Devinder S. Kumar, M.D. Pain Specialist
Patient Information Form

Patient Last Name _____ First Name _____ Middle Initial ___
Mailing Address _____ City _____ State ____ Zip _____
Home Address _____ City _____ State ____ Zip _____
Home Phone Number _____ Work Phone Number _____
Pager/Cell Phone Number _____ Alternative Phone Number _____
Email Address _____
Birth Date _____ Social Security Number _____ Sex: M / F Marital Status _____

Primary Insurance Information:
Insurance Company Name _____
Address _____ Phone Number _____
Group/Policy Number _____ Identification Number _____
Guarantor Name _____ Relationship to Insured: Self Spouse Child Other
Guarantor's Birth Date _____ Guarantor's Social Security Number _____ Sex: M / F

Secondary Insurance Information:
Insurance Company Name _____
Address _____ Phone Number _____
Group/Policy Number _____ Identification Number _____
Guarantor Name _____ Relationship to Insured: Self Spouse Child Other
Guarantor's Birth Date _____ Guarantor's Social Security Number _____ Sex: M / F

Preferred Pharmacy _____ Phone Number _____

Referring Physician (if any) _____ Phone Number _____
Primary Care Physician (if any) _____ Phone Number _____
Referring Patient (if any) _____
Employment Status: [ ] Full Time [ ] Part Time [ ] Unemployed [ ] Retired

Is this visit related to: [ ] Work Related Injury [ ] Auto Accident [ ] Personal Injury

Person to be contacted in case of emergency _____
Phone Number _____ Relationship _____

In signing this form you agree that all of the above is true and correct as of date signed. You also understand that we bill your insurance as a courtesy to our patients. If your insurance does not pay your claims for whatever reason, you understand that you are ultimately responsible for your bill. This does not apply to injury cases.

_____ _____
Patient or Patient Representative Signature Date

_____ _____
Witness Date

Ultimate Pain Management
Devinder S. Kumar, M.D. Inc.

To help us understand your problem, please complete ALL QUESTIONS on ALL of the attached forms.

Name _____ Age _____ Date _____

Who referred you to us? _____ Height _____ Weight _____

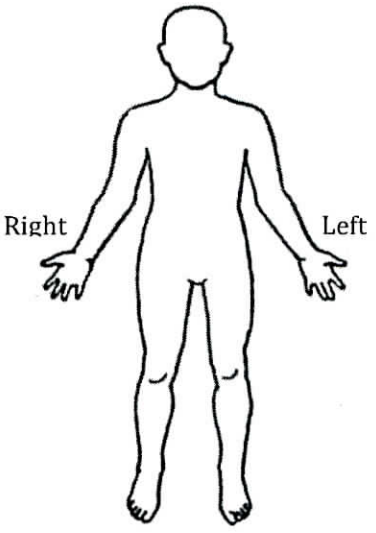
Which part of your body hurts the most? _____

How long have you had this pain? _____

On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that describes your level of pain:

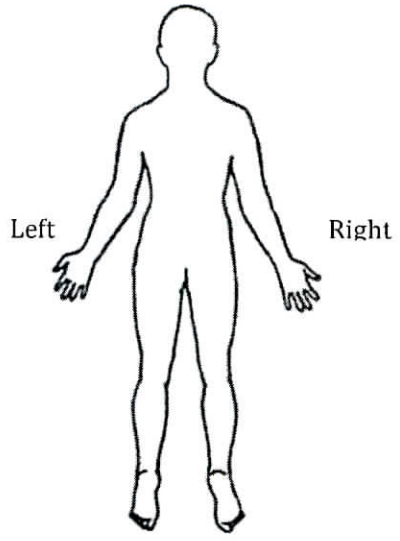
No pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst pain imaginable

*Shade in areas below where you have pain and check **ALL** the words that best describe your pain:*



Front

☐ Aching	☐ Stinging
☐ Soreness	☐ Unbearable
☐ Shooting	☐ Burning
☐ Cramping	☐ Stabbing
☐ Tingling	☐ Numbness
☐ Radiating	☐ Excruciating
☐ Hotness	☐ Coldness
☐ Tightness	☐ Heaviness
☐ Dullness	☐ Sharpness
☐ Constant	☐ Brief



Back

Pain caused from: Accident – Yes / No **Illness** – Yes / No **Unknown Cause** – Yes / No

If accident or illness explain and give dates:

_____

_____

_____

_____

Please indicate the factors or activities that increase or decrease your pain:

Factors	Increase	Decrease	No Effect	Factors	Increase	Decrease	No Effect
Weather change	☐	☐	☐	Pressure	☐	☐	☐
Heat	☐	☐	☐	Sexual activity	☐	☐	☐
Cold	☐	☐	☐	Bowel movement	☐	☐	☐
Physical activity	☐	☐	☐	Bright light / loud noise	☐	☐	☐
Posture	☐	☐	☐	Sneeze, cough	☐	☐	☐
Walking	☐	☐	☐	Lying down	☐	☐	☐
Sitting	☐	☐	☐	Other	☐	☐	☐

Please check any of the following treatments you have had for this pain problem:

Treatment	Approximate Date & Details	Improved Pain? Yes	No
☐ Pain clinic		☐	☐
☐ Nerve blocks, Epidurals		☐	☐
☐ Tens unit		☐	☐
☐ Physical therapy		☐	☐
☐ Acupuncture		☐	☐
☐ Chiropractor		☐	☐
☐ Psychiatrist/Psychologist		☐	☐
☐ Massage therapy		☐	☐
☐ Other		☐	☐

Please indicate which diagnostic procedures (tests) you have had for this pain problem:

Procedure	Body Part	Approximate Date	Facility Performed
☐ MRI Scan			
☐ CT myelogram			
☐ X-Ray			
☐ EMG/NCS			
☐ Discogram			
☐ Bone scan			

Please list other physicians you have seen for your pain:

Name	Recommendation	Specialty	Appointment date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Physician *(Name and Phone)* _____

Please list past or current medical problems:

☐ Heart disease	☐ Lung disease	☐ Diabetes	☐ Stroke	☐ Herpes (Shingles)
☐ Hypertension	☐ Kidney problems	☐ Liver disease	☐ Seizures	☐ HIV/AIDS
☐ Migraines	☐ Thyroid disease	☐ Depression / Anxiety	☐ Gerd / Ulcer	☐ Hepatitis
☐ Open wound	☐ Current infection	☐ Other		

Have you ever had cancer? ☐ Yes ☐ No If yes, which type(s)? _____
Are you currently receiving treatment? ☐ Yes ☐ No If yes, which type(s) of treatment? _____
_____

Please list all medications you are currently taking:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12.

Do you have any allergies to medication or food? **☐ Yes ☐ No**
Please list your allergies and the reaction below:

Medication / food	Reaction	Medication / food	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever taken or been given:	**Yes**	**No**	**Adverse Reaction?**
Anticoagulants, blood thinners, Coumadin, Plavix, Pletal	☐	☐	_____
Cortisone or steroids	☐	☐	_____

Please list any surgeries:

Surgery / date	Surgery / date
1.	5.
2.	6.
3.	7
4.	8.

Family Hisotry:
Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	Age	Living? Yes	No	Medical history / Cause of death
Father		☐	☐	
Mother		☐	☐	
Sibling		☐	☐	
Sibling		☐	☐	
Sibling		☐	☐	
Sibling		☐	☐	

Social History:
Marital status: ☐ Married ☐ Divorced ☐ Single

Do you currently work? ☐ Yes ☐ No What is / was your occupation? _____

Smoker? ☐ Yes ☐ No If you quit, when? _____
How many cigarettes did you / do you smoke per day? _____ Number of years? _____

Alcohol use? ☐ Yes ☐ No If yes, how much? _____

History of street drug use? ☐ Yes ☐ No If yes, which type(s)? _____

Do you have a history of alcoholism? ☐ Yes ☐ No
Family history of drug or alcohol abuse? ☐ Yes ☐ No

Is there any possibility that you are pregnant? ☐ Yes ☐ No
Have you ever been tested for HIV? ☐ Yes ☐ No Date _____ ☐ Positive ☐ Negative
Have you ever been treated for depression or any other mental health issue? ☐ Yes ☐ No
Please explain _____
Treating Physician's Name _____ Phone Number _____
Last visit _____ Frequency of visits _____
Origin of depression _____

Do you have or have you ever had (please check):

Cardiovascular	**Respiratory**	**Genitourinary**	**Muscle / Joint Disease**
☐ Palpitations	☐ Shortness of breath	☐ Change in bowel control	☐ Redness in joints
☐ Leg swelling	☐ Chronic cough	☐ Change in bladder control	☐ Arthritis / Joint disease
☐ Chest pain / Angina	☐ Wheezing	☐ Blood in urine	☐ Frequent muscle spasms
	☐ Sputum production		☐ Back or neck problems
			☐ Swelling of joints

Neurological	**Endocrine**	**Gastrointestinal**	**Hematologic**
☐ Epilepsy / Seizures	☐ Frequent Urination	☐ Nausea	☐ Easy bleeding
☐ Weakness	☐ Change in appetite	☐ Diarrhea	☐ Poor blood clotting
☐ Dizziness	☐ Heat or cold tolerance	☐ Rectal bleeding	☐ Bleeding disorder
☐ Fainting	☐ Sweating	☐ Heartburn	
☐ Numbness		☐ Constipation	
☐ Headache			

Psychiatric	**Constitutional**
☐ Depression	☐ Recent weight loss
☐ Anxiety	☐ Recent weight gain
☐ Stress	☐ Fever / Chills
☐ Previous psychiatric care	☐ Visual change
	☐ Hearing change

_____ _____
Patient Signature **Date**

Ultimate Pain Management
Devinder S. Kumar, M.D. Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONDITION OF REGISTRATION

By my signature below, I _____,

acknowledge that I have received a copy of the Notice of Privacy Practices for ULTIMATE PAIN MANAGEMENT:

DEVINDER S KUMAR, MD INC.

_____ _____

Signature of client (or personal representative) **Date**

If this acknowledgement is signed by a personal representative of the client, complete the following:

Personal representative's Name:

_____

Relationship to Client:

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (specify):

_____

_____

_____ _____

Signature of authorized personnel **Date**

Ultimate Pain Management

Devinder S. Kumar, M.D. Inc.

Narcotic Usage Contract

A consent form from the American Academy of Pain Medicine

Patient: _____ DOB: _____ Date: _____

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged.

For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to drug interactions or poor coordination of treatment.)

2. All controlled substances must be obtained at the same pharmacy, where possible. Notify our office which pharmacy you prefer. Should the need arise to change pharmacies, our office must be informed.

3. The prescribing physician has permission to discuss all diagnostic treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

4. You may not share, sell, or otherwise permit others to have access to these medications.

5. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

6. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder. Failure to provide a urine sample at time of request, without leaving the office, will constitute grounds for discharge from this clinic.

7. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest

possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

8. Original containers of medications should be brought in to each office visit.

9. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

10. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

11. Early refills will generally not be given.

12. Prescriptions may be issues early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

13. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

14. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

15. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

16. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

17. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such an explanation).

18. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____ _____

Patient Signature **Date**

_____ _____

Devinder S. Kumar, M.D. **Date**

DEVINDER S. KUMAR, MD INC

Meaningful Use Form

Patient's Full Legal Name: _____ **Date of Birth:** _____

We are now required to collect Race, Ethnicity and Language.
If you prefer not to report that information, you may choose Refused to Report/Unreported.

(Please Check ONE in EACH CATEGORY that applies)

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ White	☐ Hispanic or Latino	☐ English
☐ Non - White		☐ Spanish
☐ Black or African American	☐ Not Hispanic or Latino	☐ Urdu
☐ Asian		☐ Hindi
☐ American Indian or Alaskan Native	☐ Refused to Report/Unreported	☐ Vietnamese
☐ Refused to Report/Unreported		☐ Refused to Report/Unreported
☐ Native Hawaiian	☐ Undefined	☐ Other
☐ Other Pacific Islander		
☐ Undefined		
☐ More Than One		

Patient's Email Address: _____

HOW DID YOU HEAR ABOUT US? (Please Check the ONE that applies)

☐ Family/Friend	☐ Online Yellow Pages	☐ Employer Website	☐ Internet Search	☐ Billboard
☐ Hospital	☐ Newspaper	☐ Mailer	☐ Radio	☐ Doctor
☐ Seminar-Special Event	☐ Sports Team Support	☐ TV	☐ Worker's Comp	☐ Other:
☐ Existing Patient		☐ Self-Referral		

_____ _____

Signature of Patient, Guardian or Legal Representative **Date**