

PATIENT INFORMATION

SSN _____ Age _____ DOB _____ SEX M/F MARITAL STATUS S/M/D/W
LAST NAME _____ FIRST NAME _____ MI _____ SUFFIX _____
ADDRESS _____ CITY _____
STATE _____ ZIP _____ HOME PHONE _____ WORK PHONE _____
EMERGENCY/NEXT OF KIN: _____ PHONE _____
REFERRING PHYSICIAN _____

RELATED TO AN ACCIDENT? **Yes** No ACC DATE _____
AUTO ACC? Y/N WORKERS COMP ACC? Y/N OTHER TYPE OF ACC? _____

PRIMARY INSURANCE COMPANY (HMO, PPO, OR MEDICAL COVREGE FROM AUTO)

Insured Name (if different from above) _____
Insured DOB _____ SSN _____
Insurance Company Name _____ Phone _____
Contact/ Adjuster _____ Date of Loss _____
Claim # _____ Policy # _____

SECONDARY INSURANCE COMPANY (MOTOR VEHICLE) the other driver's

Insurance Company Name _____
Contact/ Adjuster _____ Date of Lose _____
Claim # _____ Policy # _____

WORK INJURY INSURANCE INFORMATION

Insurance Company Name _____
Contact/ Adjuster _____ Date of Lose _____
Claim # _____ Policy # _____

GUARANTOR

SSN _____ DOB _____ SEX _____
LAST NAME _____ FIRST NAME _____ MI _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ PHONE _____

MEDICARE PATIENTS ONLY

I certify that the information printed above is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf of the treating physician(s) for any services furnished by the physician(s). I authorize any holder of medical information about me, to release to the Center for Medicare Services and its agents any information needed to determine these benefits payable for related services.

PATIENT SIGNATURE _____ DATE _____

ALL OTHER PATIENTS WHEN WE FILE INSURANCE

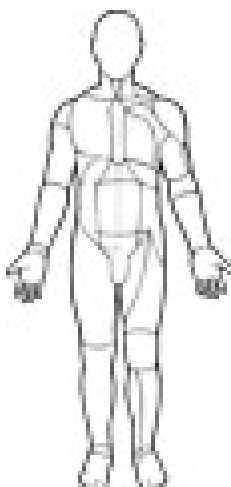
I certify that the information printed above is correct. I request that this facility file claims on my behalf to the insurance company(ies) listed above for any services furnished to me by physician(s). I authorize this facility to release to the listed insurance company(ies) and its agents any information needed to determine those benefits payable for related services. I acknowledge that I am personally responsible for any portion of that bill not paid by my insurance to include copays, coinsurance, deductibles or any other reason for payment denial stated by my insurance. I understand that it is my responsibility to resolve disputes over payment with my insurance company.

PATIENT SIGNATURE _____ DATE _____

Patient Pain Form

Using the symbols listed below, mark on the two drawings below which areas on your body where you feel the described sensations:

- Numbness = = =
- Dull Ache o o o
- Hot Burning x x x
- Sharp Stabbing ///
- Pins and Needles + + +
- Other _____
- _____



How often are you aware of your pain?

- Constant = 76-100% of the time you are awake?
- Frequent = 51-75% of the time you are awake?
- Intermittent = 26-50% of the time you are awake?
- Occasional = 1-25% of the time you are awake?

ACKERMAN FUNCTIONAL PAIN ASSESSMENT SCALE

Please circle on the line below the level or intensity of pain you are presently experiencing:

(*Use the Key Below to rate your level of Pain)

Absolutely pain free -----Worse Pain You Could Ever Have
0 1 2 3 4 5 6 7 8 9 10

- * 0 = NO PAIN
- 1-2 = Annoying pain, forgotten during activities of daily living
- 3-4 = Pain that interferes with some activities of daily living
- 5-6 = Pain that prevents some activities of daily living
- 7-8 = Pain that prevents most activities of daily living
- 9 = The most severe pain you can withstand, but you know or believe it is only temporary
- 10 = Also the most severe pain that you can withstand, however you don't know or believe it will go away

Activities of daily living include; bathing, grooming, dressing, eating, eliminating, self-care, personal hygiene, hearing, speaking, reading writing, using a keyboard, physical activities such as standing, sitting, reclining, walking, stooping, squatting, kneeling, reaching, bending, twisting, leaning, carrying, lifting, pushing, pulling, climbing, exercising, seeing, tasting, smelling, touching, grasping, holding, pinching, percussive movements, sensory discrimination, riding, driving, traveling by airplane, train or car, participating in desired sexual activity, having a restful sleep pattern, participating in individual or group activities, sports or hobbies.

Signature: _____ Date: _____