S. Vengurlekar, M.D., P.C.
Premier Pain Institute
Center for Minimally Invasive Interventions of Complex Spinal Pain
Phone: (480) 314-2288 Fax: (480) 314-1113

North Scottsdale Location
7010 E. Chauncey Lane
Suite 215
Phoenix, Arizona 85054

Date_____ **Time**_____

Phoenix Location
2915 W. Rose Garden Lane
Suite 102
Phoenix, Arizona 85027

Date_____**Time**_____

Dear Patient,
You have an appointment at Premier Pain Institute, with S. Vengurlekar, M.D., Associate or Staff, for a consultation about your pain disorder. In order to arrive at an accurate diagnosis and formulate the appropriate treatment plan, it is absolutely essential that you provide us with answers and information as outlined in the attached forms. Pain can be a very complex problem and we have found it essential to acquire this information directly from you. Casual and disinterested responses from patients in the form of "see list" or "other doctor's reports" are not acceptable. We expect our patients to take interest and responsibility in assimilation of this information, so that we provide the best care to you and strive for alleviation and reduction of your pain. **We also similarly expect that you take full responsibility for bringing with you your past relevant medical records from referring or past physicians.** This advice has been reiterated with you at the time you made your appointment on the telephone. We do not and will not be held responsible for acquiring or requesting medical records for you from your referring or past health care providers. If you have come in today without the relevant medical record or your records have not been received, please be advised that this may cause a delay in expediting your treatment. We also recommend that you look us up on our web-site listed below, where you can find valuable information about our practice including types of interventions offered.

azpainmd.com

Patient's Name_____

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PLEASE PRINT AND COMPLETE THE FOLLOWING INFORMATION - ALL BLANKS MUST BE COMPLETED

Last Name	First Name	Middle Initial	Today's Date
			/ /

Date of Birth	Age	Sex	Name of Spouse (Name of parent or guardian, if a minor)
/ /		M / F	

Arizona Address	City	Zip	Marital Status
			S M W D Sep

Permanent Address (If different from above)	City	Zip	Permanent Phone Number
			( ) -

Home Phone Number	Cell Phone Number:	Social Security Number
( ) -	( ) -	- -

Name of Employer	Work Phone Number	Occupation
	( ) -	

Spouse/Other Insurers Information Name	Address (If different than above)	
Phone Number	Date of Birth	Social Security Number

EMERGENCY CONTACT:	Phone number:

Name of Referring Physician	Address	Phone Number:
		Fax Number:

Name of Primary Care Physician (If different from Referring Physician)	Address	Phone Number:
		Fax Number:

Name of Primary Insurance Company	Name of Secondary Insurance Company

I UNDERSTAND I AM RESPONSIBLE FOR NOTIFYING THE OFFICE OF SHAM M. VENGURLEKAR, M.D. OF ANY CHANGES IN THE ABOVE INFORMATION.

Patient/Responsible Party Signature _____ Date _____

Sham Vengurlekar, M.D., P.C. – Premier Pain Institute

CONSENT FOR RELEASE OF INFORMATION, ASSIGNMENT OF MEDICAL BENEFITS, FINANCIAL POLICY AND PATIENT RESPONSIBILITY

I hereby give my consent to Sham Vengurlekar, M.D., as holder of my protected health information (PHI), to release information to my insurance carrier or any agency or representative of my insurance carrier for the purpose of obtaining payment for services provided. In addition, I authorize the payment of insurance benefits be made on my behalf directly to Sham Vengurlekar, M.D. for medical services provided. In the event that payment of benefits is made directly to me, as payee, I will endorse and release payments to Sham Vengurlekar, M.D.

I understand that per my insurance plan, I may have a co-payment, co-insurance, and deductible amount which I will be required to pay at the time of service (all contractual discounts will be applied), or my appointment may be cancelled and or rescheduled. If I am a cash pay patient, I am required to pay in full at time of service. I also understand that Dr. Vengurlekar does not accept checks.
I may pay by Cash, Cashiers Check, Visa, MasterCard, and Discover. I understand that if I do not comply with my financial obligations, Dr. Vengurlekar's practice, associates, or staff has no further obligation and or responsibility to continue my care, and that my care will be terminated.

I understand that Dr. Vengurlekar's medical practice will make every attempt to collect payment for services from my insurance company(s) in a timely manner. I also agree to stay actively involved with my insurance carrier to ensure Dr. Vengurlekar is reimbursed for services he provided. I am also fully aware that I will be billed for any services that have been deemed "not a covered benefit or not medically necessary" by my insurance company(s), (including Medicare patients as long as an Advanced Beneficiary Form (ABN) has been completed for each date of service). I understand that I am responsible for any balances on my account after my insurance has processed my claim, and agree to pay this balance in full. I also understand that if my patient balance becomes delinquent further action will be taken including and not limited to, assignment to collections agency, reporting to credit bureaus, and legal ramifications. I will be responsible for all costs incurred in this process.

I give my consent to use or disclose my PHI as needed to assist others in my medical care, and as needed for healthcare operations to support the business activities of my medical practice at the premier clinical standards.

I understand that Dr. Vengurlekar's medical practice also requires a fee for copying patient records (when requested by patient) of $12.00(minimum) per ½ hour and .25 cents per page. Additionally, there will be a pre-paid $45.00 fee (each occurrence), for all forms the practice is required to fill out (example: disability, FMLA, etc.). I allow the practice five working days to complete my request.

I have also been advised that if I fail to appear for a scheduled appointment in the office and do not call and cancel two working days in advance, I will be personally charged a fee of $75.00. If I fail to appear for a scheduled procedure and/or EMG and NCS studies, and do not call and cancel three days in advance, I will be personally charged a fee of $150.00.

I understand that any general or other specific health issues, beyond the scope of pain management, will need to be addressed by my primary care physician or another appropriate medical specialist. If I currently do not have a primary care physician, I will be responsible to locate the appropriate physician and seek the appropriate advice.

By signing below, I verify that I have read and understood the content of this form. I also agree to be personally responsible for any of the above fees (if applicable).

_____ _____

Patient/Patient's Representative Signature Date

_____

Relationship to Patient

S. Vengurlekar, M.D., P.C.
Premier Pain Institute
Center for Minimally Invasive Interventions of Complex Spinal Pain

Patient's Name_____

Date: _____

Scottsdale ____ Northwest Valley ____

Dear Patient;

I place a lot of emphasis on the details of your symptoms of pain and other aspects of your medical history. This form will help me in arriving at an accurate diagnosis and formulating the appropriate interventional pain therapies tailored to your needs.

Please pay close attention to the following items, which you need to fill out completely and accurately.

Date of Birth_____ **Height** _____ **Weight**_____ **Blood Pressure**_____
Referring Physician_____ **Pulse**_____ **Temp**_____

1.) Date of onset of pain_____ 2.) Location of primary pain _____
3.) Nature of pain _____ (e.g., sharp, stabbing, stinging, etc.)
4.) Continuous or Intermittent? _____
5.) Did you have a fall, injury, accident prior to the onset of pain? No [ ] Yes [ ]
If yes, what date? _____Briefly describe:_____

6.) Intensity of pain:
No pain 0 1 2 3 4 5 6 7 8 9 10 **Severe pain**

7.) Activities that increase your pain:
Sitting ___ Walking ___ Standing ___ Coughing/Sneezing ___
Bending ___ Sports activities ___ Lying down___
8.) List activity that relieves your pain (excluding medications):
Sitting ___ Lying down ___ Ice/Heat ___ Other _____
9.) Sleep pattern: Unchanged? [ ] Interference with sleep? [ ]
a) How many hours of sleep do you get _____
10.) Ability to pursue activities/occupation _____
11.) **Treatment you have received so far**:
a) **Current Medication**: *(list **ALL** pain medications & dosages)*

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

12.) List **ALL** medications that you have taken in the **past** to control your pain and mark in the ( ) what type of relief you received: e.g. (**R**) relief (**SR**) some relief (**NR**) No relief

_____( ) _____( ) _____( ) _____( )
_____( ) _____( ) _____( ) _____( )

13.) List any medications being taken for **other** medical disorders (also include herbal/supplements/over the counter medications):

_____ _____ _____ _____
_____ _____ _____ _____

Patient's Initials _____

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Patient's Name_____

(Cont')

14.) Check side effects that you've experienced and list the medication that caused it:
a) Gastric irritation [ ] b) Nausea [ ] c) Constipation [ ]
d) Drowsiness [ ] e) Jitters [ ] f) Other [ ]

15.) List drug allergies and type of reaction: (e.g.: penicillin, sulfa, itching, rash)

_____

16.) List all Food/Environmental allergies: _____

17.) **Other Treatment**: Please write in the ( ) whether your symptoms were:
(**W**) Worsened (**I**) Improved (**U**) Unchanged

Chiropractic	( )	**Acupuncture**	( )
Massage	( )	**Epidural Blocks**	( )
Trigger point inj.	( )		
Physical Therapy	( )		

If you have had therapy, when did you go? _____
How many sessions did you have? _____

18.) List all physicians that you have seen for this pain problem:
Anesthesiologist _____ Physical Medicine/Rehab _____
Orthopedic _____ Neurologist _____
Neurosurgeon _____ Other _____

19.) Past medical history: *(list **all** medical problems, e.g.: Asthma, High Blood Pressure, Heart disorders etc.)*

_____

_____

20.) Past surgeries: *(list **all** surgeries, e.g.: Appendectomy, Hernia surgery, Hysterectomy, Breast implants, etc.)*

_____

_____

21.) Past injuries: (sports, motor vehicle, falls, etc.)

_____

_____

22.) System Review: *(Circle all that apply)*

a) **Cardiac**: chest pain/heart attack/high blood pressure/irregular heart beat/heart murmur/shortness of breath
b) **Lungs**: cough/blood in sputum/asthma/bronchitis/valley fever/ tuberculosis
c) **Neurological**: headaches/seizures/stroke/paralysis/dizziness/ ringing in ears
d) **Skeletomuscular**: fibromyalgia/arthritis/lupus/connective tissue disorder
e) **Hormonal**: thyroid/sex hormones
f) **Metabolic**: diabetes/elevated cholesterol/elevated triglicerides
g) **Blood Disorder**: increased bleeding/thalassemia/hemophelia/ Christmas disease/sickle cell disorder/phlebitis or clots in leg or lung
h) **Urinary:** burning/lack of continence/increased frequency/kidney stone/ blood in urine/prostate problems/impotence
i) **Stomach/bowel:** ulcer/acidity/constipation/diverticulitis/diarrhea/blood in stool

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Patient's Name_____

(Cont')

23.) Menstrual history: Last menstrual period_____

a) Have you had a recent: Mammography [ ] No [ ] Yes Date:_____
Pelvic/GYN exam [ ] No [ ] Yes Date:_____
b) Post menopausal [ ] No [ ] Yes
c) Hormone replacement therapy [ ] No [ ] Yes
d) Contraceptive use [ ] No [ ] Yes

24.) Prostatic/PSA exam: [ ] No [ ] Yes Date: _____

25.) Tests performed: *(list **all**)*
Have you brought reports today? [ ] No [ ] Yes
a) Regular X-Rays of _____ b) CT Scan of _____
c) Myelogram of _____ d) MRI Scan of _____
e) Discogram of _____ f) Bone Scan of _____
g) Nerve Conduction of _____
h) Other _____

26.) Psychiatric/Psychological: *(Check **all** that apply)*
a) Depression [ ] b) Concentration difficulty [ ]
c) Memory problem or loss [ ] d) Suicidal thoughts [ ]
e) Problems with thinking/thought process [ ]

27.) Past or current exposure to:
a) Tuberculosis [ ] b) Valley fever (cocci) [ ] c) Rheumatic fever [ ]
d) Hepatitis (jaundice) [ ] e) A.I.D.S. [ ] f) Other _____

HABITS

1.) SMOKING:
a) Do you smoke now? [ ] No [ ] Yes Smoking since?_____
Cigarettes per day? _____ Cigars per day? _____ Pipe? _____
b) Have you smoked in the past? [ ] No [ ] Yes Years?_____

2.) ALCOHOL:
a) Do you drink alcohol? [ ] No [ ] Yes
If yes, how much? _____
b) Have you ever had problems with alcohol? [ ] No [ ] Yes
If yes, explain _____

3.) CAFFEINATED DRINKS:
a) Do you consume drinks with caffeine? [ ] No [ ] Yes
If yes, [ ] Coffee [ ] Tea [ ] Iced Tea [ ] Colas
[ ] Other_____ Number of cups daily _____

4.) DRUGS:
a) Use of any street or recreational drugs past or present? [ ] No [ ] Yes
If yes, explain _____
b) Use of **prescription** drugs for recreation or for use other than pain past or present? [ ]No [ ]Yes
If your answer to questions a or b is yes, would you be interested in getting rid of your addiction [ ]No [ ]Yes

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Patient's Name_____

SOCIAL INFORMATION

1.) List all the areas you have lived in (example: Phoenix, Az.):
_____

2.) Marital status: [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single
a) How long? _____

3.) Do you live: [ ] Alone [ ] With spouse [ ] With parents [ ] Other _____

4.) Number of children: Male _____ Female _____ Ages of children _____

5.) Has your pain problem changed your relationship with your spouse and family?
[ ] No [ ] Yes If yes, describe _____

FAMILY HISTORY

1.) List any pertinent family history (example: cardiac, strokes, psychiatric history, diabetes, etc.)

_____

_____

OCCUPATIONAL HISTORY:

[ ] Disabled since _____ [ ] Retired since _____ [ ] Homemaker
(If disabled, retired, over 65, or homemaker you may skip the following section)

1.) Please describe your current job (if unemployed, your very last job).
_____

a) How long have you held this job? _____
b) How many hours per week do you work? _____

2.) Have you missed much work because of your current or previous illness, injury or pain? [ ] No [ ] Yes
a) If yes, when was the last day you worked "full duty"? _____
b) If you are not working, are you currently receiving wage compensation?
[ ] No [ ] Yes

LITIGATION

1.) You have or plan to have an attorney involved? [ ] No [ ] Yes
If yes, list name and address of attorney and how he/she is helping, etc.
_____

_____

2.) Have you had any lawsuits in the past? [ ] No [ ] Yes
If yes, outcome of the lawsuit:
In favor [ ] Settled [ ] Dismissed [ ]

TREATMENT GOALS

1.) Describe goals of your treatment:
[ ] Return to work/Productivity
[ ] Be more active and functional
[ ] Not be dependent on medication
[ ] Get rid of my habituation or addiction with medication
[ ] Improve quality of life
[ ] Participate in sports
[ ] Other _____

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ADDITIONAL QUESTIONNAIRE FOR HEADACHE PATIENTS ONLY

(If you do not have any headaches, please skip this section.)

1.) When did you first develop headaches? _____
1.) Do you have more than one type of headache? [ ] No [ ] Yes
2.) Where is your headache located?
[ ] Neck [ ] Back of the head [ ] Eyes [ ] Face [ ] Temples [ ] Other_____
3.) Where does your headache start?
[ ] Neck [ ] Back of the head [ ] Behind eyes [ ] Other_____
4.) How often and what time of the day do you have headaches?
_____
5.) Which of the following words do you use to describe your headache?
[ ] Throbbing [ ] Pounding [ ] Splitting [ ] Pulsating
[ ] Piercing [ ] Dull [ ] Aching [ ] Tight [ ] Other _____
6.) How long does one episode of headache last?
Shortest _____ Longest _____
7.) What physical or environmental factors trigger the headache or make it worse? [ ] Bright light [ ] Tobacco [ ] Alcohol [ ] Exercise
[ ] Loud noises [ ] Sex [ ] Changes in weather [ ] Travel
[ ] Increased physical activity [ ] Other _____
9.) Have you noticed if any foods trigger your headaches? [ ] No [ ] Yes
If yes, list_____
10.) Do you have any craving for any particular foods prior to a headache occurrence?
[ ] No [ ] Yes If yes, list _____
11.) a) If female, do you get headaches before, during or after menstrual cycle?
[ ] No [ ] Yes
b) Have you had: [ ] Hysterectomy [ ] Ovaries removed
c) Do you have any problems with hormones? [ ] No [ ] Yes
d) Do you take any hormones? [ ] No [ ] Yes
12.) How is your headache controlled? _____
_____
13.) Do you experience any of the following?
(only mark applicable ones – not all)

	Before Headache	During Headache	After Headache
Nausea	[ ]	[ ]	[ ]
Vomiting	[ ]	[ ]	[ ]
Dizziness	[ ]	[ ]	[ ]
Abnormal Sensations	[ ]	[ ]	[ ]
Aura	[ ]	[ ]	[ ]
Sound Sensitivity	[ ]	[ ]	[ ]
Light Sensitivity	[ ]	[ ]	[ ]
Other	[ ]	[ ]	[ ]

14.) Can you tell when you are going to have a headache? [ ] No [ ] Yes
If yes, explain _____
_____
15.) Do you have neck pain associated with headaches? [ ] No [ ] Yes
During [ ] Before [ ] After [ ]

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Patient's Name_____

CERTIFICATION BY PATIENT

I certify that I have truthfully answered all the questions, and have not knowingly withheld any information concerning any of the above information either past or present. I also certify that areas where I had difficulty in filling out, I was assisted by Dr. Vengurlekar, associate or staff.

I also, acknowledge that if I withhold any information from this record or if I am non-compliant with any advice or medications, Dr. Vengurlekar will exercise his right to terminate my care.

I am also consenting, to Dr. Vengurlekar, associates or staff to conduct my history taking, physical examination and also to order any tests, including but not limited to, consultations, x-ray exams, laboratory exams, etc..

Full Name _____ Date _____

Signature of patient _____

Witness: _____

Patient's Initials _____