PATIENT REGISTRATION

CareFirst MEDICAL CENTERS

Date	_____				
Patient Information					
Name					
Address					
City		**State**		**Zip**	
DOB		**Age**		**Sex**	○ M ○ F
SSN					
Driver's Lic. #					
Marital Status	○ Single	○ Married			
	○ Widowed	○ Divorced			
Referred By:					
Phone Numbers					
Home					
Work					
Cell					
Emergency Contact					
Relationship					
Contact Number					
Employer Information					
Employer					
Address					
City		**State**		**Zip**	
Job Description					
Parent Information (if less than 18 years old)					
Name					
Relation					

Accident Information			
Is current condition due to an accident?	○ Yes	○ No	
If yes, which type of accident:	○ Auto	○ Work	
	○ Home	○ Other	
Date of Injury			
Area(s) of Injury	○ Neck	○ Upper back	
	○ Low back	○ Other	
If other, please specify:			
Description of accident			
Attorney Information			
Name			
Phone			
Health/Work Comp Insurance			
Primary Ins. Co.			
Adjuster			
Policy Number			
Group/Claim Number			
Insured's name			
SSN		**DOB**	
Employer			
Secondary Ins.			
Policy Number			
Group Number			
Personal Automobile Insurance			
Insurance Co.			
Address			
City	**State**	**Zip**	
Phone Number			
Claim Number			
Adjustor			

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FORM #1.1

HISTORY & PHYSICAL FORM - Page 1 of 3

Name (Print): _____ Date: _____
Last First MI

List your **MAIN COMPLAINTS**: _ _____
_____
_____

Describe your condition (onset, cause, etc.) _____
_____
_____

List the date & type of diagnostic procedures you've had (MRI's, CT, x-rays, etc.) _____
_____

MEDICAL HISTORY & REVIEW OF SYSTEMS

Do you have or had any of the following?

Transmissible Disease(s): ❒ None ❒ Hepatitis A-B-C ❒ HIV ❒ TB

Neurological: ❒ Headaches ❒ Stroke ❒ Epilepsy ❒ Aneurysm ❒ Other _____

Cardiovascular: ❒ Chest Pain ❒ Hypertension ❒ Heart Disease ❒ Other _____

Respiratory: ❒ Lund Disease ❒ Asthma ❒ Shortness of Breath ❒ Other _____

Are you a smoker? ❒ No ❒ Yes # of years_____-# of packs per day_____

Gastrointestinal: ❒ Ulcer ❒ Hernia ❒ Hysterectomy ❒ Other _____

Musculoskeletal: ❒ MSD ❒ Arthritis ❒ Neck or Back Pain ❒ Other _____

Metabolic: ❒ Liver Disease ❒ Thyroid Disease ❒ Bleeding Disorder ❒ Cancer/Type_____
❒ Diabetes___Meds___Insulin ❒ Other_____

Genito-Urinary: ❒ Kidney Disease ❒ Painful Urination ❒ Frequent Urination
❒ Possible Pregnancy ❒ Sexual Dysfunction ❒ Other _____

E.E.N.T.: ❒ Blindness ❒ Cataracts ❒ Glaucoma ❒ Vision Difficulty ❒ Deaf
❒ Swallowing Problems ❒ Nose Bleeds

Psychological: ❒ Anxiety ❒ Depression ❒ Fatigue ❒ Nervousness ❒ Other _____

PREVIOUS HOSPITALIZATIONS/SURGERIES (LIST TYPE AND YEAR)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

❒ See Attached

CareFirst MEDICAL CENTERS

HISTORY & PHYSICAL FORM - Page 2 of 3

MEDICATIONS YOU ARE CURRENTLY TAKING

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

❒ See Attached

LIST ALLERGIES

1. _____ 2. _____
3. _____ 4. _____

❒ See Attached

SOCIAL HISTORY

EMPLOYER:_____ Hours worked per week _____

JOB DUTIES:_____

1. USE OF ALCOHOL ❒ Never ❒ Rarely ❒ Moderate ❒ Daily
2. USE OF DRUGS ❒ Yes ❒ No Type_____
3. SLEEP HABITS ❒Good ❒ Intermittent ❒Poor
4. EXERCISE ❒ Never ❒Intermittent ❒ Frequent
5. LEISURE/HOBBIES:_____
6. EDUCATION ❒ High School/G.E.D ❒ College _____# of Years

FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Sibling(s)			
Spouse			
Children			

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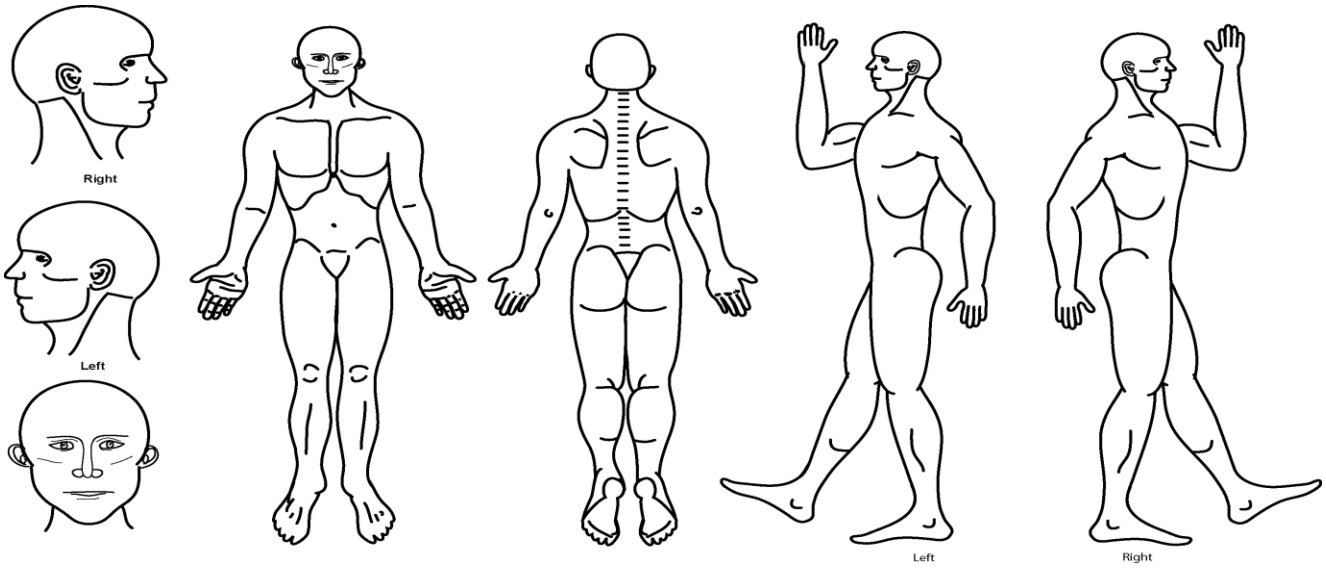
HISTORY & PHYSICAL FORM - Page 3 of 3

Shade your area(s) of pain on the figures below:



Review the information contained in the following table. Circle the number on the left that best describes your pain level today.

0	Pain Free	No medication needed
1	Very minor annoyance – occasional minor twinges	No medication needed
2	Minor annoyance – occasional strong twinges	No medication needed
3	Annoying enough to be distracting	Mild painkillers are effective. (Aspirin, Ibuprofen, Aleve)
4	Can be ignored if you are really involved in your work, but still distracting	Mild painkillers relieve pain for 3-4 hours
5	Can't be ignored for more than 30 minutes	Mild painkillers reduce pain for 3-4 hours
6	Can't be ignored for any length of time, but you can still participate in some activity.	Strong painkillers (Codeine, Vicodin, Hydrocodone) reduce pain for 3-4 hours
7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort.	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (OxyContin, Morphine)
8	Physical activity is severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.	Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3-4 hours.
9	Unable to speak. Crying out or moaning uncontrollably – Near delirium.	Strongest painkillers are only partially effective.
10	Unconscious. Pain makes you pass out	Strongest painkillers are only partially effective.

Check the box which most accurately describes the frequency of your pain (Percentage of Time in Pain):

❒ Intermittently (25%) ❒ Occasionally (26-50%) ❒ Frequently (51-75%) ❒ Constantly (100%)

Signature _____ Date: _____

CareFirst MEDICAL CENTERS

ASSIGNMENT OF BENEFITS

The undersigned patient and or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to CareFirst Medical Associates, PA the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, other doctors, or insurance adjuster, for the purposes of processing my claim for benefits and payments of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name, and prosecute and receive penalties, interest, court cost, or other legally compensable amounts owed by an insurance company, in accordance with Article 21.55 of the Texas Insurance Code, or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by CareFirst Medical Associates, PA, you are hereby tendered demand to pay in full the bill for services rendered by CareFirst Medical Associates, PA within sixty days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgment upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence for a third party, then I instruct the liability carrier to cut a separate draft to pay in full all services rendered payable directly to CareFirst Medical Associates, PA.

STATUTE OF LIMITATIONS: I waive my rights to claim any Statute of Limitations regarding claim for services rendered or to be rendered by CareFirst Medical Associates, PA, In addition to reasonable costs of collection, including attorney fees and court costs, if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to CareFirst Medical Associates, PA the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment for any insurance company representing payment for treatment and health care rendered by CareFirst Medical Associates, PA. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to CareFirst Medical Associates, PA.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my doctor, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period or time. If, during the course of my care, my insurance company required me to take examination from another doctor, I will notify CareFirst Medical Associates, PA immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as the original.

_____ _____

Signature of the patient and/or responsible parties: Date

HIPAA AUTHORIZATION FORM FOR FAMILY MEMBERS/FRIENDS

I, _____, give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	*Relationship:*
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information:
- ☐ Mental health records
- ☐ Alcohol/drug abuse treatment
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Other (please specify_____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers in writing.)

_____
Printed Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

CareFirst Medical Centers
13027 155 South • Tyler TX 75703
Phone: 903.839.1000 • 800.624.0448 • Fax: 903.839.4000
www.carefirstmed.com

OPIOID PAIN MANAGEMENT AGREEMENT

Doctor: Randall Rodgers, DO

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I agree to abstain from excessive alcohol use and I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone. I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use _____Pharmacy, located at _____, telephone number _____, for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.

I agree the medication must be *safe and effective* and help me to *function better*. The goal is to use the lowest dose that is both safe and effective. If my activity level or general function gets worse, the medication will be changed or discontinued by my doctor.

I will participate in *other treatments* that my doctor recommends and will be ready to taper or discontinue the opioid medication as other effective treatments become available.

I will take my medications exactly as *prescribed* and will not change the medication dosage or schedule without my doctor's approval. I agree to be seen by a nurse practitioner if my doctor determines my condition is stable.

I agree I may be subject to having my medication counted/inventoried through the process of random pill counts. Further, I agree that if I refuse to provide my medication(s) to be counted and/or examined within the timeframe allotted, I may be terminated from this practice.

One Doctor. All opioid and other controlled drugs for pain must be prescribed by the doctor who is named above. I will not obtain medications from other doctors or pharmacies unless I am hospitalized. I will tell any hospital or emergency room doctors that I receive pain medications from my provider. In the event of an emergency, if I am given a prescription for pain medication, I will notify my pain doctor as soon as I am able.

I understand that clinic staff (nurses, receptionists, lab staff, etc.) is very important in my success with this treatment plan. I will treat them respectfully and abide by their decisions regarding my care and the enforcement of this agreement.

If I am unable to follow the conditions of this agreement, I understand it may not be safe for me to continue opioid medications.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

OPIOID RISK TOOL

CareFirst MEDICAL CENTER

Name: _____ Date: _____

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction. Please administer to patient on initial visit or prior to opioid therapy.

SCORING		
0–3 LOW RISK	4–7 MODERATE RISK	≥8 HIGH RISK

INSTRUCTIONS: PLEASE MARK EACH BOX THAT APPLIES	FEMALE	MALE
Family History of Substance Abuse		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
Personal History of Substance Abuse		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
Age Between 16-45 Years	☐ 1	☐ 1
History of Pre-adolescent Sexual Abuse	☐ 3	☐ 0
Psychological Disease		
ADD, OCD, Bipolar, Schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

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Name: _____ DOB: _____ Date: _____

	The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers. Use ✓ to indicate your answer.	NEVER 0	SELDOM 1	SOMETIMES 2	OFTEN 3	VERY OFTEN 4
1	How often do you have mood swings?					
2	How often have you felt a need for higher doses of medication to treat your pain?					
3	How often have you felt impatient with your doctors?					
4	How often have you felt things are just too overwhelming that you can't handle them?					
5	How often is there tension in the home?					
6	How often have you counted pain pills to see how many are remaining?					
7	How often have you been concerned that people will judge you for taking pain medication?					
8	How often do you feel bored?					
9	How often have you taken more pain medication than you were supposed to?					
10	How often have you worried about being left alone?					
11	How often have you felt a craving for medication?					
12	How often have others expressed concern over your use of medication?					
13	How often have any of your close friends had a problem with alcohol or drugs?					
14	How often have others told you that you had a bad temper?					
15	How often have you felt consumed by the need to get pain medication?					
16	How often have you run out of pain medication early?					
17	How often have others kept you from getting what you deserve?					
18	How often, in your lifetime, have you had legal problems or been arrested?					
19	How often have you attended an AA or NA meeting?					
20	How often have you been in an argument that was so out of control that someone got hurt?					
21	How often have you been sexually abused?					
22	How often have others suggested that you have a drug or alcohol problem?					
23	How often have you had to borrow pain medications from your family or friends?					
24	How often have you been treated for an alcohol or drug problem?					

FOR PROVIDER USE ONLY:

Score:		Provider Signature:	
Comments:			

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CareFirst MEDICAL CENTERS

FORM 1.5

REQUEST FOR RELEASE OF MEDICAL RECORDS

NAME: _____
(Please Print)

SSN: _____ **Date of Birth** _____

TO: _____
(Physician's name)

ADDRESS: _____
(Street Name & Number) (City) (State) (Zip Code)

☐ **All Medical Records** ☐ **Records From:** _____ **To** _____

☐ **Other** _____

_____

_____

I hereby authorize _____ to release my medical records or copies of such and request these records be sent to:

☐ **CareFirst Medical Centers**
13027 155 South
Tyler, TX 75703
p. 903.839.1000
f. 903.839.4000
w. www.carefirstmed.com

The Federal Government now restricts this office and its attending providers from discussing your health information and/or condition with other family members or persons, unless you give your written permission to do so. By my signature below, I grant CareFirst Medical Centers permission to discuss my protected medical information with the following individuals (check only those persons you want to have access to your medical information):

☐ Spouse / Significant Other: (Name)_____

☐ Leave test results and/or appointment times on answering machine or leave it with your spouse or family member.

☐ Release medical records/information to these other physicians who are providing medical care:

_____ _____

_____ _____

Signature:_____Date:_____