Buffalo Interventional Pain Management

Tel: 716-203-1110

Fax:716-217-6334

Please note that this is an interventional pain management practice, and we typically do not write prescriptions for opiates/ narcotics. We provide prescriptions for certain pain medications based on the patient's need.

PLEASE COMPLETE YOUR PATIENT INFORMATION PACKET BEFORE YOUR APPOINTMENT

ALL MEDICAL REPORTS NEED TO BE FAXED TO OUR OFFICE BY YOUR REFERRING DOCTOR BEFORE YOU CAN BE SEEN. LAST 3 VISIT NOTES AND/ OR PAIN MANAGEMENT NOTES AND YOUR MEDICATION LIST IS REQUIRED.

ALL AVAILABLE IMAGING E.G. MRI, X-RAY, CAT SCAN, EMG SHOULD BE FAXED TO OUR OFFICE. PLEASE BRING ANY IMAGING IF AVAILABLE ON THE CD.

IF WE DO NOT HAVE YOUR MEDICAL RECORDS, WE CANNOT WRITE ANY PRESCRIPTIONS.

BRING YOUR INSURANCE AND PHOTO ID. COPAY OR A PAYMENT (BASED ON YOUR VISIT TYPE) FOR A HIGH-DEDUCTIBLE PLAN WILL BE DUE AT THE TIME OF YOUR VISIT.

WE ONLY ACCEPT PAYMENTS BY CASH OR CREDIT CARDS.

THERE IS A $50 NO SHOW FEE FOR APPOINTMENTS NOT CANCELED AT LEAST 24 HOURS BEFORE THE APPOINTMENT TIME.

Buffalo Interventional Pain Management

Patient Information Sheet

Welcome to our Office. Bring completed form at the time of your visit or email to info@buffaloipm.com

***Attention*: Please fill out this form COMPLETELY, write N/A where applicable and sign it. Thank you.**

Social Security#

First Name: **Last Name:** **Middle Initial:**

Date of Birth: (MM/DD/YYYY) _____ / _____ / _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address: **Apt.#:** **City:** **State:** **Zip:**

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Emergency Contact:

Emergency Telephone#: (_____) _____

Employer Name: **Occupation:**

Ref Dr: **Ref Dr's Add / City / State / Zip** **Ref Dr Phone #**

Primary Care Physician: **PCP Add / City / State / Zip** **PCP Phone #**

Primary Insurance Company Information:

Policy Holder First Name:

Policy Holder Last Name:

Policy Holders SS# _____-_____-_____ **Policy Holders Date of Birth:** _____ / _____ / _____

Gender: ☐ Male ☐ Female

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: **State:** **Zip:**

Insurance Name:

Policy ID: **Group #:**

Claim Submission Address:

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____

Referral Required: ☐ **Yes** ☐ **No**

Secondary Insurance Company Information:

Policy First Name:

Policy Holder Last Name:

Policy Holders SS# _____-_____-_____ **Policy Holders Date of Birth:** _____ / _____ / _____

Gender: ☐ Male ☐ Female

Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Address: ☐ **Same as patient**

City: **State:** **Zip:**

Insurance Name:

Policy ID: **Group #:**

Claim Submission Address:

Effective Date: _____ / _____ / _____

Do you have a Co-pay? ☐ No ☐ Yes, Amt $_____

Referral Required: ☐ **Yes** ☐ **No**

Responsible Party Information – *Please complete if the responsible for payment is not the Patient or the Policy Holder.*

Responsible Party's Name (Last / First):

Responsible Party's SSN: _____-_____-_____

Relationship to Responsible Party: ☐Self ☐Spouse ☐Child ☐Other

Responsible Party's Address / City / State / Zip:

FINANCIAL POLICY

I hereby authorize the release of any medical information necessary to process this claim and hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that it is as a courtesy that the doctor accepts my insurance for payment and that if for any reason they do not pay my bill that I am responsible.

The Practice does not accept personal checks. All patients receive a reminder call for upcoming appointments. Failure to appear or call to cancel at least 24 hours prior to an appointment (no show) will result in a $50 fee.

By signing below, I acknowledge and agree to abide by this policy. I also acknowledge that I have been given the opportunity to review the Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices and I agree to comply with all of its terms.

Today's Date:_____ Patient's Signature (or parents if under 18 years of age):_____

NAME_____ DATE OF BIRTH_____ DATE_____

MEDICAL HISTORY

REASON FOR VISIT:
Chief complaint: _____

_____

_____

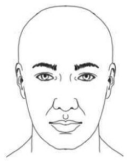
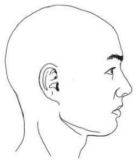
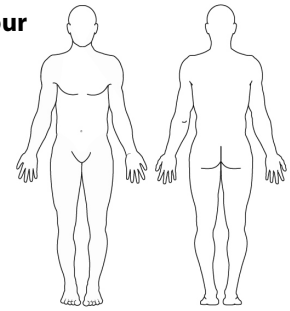
_____

_____

_____

PAIN DIAGRAM: Mark the picture where your symptoms are

Numbness	+++
Burning	XXX
Aching	===
Stabbing	/////
Pins/needles	000

Have you seen another physician for this condition/injury? YES NO If yes, where, when and whom? _____

_____

How bad is your pain? (circle) 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 (worst pain)

Duration? Less than 1 week ____ Less than 1 month _____ Less than 1 year _____ More than 1 year _____

What makes your pain better? _____

_____

What makes your pain worse? _____

_____

Which of the following treatments have you had:

Yes	No		Better	Worse	No change	
☐	☐	Physical therapy (Facility?_____)	☐	☐	☐	Lying down
☐	☐	Chiropractic (Facility?_____)	☐	☐	☐	Sitting
☐	☐	Traction/Spinal decompression (Facility?_____)	☐	☐	☐	Standing
☐	☐	Injections (Facility?_____)	☐	☐	☐	Walking
☐	☐	Orthopedic consult (Where?_____)	☐	☐	☐	Bending
☐	☐	Neurosurgical consult (Where?_____)	☐	☐	☐	Lifting
☐	☐	Surgery consult (Where?_____)	☐	☐	☐	Straining/coughing/sneezing

☐ ☐ Pain medication ☐ NSAIDs _____ ☐ Muscle relaxants _____
☐ Narcotics _____ ☐ Other _____

****LIST PREVIOUS SURGERIES**: _____

_____

Hysterectomy?	YES	NO	
Spinal cord stimulator?	YES	NO	
Intrathecal pump?	YES	NO	If yes, ☐ Morphine? ☐ Baclofen?
Metal implants?	YES	NO	Location _____
Pacemaker/AICD?	YES	NO	

PERSONAL HISTORY:

Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Hypertension	☐	☐	Ulcer/GI Bleed
☐	☐	High Cholesterol	☐	☐	Lung Disease/Asthma
☐	☐	Heart Disease	☐	☐	Cancer
☐	☐	Heart Attack	☐	☐	Hepatitis
☐	☐	Heart Surgery	☐	☐	Kidney Disease/Dialysis
☐	☐	Cardiac Angioplasty/Stent	☐	☐	Osteoarthritis/Rheumatoid
		(When? _____)	☐	☐	Aneurysm
☐	☐	Atrial Fibrillation	☐	☐	Other _____

FAMILY HISTORY:

Father	Mother	Brother	Sister	Son	Daughter	
☐	☐	☐	☐	☐	☐	**Diabetes**?
☐	☐	☐	☐	☐	☐	**Stroke**?
☐	☐	☐	☐	☐	☐	**Heart Disease**?
☐	☐	☐	☐	☐	☐	**Cancer**?
☐	☐	☐	☐	☐	☐	**Brain Tumor**?
☐	☐	☐	☐	☐	☐	**Aneurysm - brain**?
☐	☐	☐	☐	☐	☐	**Aneurysm - other**?

Patient's Signature (or parents if under 18 years of age): _____

NAME_____ DATE OF BIRTH_____ DATE_____

MEDICATIONS

Please include prescriptions, over-the-counter medications, and vitamins. (Or provide a list to be photocopied):

Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____
Name:_____	Dosage:_____	Frequency:_____

Preferred Pharmacy:_____ **Pharmacy phone** #:_____

ALLERGIES

Any allergies or adverse reactions to the following? (please list type of reaction)

Drug Allergy? YES NO (Provide details) _____
Food Allergy? YES NO (Provide details) _____
Latex Allergy? YES NO (Provide details) _____
Dye Allergy? YES NO (Provide details) _____
Any Other Allergy? YES NO (Provide details) _____

SOCIAL HISTORY

Your Occupation_____

Do you smoke?	Y N	How many packs/day? _____
Did you smoke previously?	Y N	Packs/day? _____ How many years? ____
Do you drink alcohol?	Y N	If so, how much? _____ How often? _____

REVIEW OF SYSTEMS (Circle any problems you are currently having)

CONSTITUTIONAL……	fever, weight loss, weakness, fatigue
SKIN……..	dry skin, excessive sweating, itching, sores, rashes, color change
HEMATOLOGICAL……	swollen glands, easy bruising, previous blood transfusion
HEENT……	headaches, sinus problems, allergies, nosebleeds, visual or hearing problems, wear contacts or glasses, gum disease, problems with teeth, sleep apnea, snoring
CHEST/RESPIRATORY……	cough, shortness of breath, wheezing, bronchitis, pneumonia,
CARDIOVASCULAR……	heart trouble, chest pain/angina, swelling of legs/feet, irregular Heartbeat
ABDOMINAL……	Liver disease, hepatitis, jaundice, gallbladder problems, irritable bowel syndrome, colitis, polyps, diverticulitis, heartburn, peptic ulcer, diarrhea, constipation, dark stools
GENITOURINARY……	kidney stones, kidney disease, bladder dysfunction, pain with urination, blood in urine, ovarian cysts, uterine fibroids, hernia
ENDOCRINE……..	thyroid problems, hormonal changes, diabetes, excessive thirst, recent weight loss or gain, heat or cold intolerance
MUSCULOSKELETAL……	neck or low back pain, arthritis, joint pain, muscle pain, stiffness, hip, shoulder or knee problems, carpal tunnel
NEUROLOGICAL……..	seizures, fainting spells, blackouts, weakness, dizziness, tremors, gait problems, memory problems, neuropathy, depression, anxiety

Patient's Signature (or parents if under 18 years of age): _____