JPC JACKSON PAIN CENTER

PATIENT INFORMATION

(Please fill out completely - Please Print)

PATIENT INFORMATION

Patient Name (Last, First, Maiden)	Date of Birth	Age	Social Security Number	
Address	City		State	Zip Code
Cell Phone	Home Phone		Spouse's Given Name	

EMPLOYMENT INFORMATION

Employed? ☐ Yes ☐ No	Employer			
Address	City		State	Zip Code
Position	How Long?		Business Phone	
Spouse's Employment	Address			
Position	How Long?		Business Phone	

EMERGENCY INFORMATION

Nearest Living Relative, other than Spouse	Relationship		Phone
Address	City	State	Zip Code
Employment			

INSURANCE INFORMATION

Insurance Company Name and Address	ID Number	Subscribers Name	Date of Birth
	Group Number	Insurance Company Phone Number	
Insurance Company Name and Address	ID Number	Subscribers Name	Date of Birth
	Group Number	Insurance Company Phone Number	
Referred by:			

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to Jackson Pain Center, of all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill if necessary.

Patient Signature _____ Date _____

JPC JACKSON PAIN CENTER

REV 12/07

J. Edwin Dodd, MD **Carroll M. McLeod, MD**

PAIN EVALUATION

Date of Appt.		
Name (Last, First, Middle)		
Referring Physician		
Current Marital Status: ☐Married ☐Single ☐ Divorced ☐Widowed		How Long?
Number of Children	Ages of Children	
What is your Specific Occupation - Include Housewife (Briefly describe what you do)		
Are you presently employed?	☐ Full-time ☐Part-time ☐Unemployed ☐Disabled	If unemployed/disabled,how long?
If you are Unemployed, or employed Part-time, is this due to your present Pain Condition? ☐Yes ☐No		
How long have you been working for your present employer? (or last employer if unemployed, disabled, retired, etc) _____ years		
Have you attempted to return to work? ☐Yes ☐No	If yes, did you work ☐Full Time ☐Part Time	
Did your employer allow you to return? ☐ Yes ☐ No		
Since your pain condition began, which of the following people have you consulted for treatment and Pain Relief? **Please list their name beside their specialty.**		

Name	Name
Allergist	Psychiatrist
Cardiologist (heart)	Radiologist
Dermatologist (skin)	Surgeon
Ear, Nose, or Throat	Psychologist
Endocrinologist	Chiropractor
General Practice and Family Practice	Hypnotist
Internal Medicine (Internist)	Acupuncturist
Neurologist (Nervous System)	Dentist
Obstetrician/Gynecologist	Clergyman
Ophthalmologist (eyes)	Faith Healer
Orthopedist (Bones, joints, and Muscles)	Other (Specify)
Pediatrician	
Plastic Surgeon	

Under what circumstances did the pain begin?

_____ Accident at Work
_____ Accident at Home
_____ Other Accident
_____ At Work, not an accident
_____ Following Surgery
_____ Following Illness
_____ Pain just began, I can't relate it to anything
_____ Other reasons or circumstances

PAIN EVALUATION - page 2

Would you describe briefly the circumstances you checked regarding the beginning of your pain?

Please list the approximate date that you first experienced the pain for which you are seeking help today

In what part(s) of the body did the pain begin? (name ALL the parts)

Does the pain usually wake you at night? ☐ No ☐ Yes | If so, How many times a night ___

When it wakes you up, what do you do then? ☐ Empty bladder ☐ Take medication ☐ Sit up for a while ☐ Other (Describe) _____

What do you do (activities) that will bring on pain, or make the pain worse?

What decreases the pain? (Massage, medicine, lying down, relaxing, etc) Describe exactly.

Have you been operated on for the pain? ☐ Never ☐ Once ☐ Twice ☐ Three times ☐ Four times ☐ Five times ☐ More than five times

Did any of the operations bring relief from the pain? ☐ Yes ☐ No

Have you had any nerve blocks (injections) for the pain? ☐ Yes ☐ No | How many? _____

Please list all physicians and locations where you received a nerve block procedure.

Did any of these injections bring relief from the pain? ☐ Yes ☐ No

If so, what was the longest period of relief from pain after a nerve block injection? _____

What medications do you take for PAIN? (Name ALL medicines you take for pain at any time. Tell how often you take each one.)

PAIN MEDICINE	DOSE	FREQUENCY	DATE STARTED

PAIN EVALUATION - page 3

OTHER MEDICATIONS:

Please list for what illness or problem:

MEDICATION	DOSE	FREQUENCY	DATE STARTED

Please list ALL allergies.

Please list **ALL** previous surgeries and the approximate date. (Use back for additional space)

REVIEW OF SYSTEMS

Please circle any of the following problems that apply to you now in the past 3 months

General:	weight loss	weight gain	fatigue	
Respriartory:	hemoptysis	shortness of breath	wheezing	
Cardiovascular:	ankle edema	chest pain	palpatations	
Gastrointestinal:	abdominal pain	blood in stool	vomiting	reflux
Genitourinary:	frequency	hesitancy	flank pain	
Neurological:	numbness	tingling in legs/arms	headaches	seizures
	uncoordination	bowel/bladder control	sensory alterations	weakness
Musculoskeletal:	gait abnormalities	muscle pain	joint swelling	
Skin:	rash	sores/abscess	itching	mass(es)
Hematologic:	bleeding tendecies	easy bruising	swollen lymph nodes	
Psychologic:	mood swings	agitation	anxiety	

PAIN EVALUATION - page 4

PAST MEDICAL HISTORY

Please Circle all that Apply to you

Glaucoma	High Blood Pressure	Asthma	COPD(emphysema)
Stroke	Pulmonary Embolus	Breast Cancer	Diabetes Mellitus
Heart failure	Kidney Stones	Lung cancer	Tuberculosis
Depression	Hiatal Hernia(GERD)	Lymphoma	Thyroid Disease
Arthritis	Seizure Disorder	Hepatitis	Pancreatitis
HIV/AIDS	Prostate Enlargement	Anemia	Prostate Cancer
Meningitis	Hiatal Hernia	GI Bleeding	Stomach Ulcers
Leukemia	Peptic Ulcer Disease	Liver Disease	Any mental illness
Fibromyalgia	Irritable Bowel Syndrome	Chronic Joint Pain	Migraine Headaches
Chronic Sinusitus	Recurrent Kidney infections	Sleep Apnea	Interstital Cystitis

Please list **ANY** other medical problems that you might have that are not listed above.

Family History: Does anyone in your family have a similar problem? ☐ Yes* ☐ No

Are there any hereditary diseases in your family? ☐ Yes* ☐ No

*If Yes, please list:

List any major medical problems in your family:

Do you smoke? ☐ No ☐ Yes	If so, how many packs per day?_____
Do you drink alcohol? ☐ No ☐ Yes	If so, how much per day? _____
Your Height _____	Your Weight _____

Is this pain or injury a Worker's Compensation case? ☐ Yes ☐ No

Do you have any litigation (lawsuits) pending or planned which are related to this injury or pain?

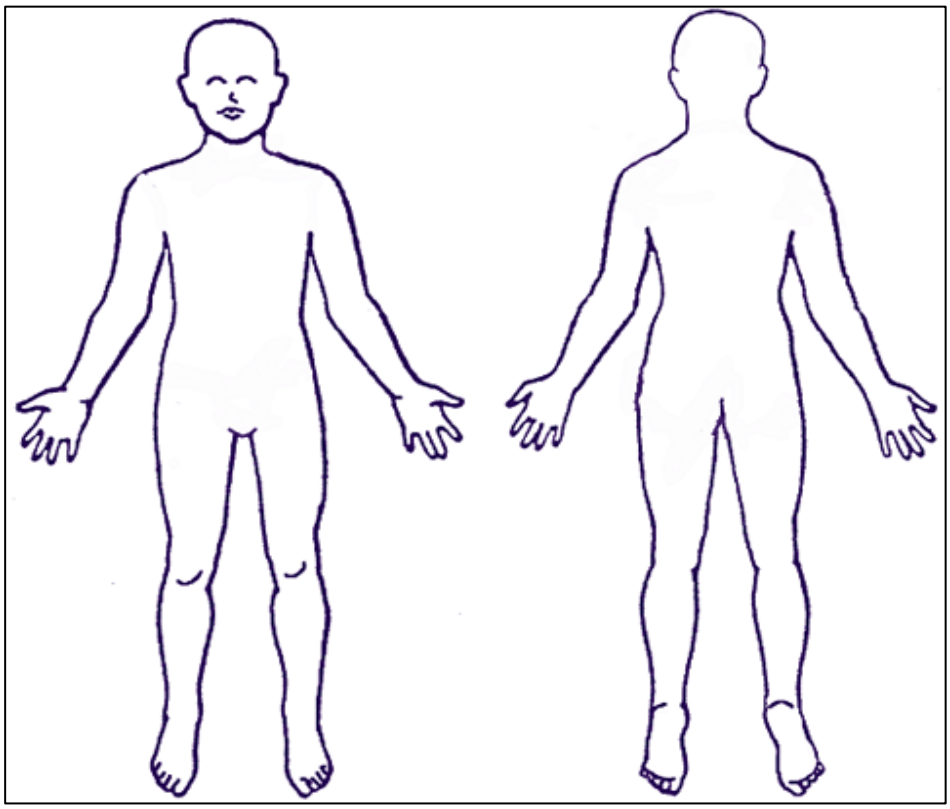
☐ No ☐ Yes

If you answered Yes to a litigation pending or planned, please explain who you are suing and why.

PAIN EVALUATION - page 5

Mark on the drawing the exact spot where your pain is. Mark this with a solid dot (**.**) If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where it starts to where it ends. If it is a whole area that hurts, shade in that area.

FRONT **BACK**



FRONT **BACK**

PLEASE CIRCLE THE APPROPRIATE WORDS THAT DESCRIBE YOUR PAIN

Aching	Shooting	Dull	Constant
Burning	Tingling	Tight	Radiating
Cramping	Hotness	Heavy	Annoying
Numbness	Coldness	Intense	Severe
Stinging	Soreness	Brief	Unbearable
Stabbing	Sharp	Transient	Excruciating

MAE Physicians Surgery Center and Mississippi Surgery Center

Advance Notice Required by Medicare Conditions for Coverage

NOTIFICATION OF OWNERSHIP

MAE PHYSICIANS SURGERY CENTER, LLC

I hereby acknowledge that MAE Physicians Surgery Center, LLC is owned by a collaboration of organizations. These organizations include:

Mississippi Sports Medicine: Jeff D. Almand, MD, Gene R. Barrett, MD, Chris Ethridge, MD, Larry D. Field, MD, Rhettson Hobgood, MD, Brian P. Johnson, MD, Penny J. Lawin, MD, James W. O'Mara, MD, James R. Ramsey, MD, and Walter R. Shelton, MD

Jackson Eye Associates: Richard Blount, MD, John Ford, MD, Ronald G. Herrington, MD, Robert Mallette, MD, Robert May, MD, John McVey, MD, Wilson Moak, MD, Troy Newman, MD, Younghyun Grace Oh, MD Philip Smith, MD, Ken Toler, MD, & Curtis Whittington, MD

Mississippi Retina Associates: Michael Borne, MD, James D. Fly, MD, Joel H. Herring, MD

Jackson Pain Center: J. Edwin Dodd, MD and Carroll McLeod, MD

**for a more detailed listing, please ask the surgery center receptionist*

MISSISSIPPI SURGERY CENTER

I hereby acknowledge that Mississippi Surgical Center is owned by a collaboration of organizations. These organizations include:

Gene R. Barrett, MD, Scott Berry, MD, G. Edward Copeland, MD, J. Edwin Dodd, MD, Jesse Ethridge,MD, Larry D. Field, MD, Leland Gebhart, MD, Robert L. Harris, MD, Scott E. Harrison,MD, John Issacs, MD, Penny J. Lawin, MD, Stephen F. Lee, MD, Carroll McLeod, MD, John B. Milam, MD, James W. O'Mara, MD, C. Michael Osbourn,MD, James R. Ramsey, MD, David Segrest, MD, Walter R. Shelton, MD, Robert Allen Smith, MD, Steven E Speights, MD, William O.B. Thompson, MD, C. Randall Voyles, MD, William Wallace, MD, and Wallace Weatherly, MD

**for a more detailed listing, please ask the surgery center receptionist*

ADVANCE DIRECTIVES

I undestand that MAE Physician's Surgical Center, LLC (MAE PSC) and Mississippi Surgical Center provide outpatient, same day surgery for elective patients. Although, I have assigned Advanced Directives, I understand that during my stay at the surgery center, my request for a "No Code" or "DNR" status will not be honored. I understand that in the case of a life-threatening emergency, the staff will employ any and all life saving measures for me. Therefore, I am waiving my rights to have a "No Code" or "DNR" status during my stay at the surgery center. If I am transferred to another facility for any reason, my Advance Directives will be part of my record and communicated to the receiving facility.

A PATIENT'S BILL OF RIGHTS

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.
3. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in care of the patient must have the permission of the patient to be present.
4. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
5. The patient has the right to voice any grievance without discrimination or reprisal and to be free from abuse and harassment.