

Scottsdale Pain Rehabilitation & Wellness

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New Patient Injection Intake Form

Date: _____
Name: _____ Age _____ Date of Birth _____
Home Address: _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-mail _____
Married _____ Single _____ Divorced _____ Widowed _____
Spouse's Name _____
Physician _____ Phone # _____
Contact in case of emergency: _____ Phone # _____

Please indicate how you found out about our office?

_____ Newspaper- Which one? _____
_____ Health Magazine- Which one? _____
_____ Local talk or lecture- Which one? _____
_____ Internet- Which category? _____
_____ Doctor referral- Who? _____
_____ Friend or Relative- Who? _____

I will be paying by CASH _____ CHECK _____ CREDIT CARD _____

- I Understand and agree that, regardless of my insurance status, I am responsible for all charges at this office at the time professional services are rendered. I agree to the services and fees rendered in this office and that they will not be subject to dispute by my insurance company.
- I certify that the information on this patient information form is true and correct to the best of my ability.
- I agree to notify you of any changes in my health status, address, etc.
- I understand that there is an OFFICE VISIT CHARGE for evaluation or re-evaluation for all visits, in addition to any TREATMENT CHARGE.
- I understand that this office is NOT A MEDICARE PROVIDER and Medicare will NOT reimburse me for my medical expenses here and I will NOT submit any claims from this office to Medicare.
- I understand that the Doctor or his staff will not submit claims to Medicare and that the doctor will not receive any direct or indirect payments from Medicare or Medicare related plans.

- I understand that this office is not a provider for other health care plans or insurance and that this office will not submit claims to them.
- I understand that the Doctor does not provide emergency or urgent care services as defined in the Social Security Act.
- I understand that all services normally covered by Medicare, such as X-Rays, Lab work and physical therapy, will not be covered under this Doctor's prescription.

- **Release of Information:**

Unless I indicate otherwise, I give Dr. Fred Arnold and Staff of Scottsdale Pain Rehabilitation and Wellness permission to discuss and/or release my personal health information to family members, other physicians, testing facilities, and diagnostic centers on an individual basis.

If there is any specific person or organization, I do not wish my personal health information to be released to, I will indicate that on this form:

Do not discuss or release my personal health information to the following:

_____ Anyone or any organization.

_____ The following specific individual(s) or organization(s):

1.

2.

3.

Patient's
Signature _____ Date _____

Please List All Sensitivities/Allergies/Reactions:

Drugs: _____ Foods: _____

Environment: _____

Review of Symptoms: Please circle all words that apply to you:

Appetite change, Weight change, Fever, Chills, Malaise, Fatigue, Itching, Rash, Hives
Skin cancer, other cancer, Seasonal allergy, Hearing change, ringing in ears, Nose bleeds,
Vision change, Headaches, Dizziness, Shortness of breath, Cough, Wheezing, Chest pain,
Edema (swelling), fainting Spells, Indigestion, Nausea, Abdominal pain, Bowel Change, diarrhea,
Constipation, Bloody stool, Dysuria (burning urination), Hematuria (blood in urine, Nocturia (getting
up at night to urinate), Decreased urine force or flow, Urethral discharge, Vaginal discharge, Diabetes,
Thyroid, Periods (y) (n) (change), Breast mass/discharge, Desires/ability changes, Joint pains, Muscle
aches, Bursitis, Gout History, Stiffness, Osteoporosis, Neck pain, Back pain, Epilepsy, Palsy, Tremor
(shaky hands), Stroke, Speech, Memory, Weakness, Tingling, Numbness, Anxious, Depressed,
Stress, Anemia, Bruise easily, Swollen glands. Other
symptoms: _____

PAIN DIAGRAM

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = Ache **B** = Burning **S** = Stabbing **N** = Numbness **P** = Pins & Needles **O** = Other

