Ventura Orthopedics

Pain Management Patient Demographic

☐ New Patient ☐ Return Patient ☐ Update | Account #: _____ | Physician: _____

Last Name _____ First Name _____ MI: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ ☐ OK to Leave Msg. Cell Phone _____ ☐ OK to Leave Msg.

Work Phone _____ ☐ OK to Leave Msg. Email _____

Do you prefer to receive reminder messages in the: ☐ Morning ☐ Afternoon ☐ Evening

Do you prefer: ☐ Voice Message ☐ Text Message ☐ ***If you would like to make special arrangements regarding how we should contact you please see a staff member.***

Family Physician _____ Address _____

Referring Provider _____ Address _____

DOB _____ Marital Status _____ Sex: ☐ M ☐ F Social Security # _____

Employer _____ Address _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Subscriber/Policy Holder Name _____ Subscriber/Policy Holder Name _____

Birth Date _____ Birth Date _____

Relationship to Patient _____ Relationship to Patient _____

Social Security # _____ Social Security # _____

ID # _____ Group # _____ ID # _____ Group # _____

If Patient is a Minor

Student Status: ☐ Full Time ☐ Part Time

Father's Name _____ Mother's Name _____

DOB _____ DOB _____

Work Phone _____ Work Phone _____

Injury Information

Date of Onset _____ Area of Pain _____

Injury? ☐ Yes ☐ No If Yes, ☐ Auto ☐ Work ☐ Other _____

How Did Injury Occur _____

Race: ☐ Hispanic ☐ White ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Other _____ ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other _____ ☐ Refuse to Report

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Japanese ☐ Other _____

Do you need an interpreter present during your examination? ☐ Yes ☐ No

Each Patient (Or Responsible Party) is Financially Responsible for Services rendered. While we are pleased to assist in the preparation of Insurance Forms, the obligation for payment of our fees remains that of the patient. I hereby authorize payment to Ventura Orthopedics for Medical Services rendered. I authorize the release of any information required in the course of my examination or treatment.

_____ Responsible Party Name (Please Print)

_____ Signature of Responsible Party

_____ Date

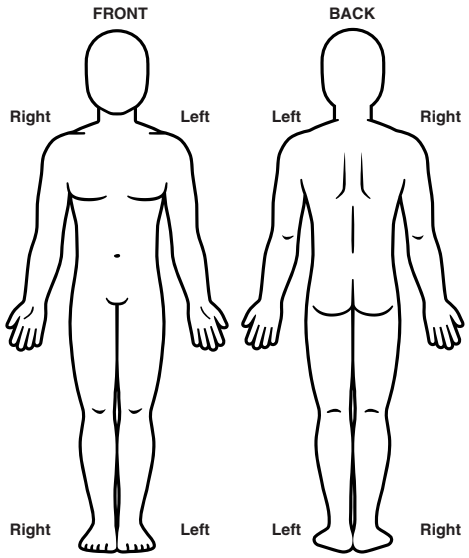
OFFICE USE ONLY

Vitals _____

Patient Name _____ Date _____

Date of Birth _____ Height _____ Weight _____

Referring Physician _____ Primary Care Physician _____



On the diagram at left, mark the area where you feel pain or sensation.

On the scale below, place an X next to your pain level (10 + worst pain)

0 **5** **10**

How much of your total pain is:

Neck or back pain _____ %

Arm or leg pain (including hip/buttocks) _____ %

Total 100 %

I. Did another doctor send you to this office for evaluation? ☐ Yes ☐ No

If yes, who referred you: _____

II. Problem involves my: ☐ Neck ☐ Back

Problem radiates to my: ☐ Right ☐ Left ☐ Shoulder ☐ Arm ☐ Hand

☐ Fingers ☐ Hip ☐ Thigh ☐ Leg ☐ Foot ☐ Knee ☐ Toes

III. Was there an injury which resulted in your symptoms? ☐ Yes ☐ No Date of injury: _____

Is the injury work related? ☐ Yes ☐ No If yes, type of work: _____

IV. Please give an approximate time (date, month, or year) when the symptoms began: _____

V. Have you sought medical treatment for this problem prior to this visit? ☐ Yes ☐ No

If so, where: ☐ Emergency Room ☐ Urgent Care ☐ Physician's Office ☐ Other

Name of care provider and/or facility who treated you: _____

What treatment was given? ☐ Physical Therapy ☐ Injections

What medication was given? ☐ Narcotic *(Vicodin, Codeine, etc.)* ☐ Anti-inflammatory medication *(Advil, Motrin, etc.)*

☐ Muscle relaxers *(Flexeril, Soma, etc.)* ☐ Steroids *(Medrol Dosepak, etc.)*

VII. Have you had any studies of the **involved area** within the **past year?**

☐ X-Rays ☐ CT/CAT Scan ☐ MRI ☐ Myelogram ☐ Discogram

Have you had surgery on this body part? ☐ Yes ☐ No

If yes, please describe: _____

Have you had symptoms or an injury to this area before? ☐ Yes ☐ No

If yes, please describe: _____

Does the pain keep you up at night? ☐ Yes ☐ No

How far can you walk (in miles or blocks)? _____

Medical History

☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Cancer

☐ Other: _____

Social History

Tobacco Use: Are you a... ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

If a smoker, how long have you smoked? ☐ <1 year ☐ 1-10 years ☐ 10+ years

How many cigarette packs per day? ☐ <1 pack ☐ 1-2 packs ☐ 3+ packs

If you used cigarettes in the past, but no longer smoke, when did you quit smoking?_____

Do you drink alcohol regularly? ☐ Yes ☐ No

How many drinks per week? ☐ <4 drinks ☐ 5-9 drinks ☐ 10+ drinks

Have you used or do you use other drugs? ☐ None ☐ Street Drugs ☐ Steroids ☐ Other _____

Level of education completed: ☐ Elementary ☐ High School ☐ College ☐ Graduate

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: _____

Family History

Mother	☐ Alive	☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Unknown
Father	☐ Alive	☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Unknown
Siblings	☐ Alive	☐ Deceased	☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Unknown

Pregnancy

If you are a Female between the age of 10-65, are you pregnant? ☐ Yes ☐ No

Allergies

Are you allergic to any medications? ☐ Yes ☐ No Please List:_____

Review of Systems: Are you experiencing any of these issues now?

General	Fever	☐ Yes	☐ No	Night Sweats/Chills	☐ Yes	☐ No
Eyes	Cataracts	☐ Yes	☐ No	Double Vision	☐ Yes	☐ No
Head/Neck	Sinusitis	☐ Yes	☐ No	Sore Throat	☐ Yes	☐ No
Heart	Chest Pain	☐ Yes	☐ No	Irregular Heart Beats	☐ Yes	☐ No
	High Blood Pressure	☐ Yes	☐ No			
Lungs	Shortness of Breath	☐ Yes	☐ No	Sputum Production	☐ Yes	☐ No
Abdominal	Heartburn	☐ Yes	☐ No	Nausea & Vomiting	☐ Yes	☐ No
Urinary	Incontinence	☐ Yes	☐ No			
Skeletal	Joint Swelling	☐ Yes	☐ No	Joint Redness	☐ Yes	☐ No
	Muscle Cramps	☐ Yes	☐ No	Stiffness	☐ Yes	☐ No
Neurologic	Seizures	☐ Yes	☐ No	Balance Problems	☐ Yes	☐ No
	Headaches	☐ Yes	☐ No			
Mental	Depression	☐ Yes	☐ No	Anxious	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No	Difficulty Sleeping	☐ Yes	☐ No
Blood	Prolonged Bleeding	☐ Yes	☐ No	Anemia	☐ Yes	☐ No

Medications *(Please list name of medication and dosage)*

_____

_____

_____

Hospitalizations *(Please list all hospitalizations you have had)*

_____

_____

_____

Surgeries *(Please list all surgeries type and year)*

_____

_____

_____

Patient Signature_____ Date _____

Physician Signature_____ Date _____

Ventura Orthopedics

Pain Management Agreement

Pain Management Agreement between _____ (patient name)

Date of birth _____ and Ventura Orthopedics.

The purpose of this Agreement is to prevent misunderstandings about certain medications the patient may be prescribed for pain management. This is to help both the patient and their provider comply with the laws regarding controlled medications.

This agreement relates to my use of controlled substances for chronic pain prescribed by any physician at Ventura Orthopedics (VO). I have been informed and understand the policies regarding the use of controlled substances required of patients and staff of VO. I understand that I will be provided controlled substances, if required, while an active patient only if I adhere to the following conditions:

1. I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of the treatment are not to completely eliminate pain, but to control my pain in order to improve my ability to function. Chronic Opioid therapy is only ONE part of my overall pain management plan.

2. I understand that my provider and I will periodically evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take medication at the DOSE and FREQUENCY prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the discontinuation of opioid therapy.

3. I will attend all appointments, treatments and consultations as requested by my providers. I will follow all pain management recommendations or contact my provider immediately to discuss why I am unable to do so. I understand that failure to keep appointments may lead to discontinuation of treatment. As an aid to your compliance, it is our intention to confirm all appointments by telephone one business day prior to the scheduled appointment.

4. I will tell my providers about the level and description of my pain, the effect of the pain on my daily life and how well the medicine and other treatments are helping to relieve my pain.

5. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine, and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition. If other treatments for my condition are available, I agree I will not refuse the alternate treatment just so that opioids will be continued. I understand that I have the right to refuse any procedure, but that does not mean that my provider must continue to prescribe narcotic or opioid medications.

6. The risks and benefits of taking opioid medications have been explained to me. I understand them. Among other side effects, opioids can cloud judgments and affect reflexes and motor skills. The patient agrees not to participate in activities that would endanger themselves or others while using these medications.

7. I agree that I will not use any illegal and/or controlled substances, including marijuana, cocaine, heroin, etc. I agree I will not use any prescription medications obtained illegally, or obtain them from friends or relatives.

8. I agree that I will not abuse alcohol. If my provider advises, I will not use any alcohol.

9. I agree that I will not share, sell or trade my medication with anyone.

10. I agree to protect my pain medicine from loss or theft. Lost or stolen medicines will NOT be replaced. I will report stolen medication to the police and to my provider and will produce a copy of the police report relating to any theft.

11. I agree that I will not attempt to obtain any opioid medicines from another doctor or provider without informing the VO doctor/ nurse practitioner first.

    I agree to have my opioid prescriptions filled only at _____ (Pharmacy)

    located at _____,

    telephone number _____. Or through the mail-order pharmacy of

    _____.

12. I agree that refills of my prescriptions for pain will be made only at the time of an office visit or during regular office hours. No routine refills will be available during evenings, after 3 pm, or on weekends, holidays, or through any urgent care or emergency rooms. Medications will not be mailed or refilled without my being seen at a monthly pain clinic appointment (if patient is receiving his/her opioids from the pain clinic).
13. I am responsible for keeping track of the amount of medications left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.
14. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication until the next office visit.
15. I agree to bring in all unused pain medicine when requested.
16. I will submit urine for drug testing if requested by my provider to determine my compliance with their program of pain control and this agreement.
17. I authorize VO to cooperate fully with any official, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
18. If in the opinion of the provider and no medical reason warrants otherwise, I will accept generic brands of my prescription medications.
19. I understand that I may become tolerant to, addicted to, or have complications from, the opioid medications. If this occurs, the medication may be changed or tapered and other methods of pain control may be used. If necessary, I will permit referral to addiction specialists.
20. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will agree to gradually modify my medication as directed by the prescribing physician.
21. I understand that if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities pharmacies and other authorities such as the local police department, drug enforcement agency, etc. as deemed appropriate by VO.

I understand that if I break this Agreement, my provider will stop prescribing pain medications and terminate all treatments.

This agreement supersedes all prior agreements.

Patient Name: _____ Date: _____

Patient Signature: _____

Witnessed by: _____ Date: _____

Witness Signature: _____

Accepted by: _____ (MD/NP/PA-C)

Ventura Orthopedics

Urine Screen Policy

Ventura Orthopedics Medical Group, Inc. participates in a proactive approach to the management of pain. One of the means that may be used is through prescribing and dispensing certain medications. This is highly regulated by federal law and the California Medical Board has issued recommendations for medication use in their policy statement entitled “Prescribing Controlled Substances for Pain.” It outlines effective measures and standards in improving appropriate prescribing of effective medications while preventing drug diversion and abuse.

Ventura Orthopedics view effective pain management as a high priority in all our patients, so to better assess our new patients and review the needs of our established patients, you may be asked to participate in periodic drug screening.

There will be an additional charge for this testing by our office and a charge for the analysis by the laboratory. Most insurance plans cover both these charges. The exact amount covered depends upon your specific insurance policy. If you need any further explanation, please ask to speak to the office manager.

Your signature below, confirms that you have read and understand this policy.

Patient Name: _____ Date: _____

Signature: _____

Ventura Orthopedics

Acknowledgement of Receipt of Notice

Ventura Orthopedics Medical Group, Inc.
www.venturaortho.com
Administrator | 805-641-6415

Patient Name _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

(please check one)

☐ Yes ☐ No I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

Online Survey

Your feedback matters!

Please help us improve the patient experience by filling out a short survey that will be sent via text message or email. Your contact information will not be used for any other reason, including junk or spam mail.

☐ Yes, I would love to help.
☐ No, I do not wish to participate.

For Office Use Only:

☐ Signed form received by: _____

Ventura Orthopedics

Request for Special Privacy Protections

Ventura Orthopedics Medical Group, Inc.
www.venturaortho.com
Administrator | 805-641-6415

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that we restrict our uses and disclosures of your protected health information with respect to treatment, payment and health care operations. You also have a right to request that we restrict our uses and disclosures of your health information with respect to disclosures to members of your family and other relatives or close personal friends or other person you identity who are involved in your care or payment for your care, or to notify or assist in notifying those individuals of your location, general condition or death. This medical practice does not have to agree to your request, but if we do, we will abide by our agreement until either of us terminates the agreement.

I hereby request special privacy protection for _____ _____
Print Patient's Name — Patient's Date of Birth

You **MAY** speak/disclose my Health Information to:

Name: _____

Phone: _____

Relationship: ☐ Spouse ☐ Child
☐ Other _____

Name: _____

Phone: _____

Relationship: ☐ Spouse ☐ Child
☐ Other _____

Name: _____

Phone: _____

Relationship: ☐ Spouse ☐ Child
☐ Other _____

You **MAY NOT** speak/disclose my Health Information to:

Name: _____

Phone: _____

Relationship: ☐ Spouse ☐ Child
☐ Other _____

Name: _____

Phone: _____

Relationship: ☐ Spouse ☐ Child
☐ Other _____

Name: _____

Phone: _____

Relationship: ☐ Spouse ☐ Child
☐ Other _____

This is a complete list of all restrictions requested. All previous restriction requests are obsolete.

Signature: _____ Date: _____

Print Name: _____ Phone: _____

If not signed by the patient (or plan member), please indicate your relationship:

☐ Parent or guardian of minor patient ☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient ☐ Other (specify) _____

NOTE: By law, this restriction will not apply with respect to information necessary to provide emergency treatment, for uses or disclosures required by law, or for certain public health activities, judicial and administrative proceedings, law enforcement purposes, coroner investigations, organ or tissue donations, research activities, specialized government functions or workers' compensation activities.