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.

Our patient base is built through referrals from healthcare professionals, our Online presence, and word-of-mouth recommendations. We do not engage in any form of patient solicitation.

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_____

Comprehensive Pain Assessment Form

Individual's Pain Control Goal	Individuals Pain Intensity Goal
☐ Sleep comfortably ☐ Comfort at rest ☐ Comfort with movement ☐ Total pain control ☐ Stay alert ☐ Perform desired activities ☐ Other:_____	0 1 2 3 4 5 6 7 8 9 10 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ (Check the correct rating)

Chief Complaint: _____

_____

Is this No Fault Injury: YES NO
Date of Injury: _____
Claim Number: _____
Describe the Incident: _____

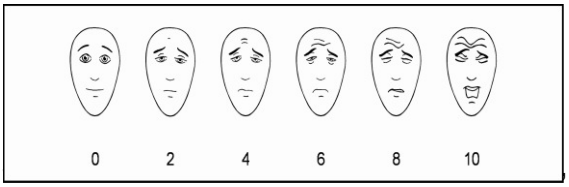
_____

Intensity of Pain: Scale Used

☐**Numerical 0-10** (circle the correct rating)

0 1 2 3 4 5 6 7 8 9 10
↑ ↑ ↑
No Pain Moderate Pain Worst Possible Pain

☐**Faces Pain Scale-Revised**



counting left to right with 0= "no pain" and 10 the intensity of your pain now.

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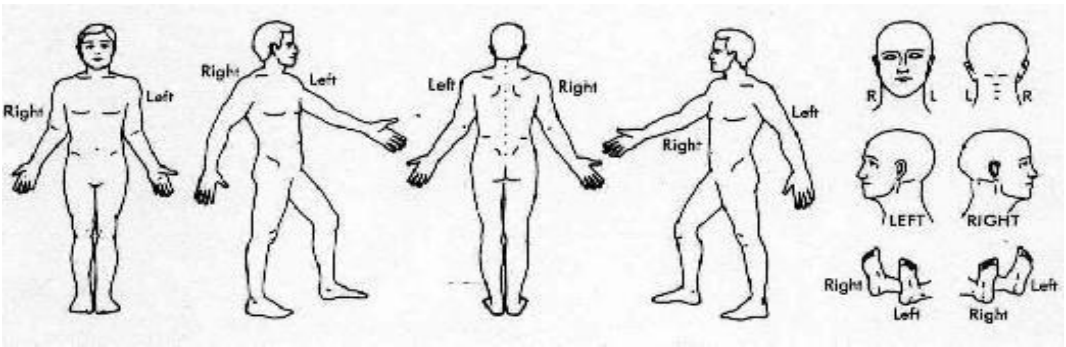
☐**Verbal Descriptor Scale**
Circle the words that best represent "worst pain possible".

No pain Mild pain Moderate pain Severe pain Extreme pain Pain as bad as could be

Location: (Individual or nurse mark drawing) Mark on the areas where you feel pain. If you feel more than one sensation in the same area, mark over that area with all the symbols that apply. Make sure you show all affected areas.

O Aching
/ Burning
 # Cramping
= Crushing
◆ Dull
*** Numbness**
+ Pins/needles
● Sharp
↓ Stabbing
↑ Throbbing



NAME_____ DATE OF BIRTH_____ DATE_____

History of Pain

Onset of Pain: ☐New (last 7 days) ☐Recent (last 3 mos.) ☐More distant (> 3 mos.) ☐Unknown

Frequency of Pain: ☐Constant ☐Frequent ☐Infrequent ☐ Unknown

Description of Pain: ☐Aching ☐Burning ☐Cramping ☐Crushing ☐Dull ☐Numbness

☐Pins & Needles ☐Sharp ☐Shooting ☐Throbbing ☐Other: _____

Change in Pattern of Pain: Has the pain changed in description or intensity the last 7 days?

☐ Yes ☐No ☐Unknown If yes, describe the change: _____

Causes/Increases in Pain: ☐Movement ☐Coughing ☐Cold ☐Heat ☐Fatigue ☐Anxiety
☐Other, describe: _____

What Relieves the Pain: ☐Cold ☐Heat ☐Exercise ☐Eating ☐ Opioids ☐Non-Opioid Meds
☐Adjuvants ☐Herbals ☐Massage ☐Relaxation ☐Rest ☐Repositioning ☐Distraction
☐ Other: _____

Effects of Pain: Using the following scale, rate how the pain has had an effect in each area in the past 24 hours: **0** (no effect) **2** (mild effect) **5** (moderate effect) **10** (severe effect)

Accompanying Symptoms (e.g., nausea)____Sleep Disturbance_____Appetite Change _____
Physical Activity Change____ Mood/Behavior____ Concentration____Relationship with Others_____ Other (describe): _____

Prior Pain Consults:

Neurosurgery Consult (Where/ When)? _____

Orthopedic Consult (Where/ When)? _____

Prior Pain Treatments:

Physical Therapy (Where/ When/ Length of Treatment)? _____

Chiropractic Therapy (Where/ When/ Length of Treatment)? _____

Pain Injections (Where/ When/ Type of Injection)? _____

List of Failed Pain Medications _____

Spinal Cord Stimulator/ DRG Implant (Where/ When)? _____

Intrathecal pump Implant (Where/ When)? _____

Surgical History:

AICD or Pacemaker Implant (Where/ When)? _____

Any Other Surgery or Implant (Provide Details)?

_____

NAME_____ DATE OF BIRTH_____ DATE_____

MEDICAL HISTORY

Please circle Yes or No to indicate if you have had any of the following:

AIDS/HIV	Y N	Depression	Y N	Liver Disease	Y N
Anemia	Y N	Diabetes	Y N	Low Blood Pressure	Y N
Anxiety	Y N	Type____ How long_____		Mental Illness	Y N
Arthritis	Y N	Emphysema	Y N	Neuropathy	Y N
Type_____		Eye Problems	Y N	Pacemaker	Y N
Artificial Heart Valve	Y N	Fibromyalgia	Y N	Paralysis	Y N
Artificial Joint	Y N	Foot Cramps	Y N	Phlebitis	Y N
Asthma	Y N	Gastric Reflux	Y N	Psoriasis	Y N
Back Problems	Y N	Gout	Y N	Rheumatic Fever	Y N
Bleeding Disorder	Y N	Headaches	Y N	Schizophrenia	Y N
Bipolar Disorder	Y N	Heart Attack	Y N	Shortness of Breath	Y N
Blood Clot/DVT	Y N	Heart Murmur	Y N	Stroke	Y N
Bypass Surgery	Y N	Heart Failure	Y N	Thyroid Problems	Y N
Cancer	Y N	Hemophilia	Y N	Type_____	
Type_____		Hepatitis	Y N	Tuberculosis	Y N
Chemical Dependency	Y N	High Blood Pressure	Y N	Ulcers (Stomach)	Y N
Chest Pain	Y N	Kidney Problems	Y N	Varicose Veins	Y N
Circulatory Problems	Y N	Leg Cramps	Y N	Wt Loss, unexplained	Y N

WOMEN, are you…..Pregnant? Y N Breastfeeding? Y N

FAMILY HISTORY

Family history (mother, father, grandparents, or siblings) of:WHO?

Heart Disease……	Y N	_____
Diabetes……	Y N	_____
High Blood Pressure……	Y N	_____
Stroke……	Y N	_____
Varicose Veins……	Y N	_____
Gout……	Y N	_____
Arthritis……	Y N	_____
Neuropathy……	Y N	_____
Bleeding Disorder……	Y N	_____
Foot Problems……	Y N	_____

SOCIAL HISTORY

Your Occupation_____

Employment Status (Circle One): **FULL-TIME** **PART-TIME** **HOMEMAKER/ UNEMPLOYED** **DISABLED**

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? _____

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)

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

_____

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

HOW DID YOU HEAR ABOUT US?

SOCIAL MEDIA (e.g. Facebook) ☐ **SEARCH ENGINE (e.g.. Google)** ☐ **WORD OF MOUTH** ☐

REFERRED BY (PHYSICIAN NAME) _____ **OTHER (SPECIFY)** _____