PATIENT REGISTRATION FORM

(PLEASE FILL OUT COMPLETELY)

□ NEW PATIENT □ UPDATE DATE: _____

PATIENT NAME_____ SSN: _____ DOB: _____

ADDRESS_____ CITY, STATE, ZIP _____

HOME PHONE_____ CELL PHONE_____ SEX: □ Male □ Female

EMAIL (FOR USE TO SETUP PATIENT PORTAL)_____

MAY WE LEAVE MESSAGES REGARDING HEALTH-RELATED INFORMATION?_____ IF SO, AT WHICH NUMBER? _____

MARITAL STATUS:_____ LANGUAGE: _____ RACE: □ American Indian / Alaska Native □ Asian
□ Black □ Caucasian □ Pacific Islander □ Other

RESPONSIBLE PARTY NAME _____ DATE OF BIRTH _____

RESPONSIBLE PARTY SSN_____ RELATIONSHIP TO PATIENT □ Self □ Spouse □ Child □ Other

PATIENT'S EMPLOYER / SCHOOL NAME_____ PHONE _____

EMERGENCY CONTACT_____ PHONE _____

PRIMARY CARE PHYSICIAN_____ PHONE _____

PHARMACY _____ CROSS ROADS_____ PHONE _____

IN ORDER TO FILE YOUR INSURANCE CLAIM, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Primary Insurance: _____ **Secondary Insurance**: _____

POLICY HOLDER NAME_____ POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT_____ RELATIONSHIP TO PATIENT_____

EMPLOYER_____ EMPLOYER _____

ID#_____ ID# _____

GROUP / CLAIM#_____ GROUP / CLAIM# _____

POLICY HOLDER SEX □ M □ F DOB_____ POLICY HOLDER SEX □ M □ F DOB _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION, FINANCIAL AGREEMENT, CONSENT TO TREAT, AND PRIVACY PRACTICES

I HEREBY AUTHORIZE PIONEER SPORTS AND SPINE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND HEREBY AUTHORIZE PIONEER SPORTS AND SPINE ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I HEREBY AUTHORIZE THE PROFESSIONAL MEDICAL STAFF AT PIONEER SPORTS AND SPINE TO EVALUATE AND TREAT ME OR MY DEPENDENTS AS THEY SEE MEDICALLY NECESSARY.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (ORIGINAL TO BE MAINTAINED IN PATIENT'S PERMANENT MEDICAL RECORD): I ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF THE OFFICE'S NOTICE OF PRIVACY PRACTICES. BY SIGNING BELOW, I AGREE WITH THE ABOVE STATEMENTS.

PATIENT OR LEGAL GUARDIAN SIGNATURE_____ **DATE** _____

PIONEER
Sports & Spine

(480)249-5525
(888)990-2056 fax
4915 E. Baseline Rd. Suite 108
Gilbert, AZ 85234

PATIENT QUESTIONNAIRE

(Please fill out completely)

Date _____

_____ _____ _____ _____

Last Name First Name MI DOB

Referring Physician: _____ Phone: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed/r Number of Children (if any): _____

Date of Pain Onset: _____ Briefly Describe Pain: _____

Medical History (diabetes, high blood pressure, etc.): _____

_____

Injuries: _____

Surgeries: _____

_____

Current Medications: _____

_____

Drug Allergies: _____

Smoking □ Yes □ No Packs per day: _____ Alcohol □ Yes □ No Drinks per day: _____

Illicit Drugs □ Yes □ No Describe: _____

Describe Current Exercise Program (if any): _____

Occupation: _____ Job duties: _____

Currently Off Work? □ Yes □ No □ Light duty □ Short-term Disability □ Long-term Disability □ Social Security Disability

If Currently Off Work, Last Date Worked: _____

Illnesses That Run in Your Family (heart, thyroid, diabetes, etc.): _____

_____

During the Past Year, Have You Had Any of the Following:

□ unexplained weight loss
□ change in appetite
□ change in bowel habits
□ change in bladder habits
□ change in sexual function
□ unexplained weakness in arms
□ unexplained weakness in legs
□ fatigue
□ dizziness
□ difficulty sleeping

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Opioid Agreement

Please review the information listed below and initial where indicated (____).

_____Patient does not plan to have Pioneer Sports and Spine prescribe opioids, but they have read and understand the information below and will abide by this agreement if prescribed opioids by Pioneer Sports and in the future.

_____Patient may be called at any time for a random pill count either at Pioneer Sports and Spine or at a local pharmacy (if patient is unable to obtain transportation to the office). If pill count shows overutilization of medications, patient is subject to discharge from the practice.

_____Patient will not drink alcohol.

_____Patient will not use illicit drugs (speed, methamphetamine, heroin, marijuana, cocaine, crack-cocaine, ecstasy, LSD, etc.)

_____Patient will not take opioids unless they are in current treatment plan as prescribed by Pioneer Sports and Spine. Opioids administered in a hospital, emergency room or urgent care clinic are acceptable. No opioid medications can be taken home from these facilities. If another provider writes an opioid prescription, patient must call the office to get permission to fill, prior to attempting to fill the prescription at a pharmacy. If patient fails to do this, they will be subject to discharge. Pioneer Sports and Spine frequently checks Arizona's prescription drug monitoring program for compliance with this policy.

_____A urine drug screen (UDS) may be performed at every visit (even when opioids are not prescribed).

- All opioids in current treatment plan should be found in UDS unless opioid is only taken for pain flares as evidenced by prescription directions and refill pattern.
- If there is a (+) finding in UDS of any illicit drug (other than marijuana), patient will be immediately discharged from the practice.
- If there is a (+) finding in UDS for (1) a legal opioid not currently prescribed by Pioneer Sports and Spine (2) alcohol (3) benzodiazepines or (4) marijuana, patient will be informed and given one chance to correct the situation (i.e. abstain from these in the future). If this occurs a second time, patient will be discharged from the practice.

_____All opioids are controlled substances and can result in a DUI (it is unlawful for a person to drive a vehicle (1) while under the influence of any drug, or any combination of liquor and/or drugs if the person is impaired to the slightest degree, OR (2) while there is any drug or its metabolite in the person's body. (Ariz. Rev. Stat. Ann. §§ 28-1381).

_____ Pioneer Sports and Spine's ideal maximum daily dose of opiates is 50 MME (morphine milligram equivalents) per day. Benzodiazepines cannot be taken with opioids (even if prescribed by another provider).

Ideal maximum total daily dose of opioids

Drug	50 MME dose
Morphine	45mg
Hydrocodone (Vicodin)	50mg
Oxycodone (Percocet, Oxycontin)	30mg
Hydromorphone (Dilaudid)	10mg
Tapentadol (Nucynta)	100mg
Oxymorphone (Opana)	15mg
Fentanyl	25mcg/hr patch
Methadone	10mg
Codeine	330mg

Benzodiazepines (not allowed by Pioneer Sports and Spine if taking opioids)

Alprazolam (Xanax)
Lorazepam (Ativan)
Clonazepam (Klonopin)
Diazepam (Valium)
Chlordiazepoxide (Librium)
Clorazepate (Tranxene)
Estazolam
Flurazepam (Dalmane)
Loprazolam (Somnovit)
Oxazepam
Triazolam (Apo-Triazo, Halcion, Hypam, and Trilam)
Temazepam (Restoril) *may be allowed if prescribed by an outside physician

Patient Signature_____ Date:_____

Printed Name_____ DOB:_____

Physician Signature_____ Date:_____

Opioid Therapy for Chronic Pain: Informed Consent

Please review the information listed below and initial where indicated (____) signifying that you understand each statement. If you have questions regarding these statements, please address them during your appointment.

_____When I take opiate medications, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems thinking clearly, slowing of my reactions, or slowing of my breathing.

_____When I take these medications it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.

_____When I take these medications regularly, I will become physically dependent on them, meaning that my body will become accustomed to taking the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

_____I may become addicted to these medications and require addiction treatment if I cannot control how I am using them, or if I continue to use them even though I am having bad or dangerous things happen because of the medications.

_____Anyone can develop an addiction to opioid pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past are at higher risk. I have told my provider if I or anyone in my family has had any of these types of problems.

_____Taking too much of my pain medication, or mixing my pain medications with illicit drugs, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.

_____I understand that taking certain medications such as buprenorphine (Suboxone®, Subutex®), naltrexone (ReVia®), nalbuphine (Nubain®), pentazocine (Talwin®), or butorphanol (Stadol®) will reverse the effects of my pain medicines and cause me to go into withdrawal.

_____It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.

_____I have discussed the possible risks and benefits of taking opioid medications for my condition with my provider and have discussed the possibility of other treatments that do not use opioid medications including supplements (e.g. vitamin D, magnesium, turmeric), muscle relaxers, SNRIs, nerve/seizure medications, CBD oil etc.

_____These medications are being prescribed to me because other treatments have not controlled my pain well enough.

_____These medications are to be used to decrease my pain but they will not take away my pain completely.

_____These medications are to be used to help improve my ability to work, take care of myself and my family, and meet other goals that I have discussed with my provider, but if these medications do not help me meet those goals, they will be stopped.

_____For Men: Taking opioid pain medications may chronically cause low testosterone levels and affect sexual function.

_____For Women: It is my responsibility to tell my provider immediately if I think I am pregnant or if I am thinking about getting pregnant. If I become pregnant while taking these medications and continue to take the medicines during the pregnancy, the baby will be physically dependent on opioids at the time of birth and may require withdrawal treatment.

I have reviewed this form with my provider and have the chance to ask any questions. I understand each of the statements written here and by signing give my consent for treatment of my pain condition with opioid medications.

Patient Signature_____ Date:_____

Printed Name_____ DOB:_____

Condition for which an opiate is being prescribed_____

Physician Signature_____ Date:_____