



Denis G. Patterson, DO
Board Certified Pain Medicine
Board Certified Physical Medicine & Rehabilitation

5578 Longley Lane
Reno, NV 89511

All Nairizi, MD, MS
Board Certified Pain Medicine
Diplomate of the American Board of Anesthesiology

2385 E. Prater Way, #204
Sparks, Nevada 89434

tele 775.284.8650
fax 775.284.8654
www.nvadvancedpain.com

Appointment Location: _____

Appointment Date : _____

Check in time: _____

(If you check in late, your appointment may need to be rescheduled)

Welcome to Nevada Advanced Pain Specialists!

We are committed to providing a comprehensive multi-disciplinary approach for each individual's pain complaints to ensure you receive the most appropriate care.

Every individual is evaluated for the root cause of their pain – not just a “quick fix” approach to only provide symptomatic relief. We employ a methodical and physical medicine oriented approach that includes analysis of biomechanics, joint motion, as well as skeletal, nerve and muscle tissues. Only the latest diagnostic tools and technologies are used by the professionals at Nevada Advanced Pain Specialists to make accurate assessments including: EMG/Nerve testing, MRIs, x-rays, bone scans, and diagnostic pain injections.

The most important information comes from you – the patient. Our providers will spend time asking questions and listening to you. We understand that your personal experiences with your pain represent some of the most important data available to us for accurate diagnosis and effective treatment.

Once an accurate diagnosis is reached, we will employ various modalities, physical therapy, medication management, and appropriate interventional techniques to treat your pain.

When pain is treated properly, the net result is a more active lifestyle, which will lead to a healthier, happier you!

Sincerely,

Denis G. Patterson, DO
Medical Director – Nevada Advanced Pain Specialists



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Please Bring and Complete the Following to Your Appointment

1. Driver's License/Photo ID
2. Health Insurance Card(s)
3. **Completed** forms from this packet
4. Radiographic Imaging (x-rays, CTs, and/or MRIs) films and reports if you have them available.
5. Any important previous medical records
6. A list of your current medications, when they were last filled, and the name of the provider who prescribed them to you.
7. **Payment is due at the time of service -IF YOU ARE UNABLE TO PAY AT THE TIME OF YOUR APPOINTMENT, YOU WILL HAVE TO RESCHEDULE.**

It is the responsibility of the patient to make sure that all of the above materials are completed and provided to our office at the time of the appointment. If any of the information is not available or incomplete, your appointment may need to be rescheduled.

Our main fax number is (775) 284-8654. Should you need to reschedule your appointment, please call us at your earliest convenience at (775) 284-8650.

We look forward to seeing you soon,
The Staff of Nevada Advanced Pain Specialists



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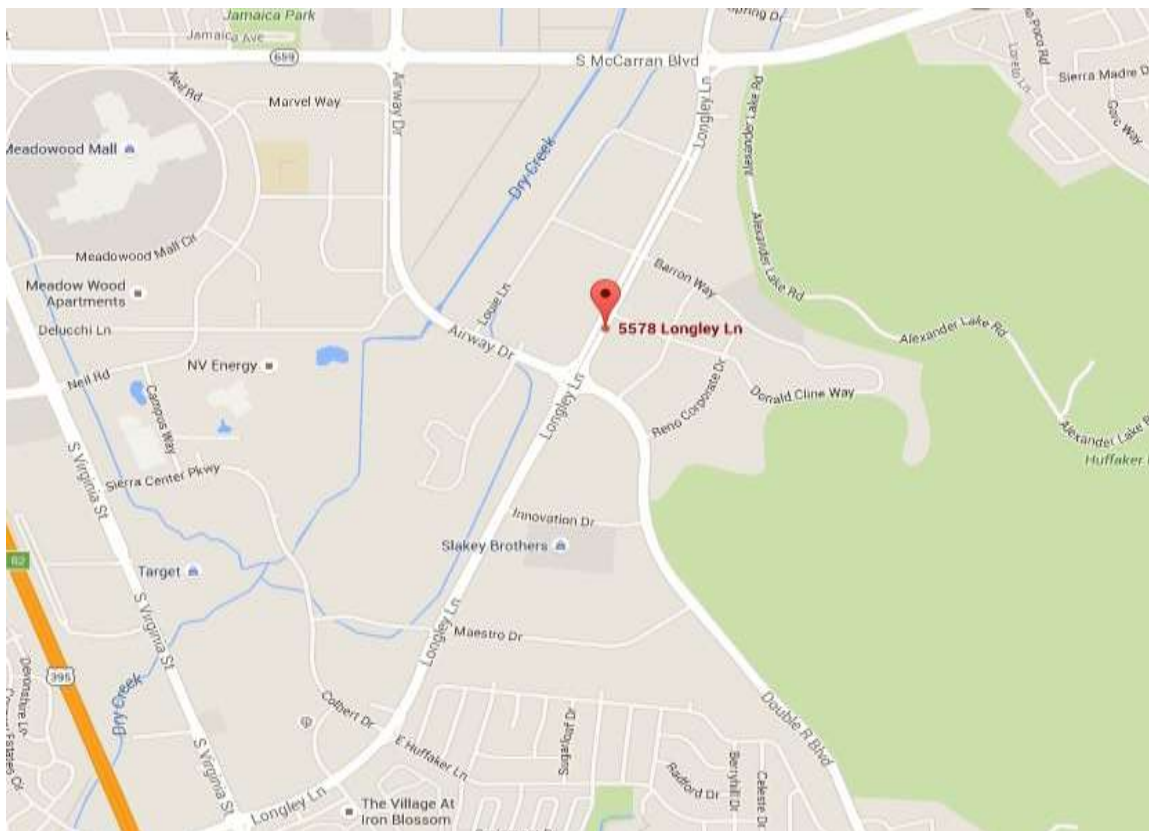
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RENO OFFICE DIRECTIONS:

Heading **SOUTH** of I-580 take exit #64 Moana Ln
Turn **LEFT** onto E Moana Ln
E Moana becomes Airway Dr
Turn **LEFT** onto Longley Ln
Our office is to the **RIGHT**

Heading **NORTH** on I-580 take exit #61 S Virginia St
Turn **RIGHT** onto S Virginia St
Turn **RIGHT** onto Longley Ln
Our office is to the **RIGHT**



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SPARKS DIRECTIONS:

Heading East on I-80 exit #21 for Vista Blvd

Turn left onto Vista Blvd.– heading NORTH. Continue on Vista Blvd. for about a mile.

Turn right onto E. Prater Way and continue east for about .4 miles.

Our office is on the right, located on the second floor of the Northern Nevada Medical Center Medical Office Building

Heading West on I-80 exit #21 for Vista Blvd

Turn right onto Vista Blvd.– heading NORTH. Continue on Vista Blvd. for about a mile.

Turn right onto E. Prater Way and continue east for about .4 miles.

Our office is on the right, located on the second floor of the Northern Nevada Medical Center Medical Office Building

2385 E. Prater Way, Suite 204, Sparks NV 89434





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**In order to bill your insurance company, you MUST complete all requested information.
Demographic information: (Please Print)**

Patient Name: _____ Birth Date: ____/____/____
Mailing Address: _____ City: _____ State: ____ Zip: _____
Home Phone: (____) ____ / _____ Cell Phone: (____) ____ / _____
Email Address: _____ Sex: M ____ F ____

Preferred Method of Contact: _____ Race: _____

Language Preference if not English: _____

Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino ____ Decline ____

Employer: _____ Employer Phone: (____) ____ / _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Individual you would like us to contact and give permission to contact in case of an emergency:

Name: _____ Phone: (____) ____ / _____

INSURANCE INFORMATION:

Primary Insurance

Insurance Name: _____ Address: _____
City: _____ State: ____ Zip: _____ Phone: (____) ____ / _____
Name of Insured (if different than patient): _____ Sex: M ____ F ____ Birth Date: ____ / ____ / ____
Relationship to Patient: _____ ID #: _____ Policy/Group #: _____

Secondary Insurance

Insurance Name: _____ Address: _____
City: _____ State: ____ Zip: _____ Phone: (____) ____ / _____
Name of Insured (if different than patient): _____ Sex: M ____ F ____ Birth Date: ____ / ____ / ____
Relationship to Patient: _____ ID #: _____ Policy/Group #: _____

WORKERS COMPENSATION:

Insurance Company _____ Date of Injury ____ / ____ / ____
Address _____ Phone (____) ____ / _____
Claim # _____ Case Manager _____
Employer at time of injury _____ State _____

Patient Name: _____

Reason for appointment:

Past Medical History:

Past Surgical History:

_____	_____
_____	_____
_____	_____
_____	_____

Family History:

* Please provide us with any medical conditions that family members have

	Condition	Age	Deceased? (Y/N)
Grandfather:	_____	_____	_____
Grandmother:	_____	_____	_____
Father:	_____	_____	_____
Mother:	_____	_____	_____
Brother:	_____	_____	_____
Sister:	_____	_____	_____

Social History:

Smoker: No ___ Yes ___ If yes, # of packs per day ___

Alcohol: No ___ Yes ___ If yes, average # of drinks per day ___

History of drug addiction: No ___ Yes ___

Place of Birth: _____

Marital Status: _____

Children: No ___ Yes ___ If yes, how many _____

Education: _____

Occupation: _____

Review of Systems:

* Mark all that apply to your current condition

General: __Fever __Weight loss __Fatigue __Special diet

Eyes: __Visual loss __Double vision __Injury __Glasses
 __Inflammation __Glaucoma

Ears: __Deafness __Ringing __Dizziness __Pain in ears
 __Discharge from ears

Nose: __Nose bleeds __Obstruction __Discharge from nose

Mouth: __Soreness mouth or tongue __Toothache

Throat: __Hoarseness __Sore Throat __Voice changes

Cardiovascular: __Palpitations __Rapid heart rate __Irregular heart beat
 __Chest pain __Shortness of breath __Leg swelling
 __Leg pains while walking __High blood pressure

Respiratory: __Shortness of breath __Wheezing __Cough __Bloody sputum
 __Night sweats __History of pleurisy __Tuberculosis
 __Pneumonia __Asthma

Gastrointestinal: __Nausea __Abdominal pain __Vomiting __Vomiting blood
 __Jaundice __Change in bowel habits __History of ulcer
 __Weight loss

Genitourinary: __Urinary tract infection __Painful urination __Kidney Stones
 __Incontinence __Blood in urine __Prostate cancer
 __Difficulty stopping and starting urine stream

Musculoskeletal: __History of fractures __Dislocations __Sprains __Neck pain
 __Arthritis __Muscle pain __Stiffness __Mid-back pain
 __Muscle weakness __Night cramps __Joint Swelling
 __Low back pain

Integumentary (skin): __Abnormal sweating __Itching __Rash

Sores that do not heal Easy bruising

Neurological:

Disturbance to smell Facial numbness Difficulty chewing

Facial weakness Taste disturbance Hearing difficulty

Balance problems Speech difficulty Headaches

Swallowing difficulties Paraplegic history

Loss of consciousness Pain going down arm

Pain going down leg Involuntary movement

Seizures/epilepsy Gait difficulty Coordination issues

Numbness, tingling or burning Urinary control problems

Prior head injury or skull fracture

Psychiatric:

Nervous breakdown Hallucinations Depression

Endocrine:

Diabetes Abnormal growth Enlarged head, feet, hands

Unusual hair growth Abnormal change in skin color

Thyroid or goiter problems Dryness of hair or skin

Heat intolerance Cold intolerance Excessive thirst

Excessive urination

Blood & Lymph Systems:

Anemia Swollen lymph nodes Abnormal bleeding

Family history of bleeding disorder

Allergy and Immune System:

Migraine Food Allergies AIDS

Immune system disorder

Women: Are you currently pregnant or think you may be pregnant? No Yes

PATIENT NAME (please print): _____

DATE

:

What percentage of your pain is (please have the total add to 100%):

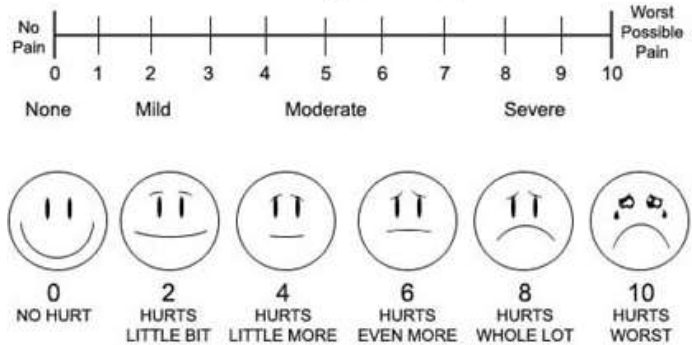
Neck pain ___% Arm Pain ___% Back Pain ___% Leg Pain ___% Head Pain ___% Hip Pain ___%

What is your overall functionality (on a scale from 0%-100%): 0% = Completely Limited / 100% = Fully Functional

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

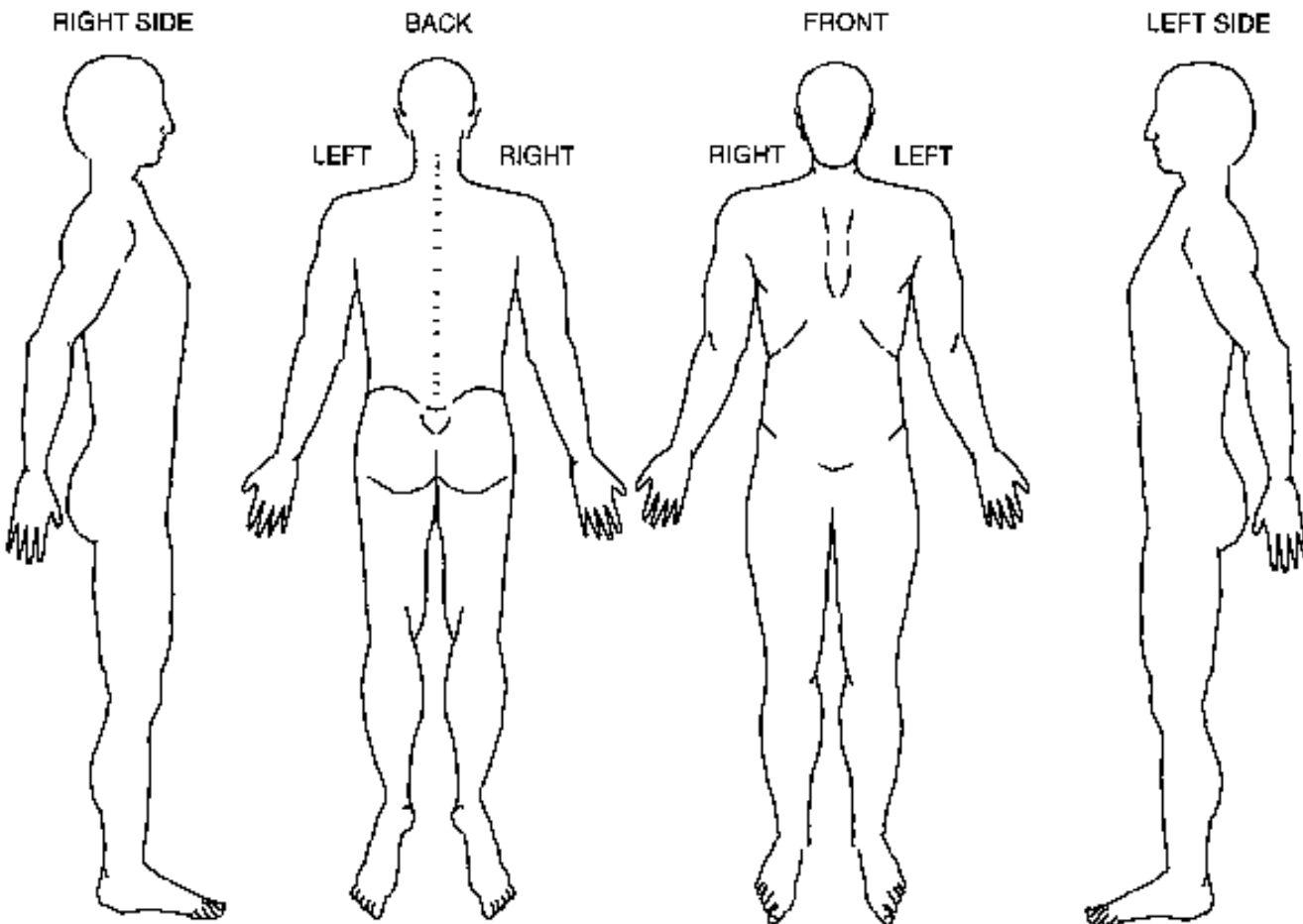
Please describe the type of pain or sensation you are currently experiencing: (check all that apply)

- Aching
- Shooting
- Throbbing
- Cramps
- Stabbing
- Swelling
- Dull
- Stiffness
- Burning
- Numbness
- Sharp
- Tingling



Other, please describe: _____

Please mark on the diagram the location of the pain:



NAME: _____

OFFICE USE ONLY:

— / + UDS: _____ Room #: _____ HT: _____ WT: _____ Pulse: _____ O2: _____ Resp: _____ B/P: _____/_____

Clinical info

Nevada Advanced Pain Specialists Intake Sheet

Where do you have pain? Check all that apply:

Neck Middle back Low back Upper extremity Lower extremity

When did your pain begin? _____

Did your pain begin due to a traumatic event? Or did it come on gradually? _____

If it was due to trauma, what happened? _____

Is your pain getting better, worse, or staying the same? _____

Describe your pain: Check all that apply:

Sharp shooting Dull Achy Burning Throbbing Stabbing Other

Does your pain radiate?

If yes, describe the path it takes: _____

Describe the radiating pain: Check all that apply:

Sharp shooting Dull Achy Burning Throbbing Stabbing Other

Do you have any numbness or tingling anywhere?

If yes, where? _____

Do you have any weakness anywhere?

If yes, where? _____

What makes your pain better? _____

What makes your pain worse? _____

Have you tried ice, heat, or a TENs unit for your pain? Is so, which one(s) do you use and have they helped your pain? _____

What medications do you take for pain? _____

Have you tried others in the past? _____

Have you tried Physical Therapy? _____

If so, when did you last have PT and did it help? _____

Have you had any injections to treat your pain? _____

If so, what type of injections and did it help? _____

Have you had surgery to treat your pain in the past? _____

If so, what type of surgery and did it help? _____

Do you have any of the following? Check all that apply:

History of cancer Fevers/chills Night sweats Night Pain Weight loss Bowel/bladder incontinence



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MEDICATION AGREEMENT & REFILL POLICY

As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. If Nevada Advanced Pain Specialists has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating Physicians, pharmacies, and hospitals.

Please initial next to each line item.

- ___ 1 I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is essential. I agree to actively participate in all aspects of my treatment plan to maximize functioning and improve coping with my condition.
- ___ 2 If it appears to the provider that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as directed by the prescribing provider.
- ___ 3 I agree to follow the dosing schedule prescribed to me by my Physician, P.A. or APN.
- ___ 4 I agree to **never** share my medications with others nor will I sell or exchange my medication for any reason.
- ___ 5 I agree to always keep my medications safeguarded and within my control.
- ___ 6 I agree to notify Nevada Advanced Pain Specialists if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medication. Before any new medication can be prescribed, I must bring the unused medication to the Nevada Advanced Pain Specialists office for disposal.
- ___ 7 I agree that if I receive narcotic medications from Nevada Advanced Pain Specialists I am **not** allowed to receive the same type of medications from another Physician (including the emergency room or clinic) without the express consent or consultation with Nevada Advanced Pain Specialists.
- ___ 8 I agree to use only one pharmacy for my pain-related medications unless extenuating circumstances prevent this from being possible. In this event, I will notify Nevada Advanced Pain Specialists of all pertinent information pertaining to additional pharmacies, mail-order, or other sources.
- ___ 9 I will count my pills that I receive from the pharmacy and will ensure that the proper amount is received. I understand that my Physician will not cover me for any shortage of medication. Any shortage found must immediately be discussed with the pharmacy upon receipt of the filled prescription.
- ___ 10 I understand that medication refills involving narcotic pain medication will require a scheduled office visit with my prescribing Physician at Nevada Advanced Pain Specialists. **Narcotic pain medication refills will not be called into a pharmacy, nor will they be increased over the telephone.**
- ___ 11 I agree to **keep all scheduled appointments. I understand no medications will be given for cancelled or no-show appointments.** I agree also to be prompt to my appointments and understand that if I am more than **15 minutes** late I will have to reschedule.
- ___ 12 I understand that medication refills cannot be made after hours or on the weekend. The Nevada Advanced Pain Specialists refill hours are 8:00am – 2:00pm. Calls after 2:00pm will be addressed the following business day.
- ___ 13 I agree to bring my medications from any other Physician's office to Nevada Advanced Pain Specialists for my office appointments.
- ___ 14 I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
- ___ 15 I understand that I am solely responsible for the safekeeping of my medication and I must treat my medications as I would my money or valuable possession. **The Nevada Advanced Pain Specialists Physician will under no circumstances replace LOST or STOLEN prescriptions or medications.**
- ___ 16 I understand that my treatment at Nevada Advanced Pain Specialists may legally require a monthly visit so that my doctor can properly evaluate my progress, and/or adjust appropriate narcotic pain medications every 30 (thirty) days.
- ___ 17 I understand that abusive behavior or harassment toward any of the Nevada Advanced Pain Specialists staff will not be tolerated. Harassment includes, but is not limited to, more than 2 (two) phone calls to the office in one business day.

- ___ **18** I will not show up at the Nevada Advanced Pain Specialists office unannounced seeking medication refills.
- ___ **19** Medication refills will be made only as often as it is directed on the label. No early refills will be authorized.
- ___ **20 I will not use "street" or illegal drugs.**
- ___ **21 I understand that I can NOT consume alcoholic beverages while taking narcotic medications.**
- ___ **22** I agree to random drug screen tests to verify that I am only using drugs consistent with this agreement. If a test is requested and I leave the office without providing one, I understand I forfeit access to future narcotic prescriptions from Nevada Advanced Pain Specialists.
- ___ **23** I understand that if I do not adhere to any item on this agreement it will result in a mandatory referral to a Behavioral Health Specialist.
- ___ **24** I understand that a forged or falsified prescription will result in the immediate dismissal from Nevada Advanced Pain Specialists and possibly criminal proceedings as required by law.
- ___ **25** I understand that if I do not follow this medication agreement, I may be dismissed from Nevada Advanced Pain Specialists, at their discretion.
- ___ **26** This contract will become part of my permanent medical record.
- ___ **27 For Women Only:** That I am not pregnant and I will inform my physician if I become pregnant.

MATERIAL RISK NOTICE

There are risks with the use of narcotics. These include, but are not limited to:

1. **BRAIN:** Sleepiness, difficulty thinking, confusion, impaired balance
2. **LUNG:** Difficulty breathing, shortness of breath, wheezing, slowing of breathing rate
3. **STOMACH:** Nausea, vomiting and constipation can be severe
4. **SKIN:** Itching, rash
5. **URINARY:** Difficulty urinating
6. **ALLERGY:** Potential for allergic reaction
7. **DRUG INTERACTION(S):** Possibility of interaction with other medications. Can make the effect of both drugs stronger when taken together.
8. **TOLERANCE:** With long term use, an increasing amount of the same drug may be needed to achieve the same pain-relieving effect.
9. **PHYSICAL DEPENDENCE/WITHDRAWAL:** Physical dependence develops within 3-4 weeks when taking these drugs. If they are stopped abruptly, symptoms of withdrawal may occur. These include, but are not limited to: abdominal cramps, abnormal heart beat, nausea and vomiting, sweating, flu-like symptoms. These may be life-threatening. All controlled substances need to be slowly tapered under the direction of your Physician or facility.
10. **ADDICTION:** This refers to the abnormal behavior directed toward acquiring or using drugs in a non-medically necessary manner. People with a history of drug and/or alcohol abuse are at increased risk of developing an addiction.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accept these terms. No narcotic or otherwise habit-forming medications will be prescribed without the acceptance of this agreement,

Pharmacy Name

Pharmacy Telephone Number

Patient Name

Patient Signature

Date



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Physicians' Information

Please list the names, specialties, and phone numbers of your other healthcare providers:

Physician Name

Specialty

Phone Number

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

Patient Name

Today's Date

KNOW YOUR INSURANCE PLAN

Your health insurance is based upon a contract between you and the insurance company, or in some cases, the insured party's employer and the insurance company. If your employer has selected your plan, it is customary for the employer to describe and discuss the benefits of the plan with the employee. It is the responsibility of the insurance company to provide supporting documentation (Plan Benefit Booklet) and the Enrollment Card of the insured.

It is the responsibility of the insured party who benefit from this plan, or who receives benefits from this insurance plan to know:

- The commencement date of the plan
- If there is an annual deductible, and how much
- Which hospital, laboratory, and radiology center the carrier is contracted with
- The amount of your co-payment

It is your responsibility to present the insurance card to the receptionist when checking in. It is also your responsibility to notify our office of any changes or termination of your plan.

The contract between the "Provider Service" (Physician) with any insurance company is:

- To provide quality medical care to the patients
- To submit the claim for service to the appropriate carrier in a timely fashion
- To give credit to the patient for any "contracted discount"
- To collect co-payments and other balances due from patient at time of service

If you ever have questions regarding your coverage, you will need to contact your employer or call the number listed on the back of your insurance card. Please refer to your Explanation of Benefits from your insurance company and your monthly statement from Nevada Advanced Pain Specialists.

We will bill services at the end of each work day. If you have provided information that is not accurate, we will be required to bill you directly. Changes made to your insurance information after the fact comes with a \$25.00 charge to you.

Signature

Date

* Physicians in this practice may have a financial interest or relationship with companies that provide products, services or facilities used in your care. This does not affect the care or medical decision-making used in your treatment and details are available upon request.



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Authorization to Release Protected Health Information & Consent for Treatment

I authorize Nevada Advanced Pain Specialists to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. The administration and performance of all treatments includes but is not limited to, the use of prescribed medication, the performance of procedures, diagnostic imaging, and utilization of urine drug testing, all of which is considered medically necessary or advisable by the treating provider.

Patient Name: _____ DOB: _____

Signature of Patient: _____ Date: _____

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing, or claims payment or other purposes as I may direct. I authorize Nevada Advanced Pain Specialists to release protected health information to the following individual(s):

Name Relationship

Name Relationship

Initial This authorization shall remain in force and effective until (9) nine months after my death or _____ (date) at which time this authorization expires.

Initial I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and Initial may no longer be protected by federal or state law.

Initial I understand that I have the right to revoke this authorization, in writing, at any time.