



NEW PATIENT PACKET

Welcome. Your care begins here.

A complete record of who you are and the symptoms you're bringing to us, so that we can offer you the most informed and considered care from your very first visit.

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Form 01

Patient Information

Demographics, contact details, and the relationships and coverage that surround your care.

i. PERSONAL INFORMATION

LAST NAME_____
FIRST NAME_____
MIDDLE_____
DATE OF BIRTH_____
AGE_____
SEX_____
SOCIAL SECURITY NUMBER

Marital Status Single Married Divorced Widowed Separated
 Significant Other

ii. CONTACT

STREET ADDRESS_____
CITY_____
STATE_____
ZIP_____
CELL PHONE_____
HOME PHONE_____
EMAIL ADDRESS_____
OCCUPATION_____
PRIMARY CARE PHYSICIAN_____
SPOUSE / SIGNIFICANT OTHER (IF APPLICABLE)

iii. INSURANCE

INSURANCE CARRIER_____
MEMBER ID

Plan Type PPO HMO Medicare Medicaid Other

iv. EMERGENCY CONTACT

NAME

RELATIONSHIP

PHONE

v. REFERRAL SOURCE

How did you hear about us? Doctor Referral Family / Friend Google Facebook
 Instagram LinkedIn YouTube TV / Radio Mailer Newspaper
 Blog / Article Other

vi. POWER OF ATTORNEY *(if applicable)*

POWER OF ATTORNEY NAME

CELL PHONE

Relationship Child Sibling Spouse Other

Form 02

Pain & Symptom History

A clear account of your symptoms, when they began, how they feel, and what you've tried, guides the entire arc of your care.

i. YOUR CURRENT SYMPTOMS

What is your main complaint or reason for today's visit?

How long have you had this problem?

Was there an injury, accident, or event that may have caused or contributed to this problem?

ii. PAIN DESCRIPTION

Where do you feel pain or symptoms? Head / Neck Back Shoulder Arm / Hand
 Hip Knee Leg / Foot Multiple Areas

How would you describe the pain? Aching Burning Sharp Stabbing Tingling
 Numbness Throbbing Cramping

PAIN AT ITS WORST (0-10)

PAIN AT ITS BEST (0-10)

PAIN RIGHT NOW (0-10)

What makes the pain better?

What makes the pain worse?

iii. PRIOR TREATMENT _____

What treatments have you tried for this problem? (medications, physical therapy, injections, surgery, etc.)

Have you seen another provider for this problem? Yes No

If yes, provider name(s) and specialty

iv. FUNCTIONAL IMPACT _____

How does this problem affect your daily life, work, or activities?

Form 03

Medical History

A complete picture of your health, past and present, informs every clinical decision we make on your behalf.

i. VITAL STATISTICS

HEIGHT

WEIGHT

ii. REVIEW OF SYSTEMS

Please mark any condition that applies currently or that you have a history of.

GENERAL

- Fatigue / tiredness
- Weakness
- Fever or chills
- Night sweats
- Appetite change
- Unexplained weight loss
- Unexplained weight gain
- Generalized pain
- Heat intolerance
- Cold intolerance

NEUROLOGICAL

- Fainting spells
- Seizures
- Dizziness
- Tremor
- Chronic headaches
- Poor balance
- Numbness or tingling
- Peripheral neuropathy
- Stroke or mini-stroke
- Memory problems

PSYCHIATRIC

- Depression
- Anxiety
- Panic attacks
- Sleep problems
- Substance use concerns

RESPIRATORY

- COPD
- Asthma
- Chronic cough
- Shortness of breath
- Sleep apnea
- History of pneumonia

CARDIAC

- Chest pain
- Rapid heartbeat
- High blood pressure
- Heart attack history
- Heart murmur
- Congestive heart failure
- Pacemaker
- Defibrillator

VASCULAR

- Leg pain with walking
- Leg pain at rest
- Blood clots in legs
- Peripheral vascular disease
- Varicose veins
- Cold feet or hands

GASTROINTESTINAL

- Heartburn or reflux
- Diarrhea
- Constipation
- Irritable bowel
- Ulcers
- Gallbladder disease
- Cancer (GI)

GENITOURINARY

- Frequent urination
- Difficulty urinating
- Loss of bladder control
- Kidney disease
- Currently on dialysis

MUSCULOSKELETAL

- Arthritis
- Joint swelling
- Joint stiffness
- Muscle aches
- Muscle weakness
- Leg cramps
- Prior fractures

ENDOCRINE

- Diabetes (Type 1)
- Diabetes (Type 2)
- Thyroid problems
- Adrenal problems

SKIN

- Rashes
- Non-healing sores
- Bruises easily
- Skin cancer history
- Very dry skin

BLOOD

- Anemia
- Bleeding / clotting problems
- Long-term blood thinner use
- Blood transfusion history

iii. SURGICAL HISTORY

Please list any surgeries you have had, with the approximate year.

iv. ALLERGIES

Please list any allergies to medications, foods, or other substances.

v. FAMILY HISTORY

Please list any significant medical conditions in your immediate family.

PATIENT SIGNATURE

DATE

Form 05

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed, and how you can get access to that information. Please review it carefully.

This Notice describes the privacy practices of Frontier Pain Relief and the licensed clinical entity providing care at this location (collectively, the “Practice,” “we,” or “us”). We are required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice, and follow the terms of the Notice currently in effect.

§ 1 HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information for the following purposes without your written authorization.

For Treatment. We use and disclose your health information to provide your medical care. For example, we may share information with other providers, specialists, or facilities involved in your care, including providers we refer you to or who refer you to us.

For Payment. We use and disclose your health information to obtain payment for services. For example, we may share information with your insurance company to verify coverage, obtain authorization, or submit claims.

For Health Care Operations. We use and disclose your health information to operate our practice. This includes activities such as quality assessment, staff training, business management, and credentialing of providers.

§ 2 OTHER USES PERMITTED BY LAW

We may use or disclose your health information without your authorization in certain other circumstances permitted or required by law, including:

- To you, or to a personal representative legally authorized to act on your behalf
- To family members or friends involved in your care, when you agree or when in our judgment it is in your best interest
- To public health authorities for disease reporting and similar purposes
- To report suspected abuse, neglect, or domestic violence as required by law
- For health oversight activities, such as audits or investigations by government agencies
- In response to a court order, subpoena, or other lawful legal process

- To law enforcement officials in limited circumstances permitted by law
- To coroners, medical examiners, or funeral directors as necessary
- To organ procurement organizations for donation purposes
- For research purposes when permitted by law and approved by an oversight body
- To prevent a serious and imminent threat to health or safety
- For specialized government functions, such as military, national security, or correctional institution purposes
- As authorized by and necessary to comply with workers' compensation laws

§ 3 USES REQUIRING YOUR WRITTEN AUTHORIZATION

Most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and disclosures that constitute a sale of your health information require your written authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke an authorization at any time, in writing, except to the extent that we have already acted in reliance on it.

§ 4 YOUR RIGHTS

Right to Access. You have the right to inspect and obtain a copy of your health information that we maintain in a designated record set, with limited exceptions. We may charge a reasonable fee for copying and mailing.

Right to Request Amendment. You have the right to request that we amend your health information if you believe it is incorrect or incomplete. We may deny your request in certain circumstances and will explain our reasons in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we have made of your health information for purposes other than treatment, payment, or health care operations.

Right to Request Restrictions. You have the right to request restrictions on how we use or disclose your health information for treatment, payment, or operations. We are not required to agree to most requested restrictions, but if we agree, we will honor that agreement except in emergencies. We will agree to a request to restrict disclosure to a health plan if the disclosure is for payment or operations and the information relates to a service you have paid for in full out of pocket.

Right to Confidential Communications. You have the right to request that we communicate with you in a specific way or at a specific location.

Right to a Paper Copy of This Notice. You have the right to receive a paper copy of this Notice at any time, even if you have agreed to receive it electronically.

Right to Notification of a Breach. You have the right to be notified if a breach of your unsecured protected health information occurs.

§ 5 EXERCISING YOUR RIGHTS · FILING A COMPLAINT

To exercise any of the rights described above, please submit your request in writing to our Privacy Officer at the address below. To file a complaint about our privacy practices, you may contact our Privacy Officer or the U.S. Department of Health and Human Services, Office for Civil Rights. **You will not be retaliated against for filing a complaint.**

§ 6 CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time. The new Notice will be effective for all health information we maintain. We will post the current Notice in our office and on our website, and you may request a copy at any time.

Form 06

Acknowledgment of Receipt

A simple acknowledgment that you have received our Notice of Privacy Practices and understand the rights described therein.

PATIENT NAME_____
DATE OF BIRTH

By signing below, I acknowledge that I have been provided with a copy of, or have been offered a copy of, the Notice of Privacy Practices for Frontier Pain Relief and the licensed clinical entity providing care at this location.

I understand that this Notice describes how my protected health information may be used and disclosed, and the rights I have regarding my health information. I understand that I may request a copy of the current Notice at any time.

PATIENT OR GUARDIAN SIGNATURE_____
DATE

· For Office Use Only ·

If the patient declined to sign or was unable to sign this Acknowledgment, the practice has documented its good-faith efforts to provide the Notice. The reason is noted below.

Reason
