PAIN
MANAGEMENT
PARTNERS, LLC

Robert J. Boolbol, MD
David C. Levi, MD

Dear Patient,

Welcome to Pain Management Partners, the practice of Doctors Levi and Boolbol. To help facilitate your care, please complete the attached paperwork and bring with you to your appointment along with your insurance card(s), pharmacy card and photo ID. If you have had a MRI or CT scan, please bring the CD provided to you by the imaging facility.

Please be advised that we do not prescribe any medications at the first visit. If you are currently prescribed medication(s) by another physician, please notify their office that they will need to provide you with medication for up to 2 weeks after your initial consultation.

If you are scheduled for a procedure, please arrange for a driver to bring you to and from the appointment unless other arrangements have been discussed. If you are scheduled to take Valium for your procedure, please pick up the medication at your pharmacy the day before your appointment. When you arrive, we will advise you when to take the medication when you check in.

Please allow 90-120 minutes for your appointment.

If you have any questions or concerns, please call 203-885-1441.

Thank you!

PATIENT INFORMATION

Patient Name_____ Nickname_____

Marital status_____Previous Name_____

Date of Birth_____

Sex □ M □ F □ Other Language_____Ethnicity_____

CONTACTS

Emergency Contact Name_____Relationship_____

Emergency Contact Phone _____

Spouse Name_____Caretaker Name_____

Patient home phone_____ Is it OK to leave a detailed message? □ YES □ NO

Patient work phone_____Is it OK to leave a detailed message? □ YES □ NO

Patient cell phone_____ Is it OK to leave a detailed message? □ YES □ NO

Email address_____Would you like enroll in the patient portal? □ YES □ NO

Preferred method to contact you: □ Home □ Work □ Cell □ Email

Home address_____

Seasonal address_____

Employers name_____Occupation_____

INSURANCE INFORMATION

Primary Insurance_____

Policy Holder Name_____Date of Birth_____

Secondary Insurance_____

Policy Holder Name_____Date of Birth_____

WORKERS'COMPENSATION/MOTOR VEHICLE ACCIDENT

Company Name_____

Adjuster Name_____Adjuster Phone_____

Claim #_____Date of Injury_____

Employer (at time of injury if work related)_____

Attorney Name (if you have one)_____

PROVIDERS

Primary Care provider_____Phone_____

Referring physician_____Phone_____

FINANCIAL POLICY

The practitioners and staff of Pain Management Partners, LLC are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following financial policy and sign. If you have any questions, please ask our staff.

INSURANCE-You, the responsible party, are responsible for providing us with up to date insurance information. We will keep a copy of your insurance card(s) on file. Kindly report any changes to your insurance coverage immediately by telephone or upon your arrival to your appointment. If your insurance changes and you do not notify our office, you may be responsible in full for any charges incurred.

REFERRALS- If your insurance plan requires referrals from your PCP to come to our office, YOU are responsible for obtaining the referral. If you do not obtain a referral you may not be seen or you may be billed for the full amount of services rendered. Please check with your insurance company if you are not sure.

COPAYS-Copays must be paid at time of service. Please come prepared to pay the specialist copay at each visit or you may not be seen.

DEDUCTIBLES and COINSURANCES- We will submit your bills to your insurance carrier(s) for processing. All balances will be billed to you and payment is expected upon receipt. If you fail to pay any balance within 90 days, you may not be seen in the office until the balance is settled. If you require a payment plan, please let staff know.

MEDICARE- Medicare patients are responsible for their annual deductible, coinsurance and any non-covered services in which you agree to pay (advanced Beneficiary Notice). We will bill your secondary insurance as appropriate to be processed in accordance with your plan. Any balances due after insurance processing will be your responsibility and will be due upon receipt. If you fail to pay any balance within 90 days, you may not be seen in the office until said balance is settled.

MOTOR VEHICLE ACCIDENT- If your charges are related to a MVA and you have med pay or PIP coverage, we will bill your auto insurance carrier. Any balances not covered by your carrier are your responsibility. We will not suspend collection of your balance until a third-party claim is settled.

WORKERS' COMPENSATION- If you have a work-related injury, we will submit all claims to your workers' compensation carrier. If your case settles, and you receive a set aside account for medical expenses, you will be billed at the current Connecticut WC rates that will be due at each visit.

PATIENTS WITHOUT INSURANCE- If you do not have insurance, you may be offered a discounted rate. Payments are due upon arrival to your appointment, there are no exceptions.

LATE CANCELLATION/NO SHOW FEES- We require 24 hours for cancelling an appointment. If you no not give adequate notice or fail to show for your appointment, we reserve the right to charge a $75.00 fee for a missed appointment and $200.00 for a missed procedure. The fee must be paid prior to rescheduling the missed appointment.

RETURNED CHECKS- All returned checks are subject to a $35.00 service fee.

PAST DUE ACCOUNTS- We expect that you will pay your account balance in a timely manner. Any account with a balance over 90 days past due will be referred to an outside collection agency and you will be responsible for any related collection costs.

Please contact our billing office if you have any questions.

I have read, understand and agree to the financial policies of Pain Management Partners, LLC.

Patient Signature_____Date_____

Print Name_____If patient is a minor, a parent or guardian must sign

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE & DESIGNATION OF DISCLOSURE

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth Pain Management Partners, LLC privacy practices and my rights regarding privacy of my protected health information.

Patient Signature_____Date_____

Print Name_____Date of Birth_____

ACCESS TO MY INFORMATION

Please list the name(s) below of anyone who may need to speak to us regarding your appointments, care and medication. Please include attorneys, caregivers and conservators and anyone who may pick up prescriptions on your behalf.

Pain Management Partners, LLC may release my information to the following people:

Name_____Relationship_____

Name_____Relationship_____

The following person(s) are NOT authorized to receive or discuss my health information:

Name_____Relationship_____

Name_____Relationship_____

CONTACT PREFERENCES

Preferred method to contact you: □ Home □ Work □ Cell Phone # _____

May we leave a detailed message? □ Yes □ No

AUDIO/VIDEO ACKNOWLEDGEMENT

Please be advised, that in order to better enable us to assure compliance with HIPAA privacy and security laws an regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited o cell phones, is strictly prohibited.

We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this policy. We appreciate your understanding and cooperation.

Patient Signature_____Date_____

ADVANCED DIRECTIVE

We are dedicated to providing comprehensive care to patients and following federal guidelines regarding important public health issues/. Please answer the following question.

Are you able to name a surrogate decision maker in the event that you are incapacitated?

If yes, please indicate below.

Name_____Relationship_____

Phone number_____

If no, please check the box below.

□ I do not wish or am unable to name a surrogate decision maker.

Patient Signature_____Date_____

PAIN MANAGEMENT PARTNERS, LLC

Welcome to Pain Management Partners, the practice of Doctors Levi and Boolbol. In order to provide you with the best possible care, it is important that we obtain a thorough medical history and have a good understanding of your pain. Please complete these forms as best as you can. Thank you!

PAST MEDICAL HISTORY

□ Anxiety
□ Asthma
□ Atrial fibrillation
□ Benign prostatic hyperplasia
□ Bipolar disorder
□ Cerebrovascular accident
□ Chronic anemia
□ Chronic obstructive lung disease
□ Chronic pain
□ Coronary arteriosclerosis
□ Deep venous thrombosis
□ Depressive disorder
□ Diabetic on insulin
□ End-stage renal disease
□ Epilepsy
□ Essential hypertension
□ Gastroesophageal reflux disease
□ Hypertension
□ History of primary
□ Hyperparathyroidism
□ History of radiation therapy
□ HIV/AIDS
□ Hypercholesterolemia
□ Hyperlipidemia
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory disease of liver
□ Ischemic heart disease
□ Leukemia
□ Malignant lymphoma (clinical)
□ Malignant tumor of lung
□ Malignant tumor of breast
□ Malignant tumor of colon
□ Malignant tumor of prostate
□ Morbid obesity
□ Multiple myeloma
□ Obesity
□ Obstructive sleep apnea syndrome
□ Primary fibromyalgia syndrome
□ Pulmonary embolism
□ Rheumatoid arthritis
□ Type 2 diabetes mellitus
□ Other_____
□ None

PAST SURGICAL HISTORY

□ Abdominoperineal resection
□ Bypass of stomach
□ Cesarean hysterectomy
□ Coronary artery bypass graft
□ Entire transplanted kidney
□ Excision of basal cell carcinoma
□ Excision of melanoma
□ Excision of squamous cell
□ Carcinoma
□ Colostomy
□ Tubal ligation
□ History of appendectomy
□ History of bilateral mastectomy
□ History of cholecystectomy
□ History of colectomy
□ History of liver excision
□ History of percutaneous
□ Transluminal coronary angioplasty
□ History of tissue graft heart valve replacement
□ History of transurethral prostatectomy
□ Hysterectomy
□ Low anterior resection of rectum
□ Lumpectomy of breast
□ Lumpectomy of left breast
□ Lumpectomy of right breast
□ Mastectomy of left breast
□ Mastectomy of right breast
□ Mechanical heart valve replacement
□ Oophorectomy
□ Pancreatectomy
□ Percutaneous extraction of kidney stone with fragmentation procedure
□ Portosystemic shunt operation
□ Prostatectomy
□ Surgical biopsy of skin
□ Tonsillectomy
□ Total hysterectomy
□ Transplantation of heart
□ Transplantation of liver
□ Other _____
□ None

INTERVENTIONAL PAIN HISTORY

□ None
□ Epidural Injection(s) - Cervical
□ Epidural Injection(s) – Thoracic
□ Epidural Injection(s) - Lumbar
□ Facet Injection(s) - Cervical
□ Facet Injection(s) – Thoracic
□ Facet Injection(s) - Lumbar
□ Intrathecal Pump
□ Medial Branch Block - Cervical
□ Medial Branch Block - Thoracic
□ Other_____
□ Medial Branch Block – Lumbar
□ Rhizotomy - Cervical
□ Rhizotomy - Thoracic
□ Rhizotomy - Lumbar
□ Spinal Cord Stimulator

MUSCULOSKELETAL DISEASE HISTORY

□ Acute poliomyelitis
□ Adhesive capsulitis of shoulder
□ Ambidextrous
□ Ankylosing spondylitis
□ Bursitis
□ Carpal tunnel syndrome
□ Chronic low back pain
□ Complex regional pain syndrome
□ Compression fracture of vertebral column
□ Disseminated idiopathic skeletal hyperostosis
□ Epidural steroid injection
□ Fracture at wrist and/or hand level
□ Fracture of ankle
□ Fracture of bone
□ Fracture of distal end of radius
□ Fracture of vertebral column
□ Hip fracture
□ Rheumatoid arthritis
□ History of osteoporosis
□ Idiopathic scoliosis
□ Impingement syndrome of shoulder region
□ Left handed
□ Osteoarthritis
□ Osteopenia
□ Primary gout
□ Prolapsed cervical intervertebral disc
□ Prolapsed lumbar intervertebral disc
□ Psoriasis with arthropathy
□ Rickets
□ Right handed
□ Sarcoma of bone
□ Sarcoma of soft tissue
□ Sciatica
□ Secondary malignant neoplasm of bone
□ Spinal stenosis in cervical region
□ Spinal stenosis of lumbar region
□ Vitamin D deficiency
□ Other_____

MUSCULOSKELETAL SURGICAL HISTORY

□ None
□ Arthroplasty of left shoulder
□ Arthroplasty of right shoulder
□ Arthroplasty of the carpometacarpal joint of the thumb
□ Bilateral replacement of knee joints
□ Decompression of lumbar spine
□ Decompression of median nerve
□ Diagnostic arthroscopy of shoulder joint
□ Excision of bunion
□ Excision of ganglion cyst
□ Exploratory lumbar laminectomy
□ History of arthroplasty of right knee
□ History of arthroscopy of knee joint
□ History of repair of musculotendinous cuff of shoulder
□ Intramedullary nailing of femur
□ Intramedullary nailing of tibia
□ Kyphoplasty of fracture of spine using fluoroscopic guidance
□ Lumbar spinal fusion
□ Open reduction of fracture of radius with internal fixation
□ Osteotomy and discectomy of cervical spine by anterior approach
□ Primary posterior decompression lumbar spine and fusion
□ Prosthetic arthroplasty of bilateral hips
□ Prosthetic arthroplasty of left hip
□ Prosthetic arthroplasty of right hip
□ Prosthetic replacement of cervical intervertebral disc
□ Prosthetic replacement of lumbar intervertebral disc
□ Release of trigger finger
□ Repair of ankle
□ Repair of meniscus
□ Repair of tendon achilles
□ Revision of total hip arthroplasty, both components, with autograft
□ Revision of total knee arthroplasty, all components
□ Revision of total prosthetic replacement of shoulder joint
□ Total reverse shoulder prosthesis
□ Total shoulder replacement
□ Other_____

MUSCULOSKELETAL FAMILY HISTORY

□ None
□ Charcot Marie Tooth Disease
□ Diabetes
□ Hypertension
□ Multiple Hereditary Exostosis
□ Osteoarthritis
□ Osteoporosis
□ Scoliosis
□ Other_____

MUSCOLOSKELETAL PEDIATRIC HISTORY

□ None
□ Breech Position
□ Cerebral Palsy
□ Flatfeet (Pes Planovalgus)
□ Genu Valgum
□ Genu Varum
□ Hip Dysplasia
□ Neonatal Sepsis
□ Pavlik Harness as Infant
□ Spina Bifida
□ Spondylolisthesis
□ other_____

MEDICATIONS Please list all current medications. □ Check here if you are providing a separate list of medications.

Medication name Dosage # of times taken per day

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES Please list all known allergies. □ Check here if you have no known allergies.

Allergy type Describe reactions severity and symptoms

_____
_____
_____
_____
_____

SOCIAL HISTORY

What is your smoking status?
□ Current everyday smoker
□ Current some day smoker
□ Former smoker
□ Never smoker
□ Cigar Smoker

Do you consume alcohol?
□ None
□ Less than one per day
□ 1-2 drinks per day
□ 3 or more drinks per day

Do you use illicit drugs? YES NO

Do you exercise?
□ Several times per day
□ Once per day
□ A few times a week
□ A few times a month
□ Never
□ Other

FAMILY HISTORY

	Alive?	Age	Deceased?	Age at death	Cause of death	Unknown
Father						
Mother						
Maternal Grandfather						
Maternal Grandmother						
Paternal Grandfather						
Paternal Grandmother						

FAMILY HISTORY (Continued)

Please check if any of your immediate family have ever had any of the following conditions, and list who.

□ Cancer_____
□ Heart disease_____
□ Diabetes_____
□ High Blood Pressure_____
□ Stroke/TIA_____
□ Alcohol abuse_____
□ Drug abuse_____
□ Psychiatric illness_____
□ Seizures_____
□ Depression/suicide_____
□ Osteoarthritis_____
□ Osteoporosis_____
□ Scoliosis_____
□ Other_____

WHEN DID YOUR PAIN BEGIN?

□ beginning after surgery
□ being involved in a motor vehicle accident
□ falling from a height
□ gradual and insidious onset
□ gradually
□ having chronic back pain
□ increased activity level
□ injury at work
□ insidious onset
□ occurred when lifting an object
□ playing a sport
□ previous episodes of sciatica
□ slipping and falling
□ suddenly
□ trauma
□ tripping on an uneven surface
□ tripping over a curb
□ twisting injury
□ walking the dog and tripping
□ other_____

WHAT IS THE TIMING OF THE PAIN?

□ acute
□ chronic
□ Constant
□ episodic
□ intermittent
□ occurs intermittently
□ random
□ variable
□ worse after activity
□ worse at the end of the day
□ worse during activity
□ worse during the day
□ worse during the night
□ worse in the morning
□ other_____

PLEASE DESCRIBE THE PAIN

□ aching
□ associated with catching
□ associated with clicking
□ associated with pins and needles-like sensations
□ associated with popping
□ associated with shooting sensations
□ associated with stiffness
□ burning
□ cramp-like
□ diminishing
□ dull
□ electric
□ gradual
□ improving
□ intermittent
□ numbness
□ pins and needles
□ pressure
□ progressive
□ radiating
□ sharp
□ shooting
□ stabbing
□ staying the same
□ swelling
□ tender to touch
□ throbbing
□ tingling
□ worse with ambulation
□ worse with extension
□ worse with flexion
□ worse with weight bearing
□ worsening
□ other_____

WHAT OTHER AREAS ARE AFFECTED BY YOUR PAIN?

_____

WHAT AGGRIVATES YOUR PAIN

□ all movement
□ bending over
□ exercise
□ lifting objects
□ lying flat
□ sitting
□ standing for prolonged periods
□ walking for long distances
□other_____

HOW SEVERE IS THE PAIN? Please rate on a scale of 1 to 10, 10 being the worst pain you have ever experienced.

Currently _____
Initially _____
on a bad day _____
on a good day _____
on an average day _____

HOW LONG HAVE YOU EXPERIENCED THIS PAIN?

_____

PLEASE CHECK ALL THAT APPLY

□ ankylosing spondylitis
□ blood thinners
□ Charcot neuropathy
□ claw toe
□ diffuse idiopathic skeletal hyperostosis (DISH)
□ history of cancer with metastasis
□ history of cancer without metastasis
□ osteoarthritis
□ osteoporosis
□ previous disc herniation
□ prior history of spine surgery
□ recurrent back pain
□ rheumatoid arthritis
□ scoliosis
□ spinal stenosis
□ other_____

PLEASE CHECK ALL THAT APPLY

□ bowel incontinence
□ constipation
□ drowsiness
□ mental slowness
□ perineal numbness
□ sexual dysfunction
□ urinary incontinence
□ other_____

WHAT ARE YOU CURRENTLY USING TO TREAT YOUR PAIN?

□ no treatment
□ activity modification
□ acupuncture
□ brace
□ capsaicin cream
□ chiropractic treatments
□ heat
□ ice
□ lidocaine patches
□ massage therapy
□ medications
□ physical therapy
□ pilates
□ sling
□ topical ketorolac
□ weight reduction
□ yoga
□ other_____

WHAT MEDICATIONS HAVE YOU USED FOR YOUR PAIN?

OPIOIDS
□ Tramadol
□ Demerol
□ Codeine
□ Fentanyl
□Hydromorphone
□ Hydrocodone
□ Oxycodone
□ Oxymorphone
□ Methadone
□ Morphine
□ Nucynta
□ Butrans
□ Suboxone

NSAIDS
□ Tylenol
□ Aspririn
□ Ibuprofen
□ Naproxen
□ Daypro
□ Indocin
□ Feldene
□ Voltaren
□ Lodine
□ Orudis
□ Relafen
□ Celebrex
□ Torodol

MUSCLE RELAXANTS
□ Some
□ Lorzone
□ Flexeril
□ Baclofen
□ Zanaflex
□ Robaxin
□ Skelaxin
□ Valium

ANTIDEPRESSANTS
□ Elavil
□ Pamelor
□ Desipramine
□ Impramine
□ Zoloft
□ Paxil
□ Prozac
□ Serzone
□ Cymbalta
□ Savlia

OTHER
□ Neurotin
□ Tegretol
□ Dilantin
□ Topamax
□ Depakote
□ Klonpin
□ Lyrica
□ Ativan
□ Xanax
□ Imitrex
□ Ergotamine
□ Mexillitine

WHAT PROCEDURES HAVE YOU HAD FOR YOUR PAIN?

_____

WHAT DIAGNOSITC TESTING HAVE YOU HAD FOR YOUR PAIN?

□ Bone Scan □ CT Scan □ EMG □ MRI □ X Ray

HOW HAS YOUR PAIN LIMITED YOU?

□ no limitations
□ attending school on a limited basis
□ difficulty getting up from a chair
□ difficulty sitting
□ difficulty standing
□ difficulty walking
□ difficulty with ADL's
□ difficulty with recreational sports participation
□ functional limitations
□ inability to attend school
□ inability to perform ADL's
□ inability to work
□ requiring constant assistance
□ requiring occasional assistance
□ working light duty
□ working on a limited basis
□ other_____

WHO HAVE YOU SEEN FOR THIS PROBLEM? (Check all that apply)

□ chiropractor
□ Emergency Room
□ Internist
□ neurologist
□ neurosurgeon
□ orthopedic doctor
□ pediatrician
□ primary care doctor
□ spine surgeon
□ therapist
□ trainer
□ urgent care center
□ walk-in clinic
□ other_____

REVIEW OF SYSTEMS (Please check all that apply)

□ joint pains
□ joint swelling
□ joint stiffness
□ unsteady gait
□ numbness
□ tingling
□ dizziness
□ headaches
□ tremors
□ fatigue
□ unexpected weight loss
□ chills
□ weight gain
□ poor healing wounds
□ redness
□ rash
□ itching
□ scarring/keloids
□ easy bleeding
□ easy bruising
□ enlarged lymph nodes
□ immunosuppression
□ allergic reaction to foods/environment
□ chest pain
□ palpitations
□ fainting
□ heart murmur
□ leg cramps
□ excessive thirst or urination
□ heat/cold intolerance
□ nose bleeds
□ ringing in ears
□ hoarseness
□ corrective lenses
□ blurred vision
□ heartburn
□ nausea/vomiting
□ constipation
□ diarrhea
□ bloody/tarry stools
□ frequent urination
□ difficult/painful urination
□ incontinence
□ blood in urine
□ shortness of breath
□ wheezing
□ cough
□ hurts to breath
□ nervousness
□ anxiety
□ depression
□ hallucination

IS THERE ANYTHING THAT WAS NOT MENTIONED ABOVE THAT YOU FEEL WE SHOULD KNOW ABOUT YOU, YOUR MEDICAL HISTORY OR YOUR PAIN?

_____

_____

_____

_____

_____

WHAT IS YOUR PREFERRED PHARMACY?

Pharmacy name_____

Pharmacy Address_____

Thank you!