

PAIN MANAGEMENT SPECIALISTS OF ATLANTA, P.C.

Randall C. Berinhout, M.D.
Pickens A. Patterson III, M.D.

210 Medical Boulevard
Stockbridge, GA 30281

616-A South 8th Street
Griffin, GA 30224

Tel: (770) 506-1800 • Fax: (770) 389-5947
www.PainManagementSpecialistsOfAtlanta.com

*** ATTENTION NEW PATIENT ***

THIS NEW PATIENT INFORMATION PACKET IS VERY IMPORTANT, AS IT PROVIDES THE PHYSICIAN(S) WITH THE INFORMATION NEEDED TO PROPERLY TREAT/DIAGNOSE YOU. THIS PACKET MUST BE COMPLETED IN FULL & RETURNED TO OUR OFFICE NO LATER THAN 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME. THIS IS MANDATORY TO PROPERLY CREATE YOUR CHART.

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT TIME. (If this packet of information is not completed in full, you must arrive **one (1) hour** prior to your appointment time.) **THIS WILL HELP TO ENSURE THAT YOU ARE SEEN ON TIME.**

WE THANK YOU IN ADVANCE FOR YOUR COOPERATION AND DILIGENCE!



Randall C. Berinhout, M.D.
Pickens A. Patterson III, M.D.

Date: _____

Dear: _____:

Welcome to the **PAIN MANAGEMENT SPECIALISTS OF ATLANTA, P.C.** For your convenience, we have offices located in Stockbridge and Griffin. Your New Patient appointment is scheduled at:

- 210 Medical Boulevard, Stockbridge, Georgia.
- 616-A South 8th Street, Griffin, Georgia.

You have been referred by _____, to be evaluated and receive possible treatment.

An **appointment** has been scheduled for you on _____, _____ at _____ am / pm, with our office. **Please remember your first visit will be for evaluation only!**

Please arrive 30 minutes prior to your appointment for registration. **Be prepared to spend two hours in our office.**

The enclosed forms will provide us with very important information for the diagnosis and the treatment plan that will be needed to help you. Please complete the attached paperwork as accurately as possible and bring it with you to your visit. Also, remember to bring your **current insurance card** and a **photo ID**. Co-payments are expected at the time of service.

Please be sure to bring all studies relating to your current problem as well the results of those studies. This includes, for example, **X-Rays, Magnetic Resonance Imaging (MRI), Bone Scans, CAT Scan (CT Scan), EMG or Nerve Conduction Studies**. If you do not have the results, please let us know, we will try to obtain these results for you. Please do NOT bring in your films, only typed reports. On occasion a signed medical release may have to be faxed to obtain these results, in which case you may have to come by our office and sign a release. If you can obtain these results, they can be faxed to us at (770) 389-5947.

We require a 24-hour cancellation notice on all appointments. If your appointment is not cancelled within 24 hours a charge of \$25.00 will apply and is not covered by your insurance.

Thank you for your cooperation. We look forward to being a part of your medical care. Should you need any further information, please contact us at (770) 506-1800. Our normal business hours are Monday through Friday 8:00a.m. - 5:00p.m.

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Stockbridge, GA 30281

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DIRECTIONS

TO OUR STOCKBRIDGE OFFICE, FROM I-75 (Interstate 75):

TAKE I-75 TO EXIT # 224, EAGLES' LANDING PARKWAY, (AND **HOSPITAL.**)

TURN, OFF THE EXIT, TOWARDS THE HOSPITAL (*Henry Medical Center*), AND FOLLOW SIGNS TO THE HOSPITAL'S MAIN ENTRANCE.

TURN LEFT (AT LIGHT) ONTO HOSPITAL DRIVE. (THIS IS THE MAIN ENTRANCE TO *HENRY MEDICAL CENTER.*)

AT THE 1st STOP SIGN, TURN RIGHT ONTO MEDICAL WAY.

GO 250 ft., TO THE NEXT STOP SIGN, AND TURN LEFT ONTO MEDICAL BOULEVARD.

THEN, GO 200 ft. PAIN MANAGEMENT SPECIALISTS OF ATLANTA, P.C. IS THE 2ND BUILDING ON THE RIGHT.
(# 210 MEDICAL BLVD.)

TO OUR GRIFFIN OFFICE, FROM I-75 (Interstate 75):

TAKE I-75 TO EXIT # 216, HWY. 155/McDONOUGH.

TURN, OFF THE EXIT, ONTO HWY. 155 SOUTH.

GO 8.7 MILES, TO THE 4-WAY STOP SIGN (GAS STATION ON RIGHT), AND TURN RIGHT (STAYING ON HWY.155 SOUTH/JACKSON ROAD)

GO 5.7 MILES, (STAY LEFT AT THE FORK), TO ANOTHER STOP SIGN AND TURN LEFT, (STAYING ON HWY.155/ N. HILL STREET. (YOU WILL THEN GO OVER THE RAILROAD TRACKS.)

GO .2 MILES TO THE 3RD LIGHT AND TURN RIGHT ONTO TAYLOR STREET. (IMMEDIATELY GET IN THE LEFT TURNING LANE), AND AT THE 1ST LIGHT (BY BURGER KING) TURN LEFT ONTO S. 8TH STREET.

THEN, GO .5 MILE. OUR BUILDING (# 614-620) IS ON THE LEFT. (ACROSS FROM *SPALDING REGIONAL HOSPITAL*).

ENTER THE 2ND DRIVEWAY, AND DRIVE AROUND BACK OF BUILDING.
OUR OFFICE IS THE 1ST DOOR ON LEFT, ON THE OTHER SIDE OF BUILDING.
(# 616-A SOUTH 8th STREET.)

***PLEASE KEEP THIS PAGE FOR YOUR RECORDS.**



RANDALL C. BERINHOUT, M.D.

PICKENS A. PATTERSON, M.D.

Dear Patient:

Physicians have always protected the confidentiality of health information by locking medical records away in file cabinets and refusing to reveal your health information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This “privacy rule” protects health information that is maintained by physicians, hospitals, other health care providers and health plans. As of April 14, 2003, your physician will need to comply with the privacy rule’s standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital and health plan will need to consider the privacy rule. All health information including paper records, oral communication, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. In addition we will be taking even more precautions in our office to safeguard your health information such as training our employees and employing computer security measures. Please feel free to ask your physician or our privacy contact about exercising your rights or how your health information is protected in our office.

The notice of Private Practices attached to this letter explains our privacy practices. It contains very important information about how your protected health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our privacy contact at (770) 506-1800, or discuss any questions you may have with your physician.

***PLEASE KEEP THIS PAGE FOR YOUR RECORDS.**

Pain Management Specialists of Atlanta, P.C. Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. PAIN MANAGEMENT SPECIALISTS OF ATLANTA, P.C., HEREIN, WILL BE REFERRED TO AS PMSA, P.C.

We understand that medical information about you and your health is personal. PMSA, P.C. is required by law to maintain the privacy of your health information, to follow the terms of the Notice, and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are required to follow the terms of the Notice that is currently in effect. A paper copy of this notice may be obtained from PMSA, P.C. upon request.

How PMSA, P.C. May Use or Disclose Your Health Information

PMSA, P.C. protects the privacy of your health information. For some activities, we must have your written authorization to use or disclose your health information. However, the law permits PMSA, P.C. to use or disclose your health information for the following purposes without your authorization:

- ~ **For Treatment.** Information obtained by PMSA, P.C. will be used for evaluation and treatment of you, the patient.
- ~ **For Payment.** PMSA, P.C. may use and disclose your health information so that your services may be billed to, and payment may be collected from, you an insurance company or a third party.
- ~ **As Required by Law.** PMSA, P.C. will disclose information about you when required to do so by federal, state or local law.
- ~ **To Advert a Serious Threat to Health or Safety.** PMSA, P.C. may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would be to someone able to help prevent the threat.
- ~ **Public Health Risks.** We may disclose health information about you for public health activities. These activities generally include the following: (1) to prevent or control disease, injury or disability; (2) to report reactions to medications or problems with products; (3) to notify people or recalls of products they may be using; (4) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (5) to notify the appropriate government authority if we believe a person has been the victim of abuse, neglect or domestic violence (we will only make this disclosure if you agree and when required or authorized by law).
- ~ **For Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include audits, investigations, inspections and licensure.
- ~ **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court order or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- ~ **For Specific Government Functions.** PMSA, P.C. may disclose health information for the following specific government functions: (1) health information of military personnel, as required by military command authorities; (2) health information of inmates, to a correctional institution or law enforcement official; (3) in response to a request from law enforcement, if certain conditions are satisfied; and (4) for national security reasons.

When PMSA, P.C. May Not Use or Disclose Your Health Information

Expect as described in this Notice, will not use or disclose your health information without your written authorization. If you do not authorize PMSA, P.C. to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

You Have the Following Rights With Respect to Your Health Information.

- ~ You have the right to request restrictions on certain uses and disclosures of your health information. PMSA is not required to agree to a restriction that you request. If we do agree to any restrictions, we will put the agreement in writing and follow it, except in emergency situations. We cannot agree to limit the used or disclosures of information that are required by law.
- ~ You have the right to inspect and copy your health information as long as PMSA, P.C. maintains the health information. Your health information usually will include the dictated physicians' progress notes and billing records. To inspect or copy your health information, you must submit a written request to PMSA, P.C. We may charge a fee for the cost of copying, mailing or other supplies that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
- ~ You have the right to request that PMSA, P.C. amend your health information that is incorrect or incomplete. To request an amendment, you must submit a written request to PMSA, P.C., along with the reason for request. PMSA, P.C. is not required to amend health information that is accurate and complete. PMSA, P.C. will provide you with information about the procedure for addressing any disagreement with a denial.
- ~ You have a right to receive an accounting of disclosure of your health information we have made after April 14, 2003 for purposes other than disclosures (1) for treatment, payment or health care operation, (2) to you or based upon your authorization and (3) for certain government functions. To request an accounting, you must submit a written request to PMSA, P.C. You must specify the time period, which may not be longer than six years.
- ~ You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about health matters only in writing or at a different residence or post office box. To request confidential communication of your health information, you must submit a written request to PMSA, P.C. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

PATIENT'S BILL OF RIGHTS

- 1) The patient has the right to considerate and respectful care.
- 2) The patient has the right to obtain complete current information concerning diagnosis, treatment, and prognosis in terms they can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on their behalf. A patient has the right to know by name the physician responsible for coordinating their care.
- 3) The patient has the right to receive from their physician any information necessary to give informed consent prior to the start of any procedure and /or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and/or treatment.
- 4) The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of this action.
- 5) The patient has the right to expect all communications and records pertaining to their care should be treated as confidential.
- 6) The patient has the right to every consideration of privacy concerning their own medical care program. Case discussion ,consultation, examination and treatment are confidential and should be conducted discretely. Those not directly involved in treatment must have the permission of the patient to be present.
- 7) The patient has the right to expect that within its capacity, an office must make reasonable response to the request for services. Medical facilities must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medical permissible, the patient may be transferred to another facility only after receiving complete information and explanation concerning the needs for an alternative to a transfer.
- 8) The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating them.
- 9) The patient has the right to expect reasonable continuity of care, as well as the right to know in advance what appointment times and physicians are available.

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PATIENT'S CONSENT TO PHOTOGRAPH

I, the undersigned, do hereby authorize Pain Management Specialists of Atlanta, P.C. to photograph, _____ while under the care of the above institution. I understand that this is solely for identification purposes, and will not be used for any other reason.

Patient

Date

Witness

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date of Birth: _____ Social Security Number: _____

I, _____, hereby authorize _____ to

	Release To	Obtain From
Name: _____	_____	_____
Address: _____	_____	_____
_____	_____	_____

any medical information from my health record for the purpose of continuity of care. Information to be disclosed includes: Office notes, test results, medication history, surgery reports and lab results, for the purpose of treatment.

AUTHORIZATION INCLUDES AUTHORITY TO RELEASE MENTAL HEALTH / REHABILITATION / ALCOHOL OR DRUG RECORDS / HIV TEST RESULTS AND/OR AIDS DIAGNOSIS AND TREATMENT. (IF UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN.) INITIAL EACH BOX THAT APPLIES IF SUCH INFORMATION IS NOT TO BE RELEASED.

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency may not be released to the recipient noted above.
- My diagnosis and/or treatment concerning mental health/rehabilitation may not be released to the recipient noted above
- HIV Antibody test results and/or AIDS diagnosis and treatment may not be released to the above noted recipient.

Purpose of disclosure: _____

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of the signature or automatically when the records requested on this form have been mailed/faxed to the requestor.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.

Date: _____ Signed: _____
(Patient)

Medical Record #: _____ Signed: _____
(Witness)

If Patient is unable to give consent because of physical condition or age, complete the following: Patient is a minor, ____ years of age or is unable to give consent because (describe condition):

Date: _____ Signed: _____
(Parent/Guardian)

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FINANCIAL POLICY

Insurance coverage is a contract between you, the patient, and your insurance company; therefore, any questions about policy coverage or claims payment should be directed to your carrier. Your insurance carrier will determine the insurance reimbursement. You will receive a statement each month if your account has a balance due.

While the filing of the insurance is a courtesy that we do extend to our patients, all charges are the patient’s responsibility from the day the services are rendered. We realize that temporary financial problems may, at times, affect timely payment of your account. Upon request, special considerations may be extended. To avoid any misunderstanding, we ask that you make these arrangements with the financial counselor prior to services being rendered.

I understand from time to time I may incur services that my insurance company considers to be not medically necessary and/or non-covered. I agree and warrant that in such an event, I will pay for those charges incurred in connection with this determination. I have read, understand and agree to the financial policy as stated above.

Patient’s Signature

Date

Witness

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the “Notice of Privacy Practices”, and I have been provided an opportunity to review it.

Name: _____

Date of Birth: _____

Signature: _____

Date: _____

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REGISTRATION

Patient Information (PLEASE PRINT)

Date _____ Home Phone _____ Cell Phone _____

Patient Name _____
Last Name First Name Middle Name

Responsible Party (if patient is a minor) _____

Street Address _____ City _____ State _____ Zip _____

Sex: ___ M ___ F Date of Birth _____ Age _____ ___ Single ___ Married ___ Widowed ___ Divorced

Patient Employed By _____ Business Phone _____

Spouse's Name _____ Date of Birth _____ Business Phone _____

Patient's Social Security # _____ Spouse's Social Security # _____

In case of emergency, who should be notified? _____ Phone _____

If pain/injury is related to Automobile Accident or Worker's Compensation, please provide the appropriate information below.

Primary Insurance

Name of Primary Insurance _____ Policy Holder's Name & S.S.# _____

Address for Claims _____

Phone # _____ Subscriber # _____

Policy/Claim # _____ Group # _____

Secondary Insurance

Name of Secondary Insurance _____ Policy Holder's Name & S.S.# _____

Address for Claims _____

Phone # _____ Subscriber # _____

Policy/Claim # _____ Group # _____

Referral Information

How did you learn of our practice? _____

Assignment and Release

I hereby authorize Pain Management Specialists of Atlanta, P.C., to release any information concerning treatment of the undersigned patient to any insurance company for the purpose of determining eligibility for payment of insurance benefits and to secure those payments. This includes information on substance abuse and/or HIV. I authorize assignment of group insurance, hospital, surgical, medical and any other insurance benefits payable directly to Pain Management Specialists of Atlanta, P.C. I understand that I am financially responsible for any charges not paid by insurance. Interest will be charged on all unpaid balances at the rate of 1.5% per month. Should the account be referred to an attorney or collection agency, I shall pay reasonable attorney's fees and collection expenses. I certify that the information I have given in applying for payment under Title V, XVIII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid claim.

Signature of Insured

Date

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NEW PATIENT PAIN HISTORY

1. Today's date: _____
2. Date pain began: _____
3. Where is your pain: _____
4. What caused your pain? () Work Injury () Auto Accident () Home Injury () Unknown
5. Description of Injury: _____

6. Which best describes your pain? () Mild () Moderate () Severe
7. Rate your pain on a scale from 1 to 10 (10 being the worst pain): _____
8. What type is your pain? () Sharp/Stabbing () Shooting () Burning () Electric () Dull/Aching () Cramp/spasm
9. How frequent is your pain? () Constant () Sometimes How often? _____
10. Do you experience the following? () Pins & Needles () Numbness () Weakness
11. If you answered yes to #10, where do you feel it? _____
12. Is your pain related to activity? () Yes () No
13. What makes your pain better? () Nothing () Lying on your back () Lying on your side () Sitting () Bending
14. What makes your pain worse? () Sitting () Standing () Walking () Lifting () Coughing () Sneezing
15. Which do you have? () Trouble sleeping () Urine Leakage () Leakage of bowels () Sexual dysfunction
16. Does your pain cause you to feel any of these symptoms? () Depressed () Anxious () Angry

Additional Notes by Doctor:

PATIENT HISTORY

HISTORY	YES	NO	COMMENT	HISTORY	YES	NO	COMMENT
Do you smoke?				High Blood Pressure			
Do you drink?				Chest Pain/Angina			
Headaches				Heart Attack(s)			
Osteoporosis/Arthritis				Bleeding Disorder			
Thyroid Problems				Jaundice/Hepatitis			
Diabetes				Liver Problems			
Hiatal Hernia/Ulcers				Kidney Problems			
Stroke				Convulsions/Epilepsy			

GENERAL		
<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Loss of Weight	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> If man > 50 y/o+, date of last PSA	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> History of Cancer in Patient
<input type="checkbox"/> If woman > 40 y/o+, date of last mammogram	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Problems with bladder or bowel control

ALLERGIES	Vital Signs	Blood Pressure
	Height	Pulse
	Weight	Respirations

SOCIAL HISTORY	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	No. of Children:
Work Status: <input type="checkbox"/> Working <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	Type of Work: How Long? By Which Doctor? Attorney's Name:

PAST TREATMENTS	
<input type="checkbox"/> Pain Management Procedures:	
Where on body?	Performed by (Dr.'s Name)?
What Type?	Helped pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many?	If so, how long?
When?	
<input type="checkbox"/> Physical Therapy:	
Helped? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> TENS UNIT:
	Helped? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Previous Surgeries:	
Date:	Type: Dr.'s Name:
Date:	Type: Dr.'s Name:
Date:	Type: Dr.'s Name:
Date:	Type: Dr.'s Name:

<input type="checkbox"/> Doctors Currently Treating Patient:		
Name:	Type:	Phone:
Name:	Type:	Phone:
Name:	Type:	Phone:

MEDICATIONS	Additional Information:
Current Medication	Dosage/Frequency
How Long?	
Past Medication	Dosage/Frequency
How Long?	

ALLERGY QUESTIONNAIRE

If you are allergic to any substance listed below, please mark "X" in the corresponding box. Then, on each corresponding line, list the adverse reaction(s) you experience to each of the substances selected.

- Latex _____
- Betadine/Iodine _____
- Penicillin _____
- Metal (any type) _____
- IVP Dye _____
- Fentanyl _____
- Kenalog _____
- Lidocain _____
- Marcaine _____
- Sodium Chloride _____
- Sulfur _____
- Versed _____
- Sarapin _____
- Wydase _____
- Steroids _____
- Anti-inflammatory _____
- Codeine _____
- Alcohol _____
- Omnipaque _____
- Aspirin _____
- Shell Fish _____
- Peanuts/Peanut oil/Peanut butter _____
- Strawberries _____
- Anesthesia _____
- Pain Medications _____

If you have allergies to any substance not listed above, please notate below:

Patient's Signature

Date

PATIENT'S FAMILY HISTORY

PAIN MANAGEMENT SPECIALISTS OF ATLANTA, P.C.

RANDALL C. BERINHOUT, M.D.
PICKENS A. PATTERSON III, M.D.

Name: _____ Today's Date: _____

FAMILY HISTORY

1. Do you live: Alone with Spouse with Spouse/Children with other Relatives
 with Friend Other _____
2. Is your mother living? Yes, Age _____ No, Cause of Death _____
Age at time of Death _____
3. Is your father living? Yes, Age _____ No, Cause of Death _____
Age at time of Death _____
4. How many siblings do you have? _____
5. Please check any of the following symptoms/diseases your family has experienced and/or are currently experiencing:

Irregular Heart Beat	Ulcers/Haitian Hernia	Tremors
Heart Attack	Hepatitis	Memory Loss
Chest Pain	Gallbladder Disease/Gallstones	Bleeding Disorder
Shortness of Breath	Diverticulosis/Diverticulitis	Kidney Disease/Stones
Heart Murmur	Crohn's Disease	Bladder Dysfunction
Heart Failure	Fractures/Dislocations	Bowel Dysfunction
Thyroid Disease/Goiter	Osteoporosis	Blood in Urine
Diabetes	Psoriasis	Anemia
Emphysema/Asthma	Convulsions/Seizures	Cancer
High Blood Pressure	Stroke/TIA	HIV/AIDS

