Providence
St. Jude Heritage Medical Group

LABEL

Pain Management
100 E. Valencia Mesa Dr.
Suite 310
Fullerton, CA 92835
714-446-5200
providence.org

DO NOT MAIL IN FORMS – PLEASE BRING THEM WITH YOU TO YOUR APPOINTMENT

Thank you for choosing Providence St. Jude Heritage Medical Group – Pain Management as your health care provider.

Before visiting the clinic, you will be asked to obtain a referral from your primary care physician or specialist. Your HMO health care insurance company may require prior authorization, or your PPO insurance plan may require pre-certification to ensure coverage for our services.

Please let our staff know if you have had any demographic or coverage changes since your last appointment. Insurance cards must be provided at every visit. You will be asked to fill out new registration forms annually so we may update your information.

Copayments, deductibles and past due balances

All copayments and past due balances are due at time of service, unless a prior agreement has been made with our billing department. Patients' insurance plan benefits that include an annual deductible will be asked to make a payment towards their unmet deductible at the time of service. A $60.00 deductible will be collected for a visit with a provider. We understand you may be accustomed to paying the deductible at a later date, which is why we are sharing this information with you now, so you can be prepared to make a payment towards your deductible at your next office visit.

Parking

Patient and visitor parking is available at a cost. Valet parking is available at the front of the building, as well as additional parking behind the building in the multistoried parking structure. We do not validate for any visits.

What to bring

- Insurance card(s)
- New patient packet
- Driver's license

Getting here

100 E. Valencia Mesa Drive
Suite 310
Fullerton, CA 92835
Phone: 714-446-5200
Fax: 714-446-5476
Hours: Mon-Fri 0800-1700

Appointment information

Provider: _____

Appointment Date/Time: _____ Check-in Time: _____

Special instructions: _____

Please have your paperwork filled out prior to your appointment. We ask all patients to arrive early for adequate check-in process.

CA Assembly Bill 1278 requires physicians and their employers to provide patients with notices about the Open Payments database starting January 1, 2023.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

I have read the above notice for the Open Payments database. By signing this document, I certify that I am aware of the Open Payments database.

Signature: (*Patient, Legal Representative*)_____

Date:_____ Time:_____

If signed by other than patient, indicate relationship: _____

Witness Signature:_____

Date:_____ Time:_____

(12/13/22)

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OPEN PAYMENTS DATABASE NOTICE

Patient Name: _____

DOB: _____

MRN#: _____

Date of Service: _____

Providence
Medical Group

Pain Management Department
100 E. Valencia Mesa Drive, Suite 310
Fullerton, Ca 92835
P: 714-446-5200
providence.org

Introduction to Advance Health Care Directives

California law gives you the ability to ensure that your health care wishes are known and considered if you become unable to make these decisions yourself.

What is an Advance Health Care Directive?

An Advance Health Care Directive is the best way to make sure that your health care wishes are known and considered if for any reason you are unable to speak for yourself. Completing a form called an "Advanced Health Care Directive" allows you, under California law, to do either one or both of the following things:

First, you may appoint another person to be your health care "agent". This person (who may also be known as your "attorney-in-fact" will have legal authority to make decisions about your medical care if you become unable to make these decisions for yourself.

Second, you may write down your health care wishes in the Advance Health Care Directive form. For example, a desire not to receive treatment that only prolongs the dying process if you are terminally ill. Your doctor and your agent must follow your lawful instructions.

The booklet "Finding Your Way" is a useful guide to help with thinking about and discussing these issues. To receive a copy, send $1.50 to CAHHS, Sales Center, P.O. Box 340100, Sacramento, CA 95834. You can also view the booklet at www.sachealthdecisions.org.

For more information about end-of-life medical decisions, go to www.finalchoices.calhealth.org, the website for the California Coalition for Compassionate care or www.sachealthdecisions.org the website for Sacramento Healthcare Decisions. You may also call the Partnership for Caring at 800-989-9455 to receive forms and general information.

_____ _____

Patient Signature Date

New Patient Assessment Form

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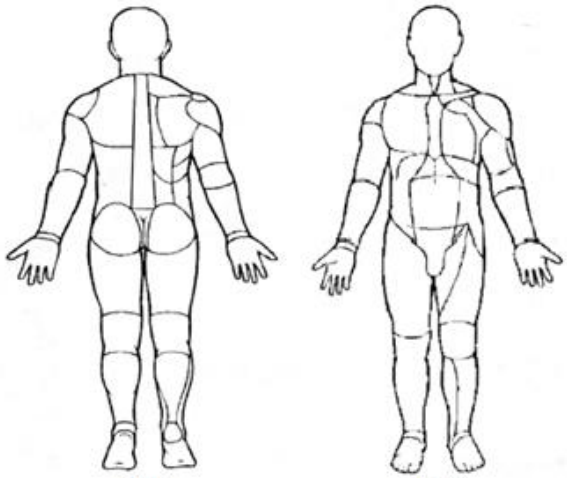
Place an "X" on the figure where your pain starts and show where it goes with an arrow:



Where is your pain? _____

When did it start? _____

Frequency of pain: Constant or Intermittent

Rate your pain on a scale from 0-10, with 10 being the worst imaginable pain and 0 being no pain:

Worst: _____

Best: _____

Average: _____

Description of pain: *(Circle all that apply)*

Sharp	Stabbing	Burning	Shooting	Dull	Deep
Aching	Throbbing	Tight	Pulling	Cramping	Heavy

What makes your pain worse? *(Circle all that apply)*

Bending	Sitting	Standing	Walking	Lying down	Lifting
Stairs	Coughing	Sneezing	Defecation	Sexual intercourse	

What makes your pain better? *(Circle all that apply)*

Heat	Ice	Rest	Sitting	Lying down	Massage
Exercise	TENS	Traction	Medication(s): _____		

Do you have any associated symptoms? *(Circle all that apply)*

Arm weakness	Leg weakness	Numbness/tingling	Bowel/bladder change
Dizziness	Incoordination	Insomnia	Depression
Nighttime pain	Night sweats	Unintentional weight loss	

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What have you tried previously? *(Circle all that apply)*

Physical Therapy	Chiropractic care	Acupuncture	Massage	Heat/ice
Cognitive Behavioral Therapy		Biofeedback	Other: _____	

What tests have you had for your pain? *(Circle all that apply)*

X-ray	CT scan	MRI	EMG/NCV	Myelogram

Have you had any injections or surgery for your pain? If yes, please describe.

_____

_____

Which of the following medications have you taken prior to your arrival here today?

- ☐ Tylenol®/acetaminophen
- ☐ Muscle relaxants/Flexaril®
- ☐ By mouth: Steroids/Medrol® dose pack
- ☐ Non-steroidal anti-inflammatory agents/NSAIDs/Motrin®/Ibuprofen®
- ☐ Amitriptyline®/Nortriptyline®/Prozac®/Cymbalta/Effexor
- ☐ Morphine/Methadone®/Percocet®/Norco
- ☐ Tegretol®/Neurontin®/Topamax®/Lyrica

Have you taken any of the following to treat your pain?

- ☐ Marijuana/CBD
- ☐ Xanax®
- ☐ Ativan®
- ☐ Valium®

Medications you take:

Medication	Dosage (mg)	How often?

Any allergies? _____ If yes, reaction(s): _____

Past Medical History: *(List all medical problems)*

_____

_____

Past Surgical History: *(List all surgeries and dates)*

_____

_____

Social History:

Occupation: _____

Tobacco Use: *(Type, frequency)* _____

Alcohol Use: If yes, type: _____ # Drinks per week: _____

Recreational Drug Use: *(Type, frequency)* _____

Family History:

Mother:	☐ Living	☐ Deceased	Age: _____	Health issues: _____
Father:	☐ Living	☐ Deceased	Age: _____	Health issues: _____
Brother(s):	☐ Living	☐ Deceased	Age(s): ____	Health issues: _____
Sister(s):	☐ Living	☐ Deceased	Age(s): ____	Health issues: _____

Review of Systems *(Check all that apply)*

Constitutional	**Cardiovascular**	**Genitourinary**	**Neurologic**
☐ Fever ☐ Weight loss ☐ Fatigue	☐ Chest pain ☐ Light headedness ☐ Palpitations ☐ Limb swelling ☐ Shortness of breath ☐ Fainting	☐ Incontinence ☐ Painful urination ☐ Blood in urine	☐ Weak arms/legs ☐ Numbness/tingling ☐ Headache ☐ Seizures ☐ Trouble concentrating ☐ Memory loss
EYES	**Respiratory**	**Musculoskeletal**	**Psychiatric**
☐ Blurry vision ☐ Double vision ☐ Loss of vision ☐ Eye pain ☐ Eye redness ☐ Eye dryness	☐ Trouble breathing ☐ Coughing blood ☐ Cough	☐ Back pain ☐ Neck pain ☐ Muscle pain ☐ Joint pain ☐ Muscle spasm ☐ Weakness	☐ Depression ☐ Suicidal thoughts ☐ Hallucinations
ENT	**Gastrointestinal**	**Skin**	**Hematologic**
☐ Trouble hearing ☐ Ringing ☐ Dizziness ☐ Imbalance ☐ Ear pain ☐ Ear discharge	☐ Abdominal pain ☐ Nausea/vomiting ☐ Diarrhea ☐ Constipation ☐ Bloody stools	☐ Rash/redness ☐ Sweating change ☐ Discoloration	☐ Night sweats ☐ Abnormal bleeding ☐ Easy bleeding
Endocrine ☐ Frequent urination ☐ Heat/cold intolerance ☐ Excessive thirst			

Person completing this form: _____ Relationship to patient: _____

Patient signature: _____ Date: _____

Reviewed by physician (Signature): _____

Date: _____

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