Nova Pain Management, P.A.
1813 S. Glenburnie Rd., New Bern, NC 28562

Phone: (252) 672-0095
Fax: (252) 672-9897

PATIENT INFORMATION:

Name:_____ Date:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:( )_____ Work Phone: ( )_____ Ext:_____
Best time and number to reach you: _____
Sex: ( ) M ( ) F Age:_____ Birth date: _____ SS#:_____
Martial Status: ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced
Occupation: _____ Employer:_____
Employer's Address: _____
Employer's Phone #: (___) _____ Contact Person:_____
Spouses Name:_____ Birth date: _____
SS#:_____ Spouse's Employer: _____
Whom may we thank for referring you? _____
In case of emergency, contact:
Name:_____ Relationship: _____
Home Phone: (_) _____ Work Phone (_) _____ Ext: _____

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INSURANCE INFORMATION:

Who is responsible for this account? _____Relationship to patient: _____
Insurance company: _____ Group # : _____
Is patient covered by additional insurance? ( ) Yes ( ) No
Subscriber's Name:_____
Birth date: _____ SS#: _____
Relationship to patient: _____
Insurance Company: _____ Group #: _____

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ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

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ACCIDENT INFORMATION:

Is condition due to an accident? ( ) Yes ( ) No Date:_____
Type of accident: ( ) Auto ( ) Work ( ) Home ( ) Other
To whom have you made a report of your accident?
( ) Auto insurance ( ) Employer ( ) Worker Comp. ( ) Other
Attorney Name (if applicable) _____

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(Confidential)

Patient Name: _____ Today's Date: _____

Age: _____ Birth date: _____ Date of last physical examination: _____

What is your reason for visit? _____

Symptoms — Check conditions you currently have or have had in the past year.

General
( ) Chills
( ) Depression
( ) Dizziness
( ) Fainting
( ) Fever
( ) Forgetfulness
( ) Headache
( ) Loss of sleep
( ) Loss of weight
( ) Nervousness
( ) Numbness
( ) Sweats

Muscle/ Joint/ Bone
( ) Arms ( ) Hips
( ) Back ( ) Legs
( ) Feet ( ) Neck
( ) Hands ( ) Shoulders

Genito-urinary
( ) Blood in urine
( ) Frequent urination
( ) Lack of bladder control
( ) Painful urination

Gastrointestinal
( ) Bloating
( ) Bowel changes
( ) Constipation
( ) Diarrhea
( ) Excessive thirst
( ) Excessive hunger
( ) Gas
( ) Hemorrhoids
( ) Indigestion
( ) Nausea
( ) Poor appetite
( ) Rectal bleeding
( ) Stomach pain
( ) Vomiting
( ) Vomiting blood

Cardiovascular
( ) Chest pain
( ) High blood pressure
( ) Irregular heart beat
( ) Low blood pressure
( ) Poor circulation
( ) Rapid heart beat
( ) Swelling of ankles
( ) Varicose veins

Eye, Ear, Nose, Throat
( ) Bleeding gums
( ) Blurred vision
( ) Crossed eyes
( ) Difficulty swallowing
( ) Double vision
( ) Earache
( ) Ear discharge
( ) Hay fever
( ) Hoarseness
( ) Loss of hearing
( ) Nosebleeds
( ) Persistent cough
( ) Ringing in ears
( ) Sinus problems
( ) Vision-flashes
( ) Vision-halos

Skin
( ) Bruise easily
( ) Hives
( ) Itching
( ) Change in moles
( ) Rash
( ) Scars
( ) Sore that won't heal

Men Only
( ) Breast lump
( ) Erection difficulties
( ) Lump in testicles
( ) Penile discharge
( ) Sore on penis

Women Only
( ) Abnormal Pap Smear
( ) Bleeding between periods
( ) Breast lump
( ) Extreme menstrual pain
( ) Hot flashes
( ) Nipple discharge
( ) Painful intercourse
( ) Vaginal discharge
( ) Other
Date of last menstrual period _____.
Date of last Pap smear _____.
Have you had a mammogram? _____.
Are you pregnant? _____.
Number of children _____.

Conditions — Check conditions you currently have or have had in the past year.

( ) AIDS
( ) Alcoholism
( ) Anemia
( ) Anorexia
( ) Appendicitis
( ) Arthritis
( ) Asthma
( ) Bleeding disorders
( ) Breast lump
( ) Bronchitis
( ) Bulimia
( ) Cancer
( ) Cataracts
( ) Chemical Dependency
( ) Chicken Pox
( ) Diabetes
( ) Emphysema
( ) Epilepsy
( ) Glaucoma
( ) Goiter
( ) Gonorrhea
( ) Gout
( ) Heart Disease
( ) Hepatitis
( ) Hernia
( ) Herpes
( ) High Cholesterol
( ) HIV Positive
( ) Kidney Disease
( ) Liver Disease
( ) Measles
( ) Migraine Headaches
( ) Miscarriage
( ) Mononucleosis
( ) Multiple Sclerosis
( ) Mumps
( ) Pacemaker
( ) Pneumonia
( ) Polio
( ) Prostate Problem
( ) Psychiatric Care
( ) Rheumatic Fever
( ) Scarlet Fever
( ) Stroke
( ) Suicide Attempt
( ) Thyroid Problems
( ) Tonsillitis
( ) Tuberculosis
( ) Ulcers
( ) Vaginal Infections
( ) Venereal Disease

OFFICE USE ONLY

T ____ R____ P____ BP __ HT ____WT _____ P/S __

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Family History

Relation Age State of Health Age of Death Cause of Death

Check if, your blood relatives had any of the following:
Disease Relationship to you

Father_____
Mother_____
Brothers _____
_____
_____
_____
Sisters_____
_____
_____
_____

Arthritis, Gout_____
Asthma, Hay Fever_____
Cancer_____
Chemical Dependency_____
Diabetes_____
Heart Disease, Strokes_____
High Blood Pressure_____
Kidney Disease_____
Tuberculosis_____
Other _____

Hospitalizations

Year Hospital Reason for Hospitalization and outcome

_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had a blood transfusion? Yes___No___.
If yes, please give approximate dates_____

Pregnancies

Year of Birth Sex of Birth Complications if any

_____
_____
_____
_____
_____

Health Habits

Check which substances you use and describe how much you use.

Caffeine_____
Tobacco_____
Drugs_____
Other_____

Serious Illness/ Injuries Date Outcome

_____
_____
_____
_____
_____
_____
_____
_____

Occupational
Check if your work exposes you to the following

_____

Stress Hazardous Substances
Heavy Lifting Other
Occupation _____

I certify that the above information is correct to the best of knowledge. I will not hold my doctor or any members of his/her staff responsible if any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed By Date

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Patient Name: _____ Date: _____

Injuries/Surgeries you have had:	Description:	Date:
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries:		

****

Medications:	Allergies:	Vitamins:
Pharmacy name:		
Pharmacy phone:		

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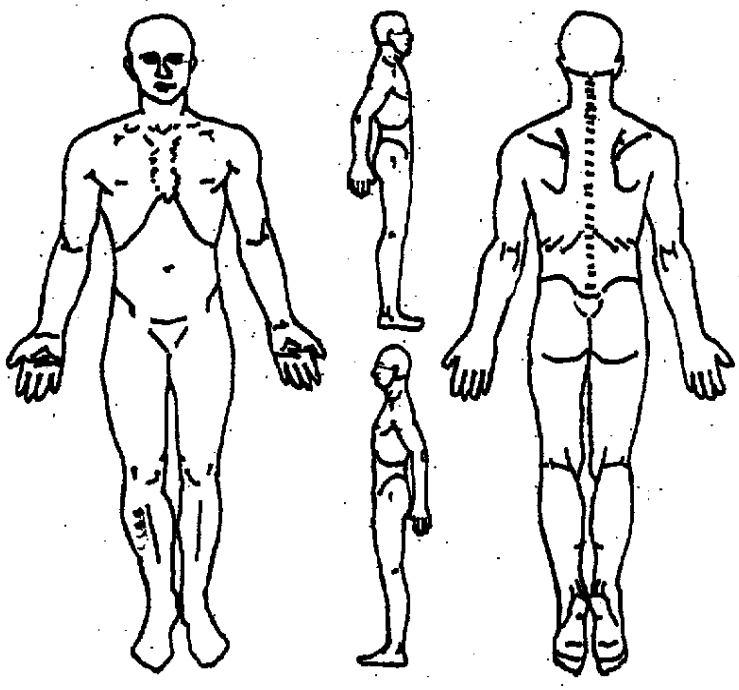
Please draw the location of your pain for discomfort on the images below. Use the symbols show to represent the type(s) of pain: D=Dull B=Burning N=Numb S=Stabbing/Cutting T=Tingling (Pins & Needles) C=Cramping.



On the scales below, please draw a vertical line representing your pain or discomfort.

Rate the pain you have right now:
No Pain Unbearable Pain
_____

Rate your pain at its best in the past week:
No Pain Unbearable Pain
_____

Rate your average pain in the past week:
No Pain Unbearable Pain
_____

Rate your worst pain in the last week:
No Pain Unbearable Pain
_____