUIRED)

Primary Insurance _____ Effective Date _____

Name of Insured/Subscriber _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's I.D. No. _____ Group No. _____

Insured's SSN: _____ Insured's Home Address _____
(If different from patient's address)

Telephone No. _____ Insured Party Employed by _____

Employer's Address _____ Telephone No. _____

Secondary Insurance _____ Effective Date _____

Name of Insured/Subscriber _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's I.D. No. _____ Group No. _____

Insured's SSN: _____ Insured's Home Address _____
(If different from patient's address)

Telephone No. _____ Insured Party Employed by _____

Employer's Address _____ Telephone No. _____

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION: I hereby authorize this St. Luke's Medical Group physician to administer / perform any medical and or surgical procedure deemed necessary, and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to St. Luke's Medical Group, and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with care provided by any facility of St. Luke's Medical Group

Signature of Responsible Party _____ Date _____

Acknowledgement of Privacy Practice and Patient Rights

1. Patient Rights: A copy of my Patient Rights has been made available to me.
2. Notice of Privacy Practice: A copy of St. Luke's Hospital Notice of Privacy Practice has been made available to me.

_____ _____ _____
Signature of Patient (or Legal Guardian/Representative) **Date** **Relationship to Patient**

❑ Patient unwilling or unable to sign acknowledgement **Reason:** _____

Premier Pain Consultants

232 South Woods Mill Rd., Ste. 400East
Chesterfield, MO 63017
Phone: 314-205-6744 Fax: 314-590-5936

Procedure/ Injection Billing Information

Premier Pain Consultants understands that health care can be very expensive and accumulating bills can increase stress. We want to provide you with as much information as possible so that you can make an educated choice about where you choose to receive services and how those services will be paid. Premier Pain Consultants will attempt to verify and explain your insurance benefits. However, it is your responsibility to speak to your insurance company and understand your benefits. We are not able to confirm the accuracy of the benefits quoted by your insurance provider. Our explanation or quote of our benefits is NOT a guarantee of bill payment. We are only repeating benefit information that was provided to us by your insurance company representative. We strongly recommended that you speak directly with the insurance company to make sure that you completely understand your coverage and financial responsibility. Premier Pain Consultants may attempt to authorize your treatment with your insurance provider prior to your admission. This means that we will provide information to the insurance provider explaining the reason that treatment is needed. Insurance companies give criteria that they use to determine whether a condition meets "medical necessity" for them to pay for treatment. The insurance company may or may not agree to authorize treatment based on the information provided. You and/or your physician may believe that a specific type of treatment is needed but the insurance provider may disagree or refuse to authorize payment for treatment. If this happens, you can choose not to use your insurance, but you would be responsible for all bills associated with the unauthorized treatment. However, even if the insurance company authorizes treatment, authorization is NOT a guarantee of bill payment in full. Even if the insurance company authorizes treatment, they may later determine that there were insufficient benefits for treatment and not pay for the care.

Please be aware that all injections/procedures are performed in a hospital outpatient facility and are subject to any eligible charges by St. Luke's Hospital. You will need to check with your insurance to determine your level of coverage and benefits. As a patient at Premier Pain Consultants, you will recieve separate bills from the Physician and from the St. Luke's Hospital if you receive an injection/procedure in our procedure facility. ***Premier Pain Consultants submits bills for the physician and professional fees. St. Luke's Hospital submits bills for any eligible hospital and facility charges.*** Depending on your insurance you may not receive a bill at all, but instead recieve an explanation of benefits, which will outline what your insurance was charged and what was paid on your behalf.

I have read and understand the above information

Signed Date

If Dr. Rahimi and his staff determine you are a candidate for an injection, you have the option to be given conscious sedation with your injection. In order to receive conscious sedation, you CAN NOT **eat or drink for 6 hours prior to your appointment time**, and you **must have a driver present to sign you in and out.**

If you are **on a blood thinner**, such as Plavix, Clopidogrel, Coumadin, Warfarin, Heparin, Lovenox, Effient, Aggrenox, Pradaxa, Eliquis, or Xeralto, etc, please consult with Dr. Rahimi and his staff before stopping your blood thinner.

Premier Pain Consultants

232 South Woods Mill Rd., Ste. 400East
Chesterfield, MO 63017
Phone: 314-205-6744 Fax: 314-590-5936

Authorization for use and disclosure of Protected Health Information (PHI)

Patient Name: _____ Date of Treatment: _____-

Last 4 Digits of Social Security Number: _____ Date of Birth: _____

I hereby authorize: _____

To Release Information To: To Obtain Information From:

_____

Name of Facility/Individual: Name of Facility/Individual:
Premier Pain Consultants _____
Street Address Street Address
232 South Woods Mill Rd Ste;400East _____
City/State/Zip City/State/Zip
Chesterfield MO 63017 _____
Telephone / Fax Telephone /Fax
314-205-6744/314-590-5936 _____

I specifically authorize the use or disclosure of the following:

☐ Progress Notes ☐ History and Physical
☐ Photographs/Digital Imaging ☐Consultation Reports OR ☐ Complete Medical Record
☐ Laboratory Results ☐Discharge Summary

The Information to be used or disclosed pursuant to this authorization may include information relation to (1) AIDS or HIV ;(2) treatment of drug and alcohol use ;(3) mental/behavior/psychiatric care.

I may revoke this authorization in writing at any time. I understand that such revocation will not have any effect on the information already used or disclosed before receipt of my written notice of revocation. I may request to inspect or copy the information to be disclosed. Once release of this information is made to the above name/person/organization, my information may be subject to re-disclosure by the recipient. I may be charged fees for the copying of such information if I am requesting for myself or a third party. Such fees will comply with state and federal laws. I have read the above information and authorize disclosure of the identified information to the name/person/organization and for the purpose of described herein. I understand that by signing this document, I release and discharge the disclosing entity from any liability and will hold it harmless for any release made pursuant to the authorization.

Signature: _____ Date: _____

ST. LUKE'S MEDICAL GROUP

e-Prescribing and E-Messaging Consent

e-Prescribing Consent

ePrescibing is defined as a Physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that that ability to electronically send prescriptions is an important element in improving the quality of Patient care. ePrescribing greatly reduces medication errors and enhances Patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe Program. These include:

- ☑ Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- ☑ Medication history transactions – Provides the physician with information about medications the Patient is already taking to minimize the number of adverse drug events.
- ☑ Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the Patient's prescription has been picked up, not picked, or partially filled.

By signing this consent form you are agreeing that (Practice Name) can request and use your prescription medication history from other healthcare Providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to (Practice Name) to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: _____ Patient DOB: _____

Signature of Patient or Guardian: _____ Date: _____

Relationship to Patient: _____

E-Messaging Services

Please note: our Practice will now be sending notifications to our Patient's using an electronic reminder system through our Electronic Health Records. Please select the types of alerts you would like to receive and indicate how you would like to receive these alerts. (Via, Phone Call/Text Message)

Type of Patient Notification	Method of Communication	Preferred Time to Call	Preferred Language
❑Patient Appointments ❑Lab Results ❑Health Maintenance ❑RX Confirmation ❑General Notification	❑Home Phone ❑Work Phone ❑Cell Phone (Phone Call) ❑Cell Phone (Text MSG)	❑AM (6am-12pm) ❑Afternoon (12-4pm) ❑PM (4-9pm)	❑ English ❑ Spanish

Please list all individuals that we may communicate with regarding your medical information

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Patient Signature: _____ Date: _____

* P M C 2 0 0 1 *

Please complete all pages

Name: _____ Age: _____ Today's Date: _____

Name of the Doctor you are seeing today: _____

Primary Care Doctor's Name: _____ Phone number or FAX: _____

Name of referring Doctor: _____ Phone number or FAX: _____

Have you ever been seen at another pain clinic? If so,

a. When? _____

b. By whom? _____

Allergies to Medicines:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medications:

Drug	Dose	Frequency	Drug	Dose	Frequency

Are you on any blood thinners? ☐ Yes ☐ No

☐ Coumadin ☐ Heparin ☐ Plavix ☐ Lovenox ☐ Other _____

History of Present Illness

Chief complaint: (Describe your pain problem) _____

_____

_____

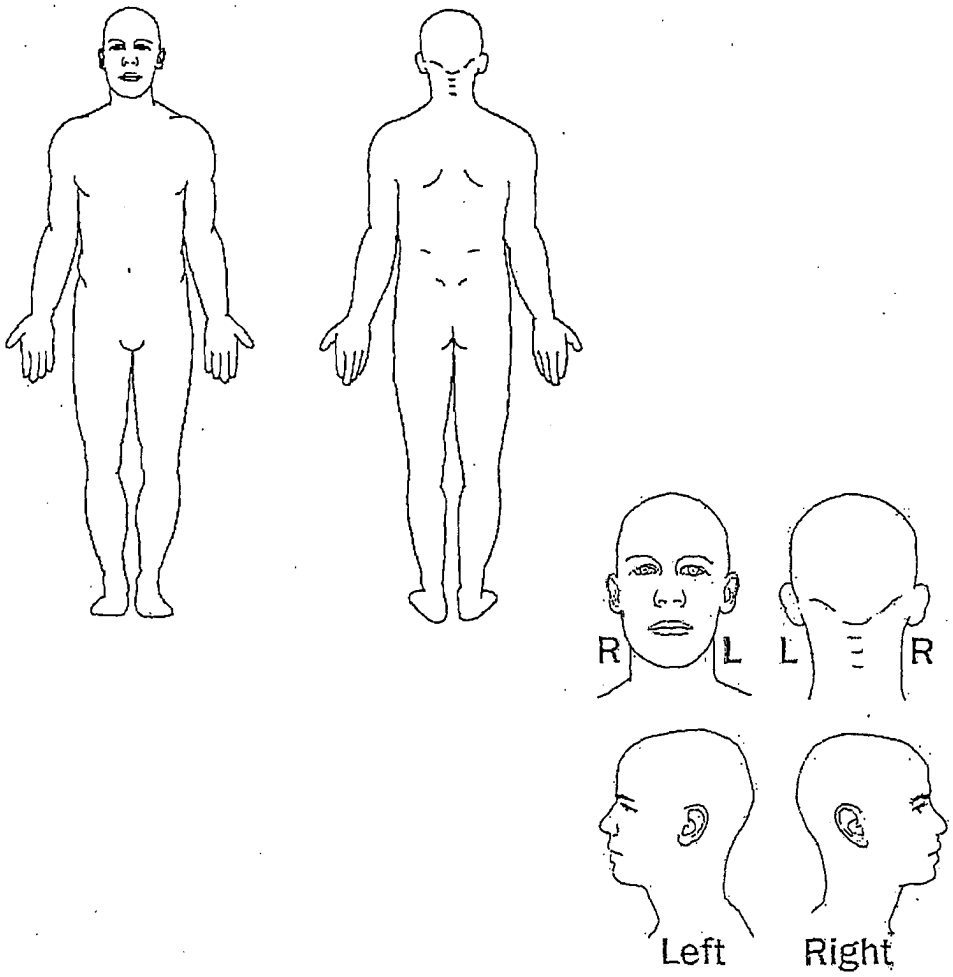
1. When did the pain first begin? _____ Years _____ Months _____ Weeks ago.
2. What caused the pain? _____
3. How did the pain come on at first? ☐ Gradually? ☐ Suddenly? ☐ Explosively?
4. Where on your body does the pain start? _____
5. Where does the pain seem to travel? _____

NEW PATIENT QUESTIONNAIRE

Pain Management Center

St. Luke's Hospital
232 So. Woods Mill Rd Chesterfield, MO 63017

Location of your pain:
Please use the figures below to shade in the area where you have pain. If your pain moves around, put an "X" where is starts and draw and arrow to where it spreads.



6. **Rate your pain intensity:** On a scale of 1 to 10, with "0" representing no pain, "1" respresenting a nuisance which would not interfere with daily activities (ie. toothache) while "10" would be the most sever pain imaginable (suicidal pain, having a baby or pain of a kidney stone), which number would describe your pain?

a. what is your pain like *today*?	0	1	2	3	4	5	6	7	8	9	10
b. what is your *least* pain?	0	1	2	3	4	5	6	7	8	9	10
c. what is your *worst* pain?	0	1	2	3	4	5	6	7	8	9	10
d. overall *average* pain?	0	1	2	3	4	5	6	7	8	9	10

St. Luke's Hospital
232 So. Woods Mill Rd Chesterfield, MO 63017

7. Which words best describe your pain? *(check all of the following that applies)*:

☐ shooting ☐ dull ☐ sharp ☐ burning
☐ throbbing ☐ aching ☐ electric shock

8. Which of the following best describes the quality of the pain? *(check all of the following that applies)*:

☐ severe ☐ moderate ☐ mild

9. Which words describe the timing of the pain? *(check all that applies)*:

☐ constant ☐ mostly in the morning ☐ mostly in the evening
☐ intermittent ☐ mostly in the afternoon ☐ very variable

10. As time goes on, is the pain getting:

☐ worse? ☐ about the same? ☐ better?

11. Which of the following symptoms is this pain associated with *(check all that applies)*:

☐ numbness ☐ weakness ☐ nausea/vomiting
☐ tingling ☐ headache ☐ bowel/bladder dysfunction

12. Which of the following make the pain worse? *(check all that applies)*:

☐ coughing ☐ sexual activity ☐ touch ☐ sneezing
☐ weather changes ☐ rolling in bed ☐ exercise ☐ bright lights
☐ moving from sitting to standing ☐ walking ☐ noise
☐ sitting ☐ cold ☐ taking stairs ☐ standing
☐ driving ☐ stress/fatigue ☐ lying down ☐ menstrual cycle

13. Which factors seem to relieve the pain? *(check all that applies)*:

☐ sitting ☐ sexual activity ☐ walking ☐ standing
☐ heat ☐ ice ☐ lying down ☐ massage
☐ relaxation ☐ alcoholic drinks ☐ medicines

14. Which of the following previous treatments have you tried? *(check all that applies)*:

☐ physical therapy ☐ cold therapy ☐ relaxation training ☐ chiropractic care
☐ bedrest ☐ occupational therapy ☐ acupuncture ☐ surgery
☐ cortisone injection ☐ biofeedback ☐ traction ☐ heat
☐ psychologist ☐ nerve blocks ☐ epidural steroid injection
☐ TENS unit ☐ trigger point injections ☐ Other: _____

15. Have you ever had any previous Physical Therapy? If so,

When: _____

Where: _____

16. List all the past medications you have taken for your pain problem:

_____

_____

_____

Past Medical History:

10. In your past, have you ever had any of the following health problems? *(check all that apply or write in).*

Cardiovascular:
☐ None ☐ Congestive heart failure ☐ High blood pressure
☐ Angina (chest pain) ☐ Heart attack
Other _____

Endocrine:
☐ None ☐ Diabetes ☐ Thyroid disease.
Other _____

Cancers:
☐ None ☐ Prostate ☐ Breast
☐ Skin
Other _____

Hematological:
☐ None ☐ Sickle cell
☐ Anemia
Other _____

Autoimmune:
☐ None ☐ Lupus ☐ Osteoarthritis
☐ TMJ ☐ Rheumatoid arthritis ☐ Fibromyalgia
Other _____

Renal:
☐ None ☐ Kidney infections ☐ Kidney stones
Other _____

Genitourinary:
☐ None ☐ Urinary incontinence
☐ Prostate problems ☐ Bladder infections
Other _____

Central nervous system:
☐ None ☐ Stroke ☐ Headaches
☐ Nerve damage ☐ Migraines
Other _____

Gastrointestinal:
☐ None ☐ Diverticulosis ☐ Peptic ulcer
☐ Reflux esophagitis ☐ Irritable bowel syndrome
Other _____

Pulmonary:
☐ None ☐ Chronic bronchitis
☐ Asthma ☐ Pneumonia
Other _____

Infectious disease:
☐ None ☐ Mononucleosis ☐ Hepatitis
Other _____

Psychiatric:
☐ None ☐ ECT treatments ☐ Depression
☐ Alcoholism ☐ Anxiety ☐ Drug addiction
☐ Panic attacks
Other _____

Past Surgical History:

18. Have you had any surgeries in the past? Please list *(even if they seem unrelated to your pain problem).*

Date	Procedure	Doctor	Facility

Family History:

19. How is the general health of your family? Please write in any serious health problems or diseases. Also, please indicate if any of your family has ever had similar pain problems as you. Please indicate if living or deceased.

Mother _____ Brother _____

Father _____ Sister _____

Social History:

Marital status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Are you pregnant or do you plan to become pregnant? ☐ Yes ☐ No

How many children do you have? _____ children

Who do you live with at home? _____

How far did you get in your education? _____ level

Describe your occupation status:

☐ Employed. What work do you do? _____

☐ Retired. What occupation did you have? _____

☐ Unemployed.

☐ Disabled. What was the cause of your disability? _____

☐ If married, describe spouse's occupation: _____

Are you being treated under Workmen's Compensation? ☐ Yes ☐ No

Are you currently receiving disability benefits? ☐ Yes ☐ No

Are you involved in legal action related to your pain problem or considering it in the future? ☐ Yes ☐ No

If yes, describe your current state of litigation: _____

_____

_____

_____

_____

Habits: *Please check or write in all that applies:*

Tobacco ☐ No Tobacco ☐ Currently smoking _____ packs/day ☐ Quit smoking for_____ years

Alcohol ☐ No alcohol ☐ Social consumption of alcohol_____beverages/day containing alcohol

Caffeine ☐ No Caffeine ☐ _____beverages/day containing caffeine

Exercise ☐ None ☐ Rarely ☐ Regularly

Drugs

Do you or have you ever used recreational drugs? ☐ No ☐ Yes

If yes, which drugs? _____

Have you ever had drug or alcohol dependency? ☐ No ☐ Yes

If yes, which drugs?_____

20. Have you had any of the following tests performed within the last 24 months?

Test	Date	Facility where it was tested	Results
Xray			
Cat scan			
MRI			
Laboratory			
EMG			
Myelogram			
Other			

Review of Systems:

21. Are you experiencing any of the following symptoms with regularity that is different than what you listed before? If so, *please check.*

General:
☐ weight
☐ appetite changes
☐ fever/chills
☐ disturbed sleeping habits

Eye:
☐ eye infections
☐ blurred vision
☐ double vision
☐ blindness

Psychiatric:
☐ depression
☐ mood swings
☐ anxiety

ENT:
☐ hearing loss
☐ dizziness
☐ hoarseness
☐ sore throat
☐ bloody nose
☐ sinusitis

Cardiac:
☐ chest pains
☐ heart murmur
☐ skipped beats

Genitourinary:
☐ bladder incontinence
☐ difficulty urinating

Endocrine:
☐ hot or cold flashes

Respiratory:
☐ cough
☐ coughing up blood
☐ wheezing
☐ shortness of breath
☐ difficulty in breathing with exertion

Gastrointestinal:
☐ constipation
☐ diarrhea
☐ bloody stools
☐ nausea/vomiting
☐ bowel incontinence

Hematological:
☐ easy bruisability
☐ difficulty in clotting the blood

Neurologic:
☐ headaches
☐ dizziness
☐ falling
☐ seizures
☐ numbness
☐ tremor

Skin:
☐ lacerations
☐ abrasions
☐ pustules
☐ nodules
☐ tumors
☐ breast changes

Oswestry Questionnaire

Could you please complete this questionnaire. It is designed to give us information as to how you pain has affected your ability to manage in everday life.

Please answer every section. Mark one box *only* in each section that most closely describes you

Mark one box only in each section that most closely describes your pain.

Section 1: Pain intensity

☐ 0. I have no pain at the moment
☐ 1. The pain is very mild at the moment
☐ 2. The pain is moderate at the moment
☐ 3. The pain is fairly severe at the moment
☐ 4. The pain is severe at the moment
☐ 5. The pain is the worst imaginable at the moment

Section 2: Personal care (washing, dressing, etc.)

☐ 0. I can look after myself normally without causing extra pain
☐ 1. I can look after myself normally but it is very painful
☐ 2. It is painful to look after myself and I am slow and careful
☐ 3. I need some help but manage most of my personal care
☐ 4. I need help everyday in most aspects of my personal care
☐ 5. I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

☐ 0. I can lift heavy weights without extra pain
☐ 1. I can lift heavy weights but it gives extra pain
☐ 2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned; for instance, on a table
☐ 3. Pain prevents me from lifting heavy object but I can manage light to medium weights if they are conveniently positioned; for instance, on a table
☐ 4. I can only lift light weights
☐ 5. I cannot lift or carry anything at all

Sections 4: Walking

☐ 0. Pain does not prevent me walking any distance
☐ 1. Pain prevents me walking more than 1 mile
☐ 2. Pain prevents me walking more than a quarter mile
☐ 3. Pain prevents me walking more than 100 yards
☐ 4. I can only walk using a stick or crutches
☐ 5. I am in bed most of the time and have to crawl to the toilet

Section 5: Sitting

☐ 0. I can sit in any chair as long as I like
☐ 1. I can sit in my favorite chair as long as I like
☐ 2. Pain prevents me from sitting more than 1 hour
☐ 3. Pain prevents me from sitting more than a half of an hour
☐ 4. Pain prevents me from sitting more than 10 minutes
☐ 5. Pain prevents me from sitting at all

Section 6: Standing

☐ 0. I can stand as long as I want without extra pain
☐ 1. I can stand as long as I want but it gives me extra pain
☐ 2. Pain prevents me from standing more than 1 hour
☐ 3. Pain prevents me from standing more than a half of an hour
☐ 4. Pain prevents me from standing more than 10 minutes
☐ 5. Pain prevents me from standing at all

Section 7: Sleeping

☐ 0. My sleep is never disturbed by pain
☐ 1. My sleep is occasionally disturbed by pain
☐ 2. Because of pain, I have less than 6 hours of sleep
☐ 3. Because of pain, I have less than 4 hours of sleep
☐ 4. Because of pain, I have less than 2 hours of sleep
☐ 5. Pain prevents me from sleeping at all

Section 8: Sex life

☐ 0. My sex life is normal and causes me no extra pain
☐ 1. My sex life is normal but causes some extra pain
☐ 2. My sex life is nearly normal but is very painful
☐ 3. My sex life is severely restricted by pain
☐ 4. My sex life is nearly absent because of pain
☐ 5. Pain prevents any sex life at all

Section 9: Social life

☐ 0. My social life is normal and causes me no extra pain
☐ 1. My social life is normal but increases the degree of pain
☐ 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg. sports, etc.
☐ 3. Pain has restricted my social life and I do not go out as often
☐ 4. Pain has restricted social life to my house
☐ 5. I have no social life because of pain

Section 10: Traveling

☐ 0. I can travel anywhere without pain
☐ 1. I can travel anywhere but it gives me extra pain
☐ 2. Pain is bad but I manage journeys over 2 hours
☐ 3. Pain restricts me to journeys of less than 1 hour
☐ 4. Pain restricts me to short necessary journeys under 30 minutes
☐ 5. Pain prevents me from traveling except to receive treatment

Patient Signature:_____ Date:_____ Time:_____