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, PRIVACY PRACTICES, AND PATIENT RIGHTS

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 ME 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.

IF I AM AN INTRATHECAL PUMP PATIENT, I UNDERSTND THAT MEDICATIONS ARE ORDERED FROM OUTSIDE PHARMACIES AND IF I MISS OR RESCHEDULE MY APPOINTMENT, I MAY HAVE TO PAY CASH FOR MEDICATION THAT IS NOT USED OR EXPIRES.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND PATIENT RIGHTS (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 AND PATIENT RIGHTS. BY SIGNING BELOW, I AGREE WITH THE ABOVE STATEMENTS.

PATIENT OR LEGAL GUARDIAN SIGNATURE____________ DATE ____________

(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 and Informed Consent

Opioid Agreement

Please review the information listed below and sign and date on page 4.

Even if I do not plan to have Pioneer Sports and Spine prescribe opioids, I have read and understand the information below and will abide by this agreement if prescribed opioids by Pioneer Sports and in the future.

- I 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.
- I will not drink alcohol.
- I will not use federally illicit drugs (marijuana—specifically THC—, speed, methamphetamine, heroin, cocaine, crack-cocaine, ecstasy, LSD, etc.). Marijuana is legal in Arizona, but our providers get their license to prescribe opiates from the federal government where marijuana is still illicit. CBD products <u>are</u> permitted. Low levels of THC as could be contained in CBD products or THC creams may be permitted (speak with your provider about this). Those who do not take oral narcotics may be permitted to use marijuana—CBD and THC containing products—(speak with your provider about this).
- I 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 clinics 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 federally illicit drug (excluding marijuana), patient will be immediately have care withdrawn.
    - 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—specifically THC—,

patient will be informed and given a chance to correct the situation (i.e. abstain from these in the future). Care may be withdrawn at any time if the (+) findings occur again.

- All opioids are controlled substances and can result in a DUI [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/day
Hydrocodone (Vicodin)	50mg/day
Oxycodone (Percocet, Oxycontin)	30mg/day
Hydromorphone (Dilaudid)	10mg/day
Tapentadol (Nucynta)	100mg/day
Oxymorphone (Opana)	15mg/day
Fentanyl	25mcg/hr patch
Methadone	10mg/day
Codeine	330mg/day

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

Informed Consent

- 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 opioids, 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 will discuss the possible risks and benefits of taking opioid medications for my condition with my provider and 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.
- Opioid medications are being prescribed to me because other treatments have not controlled my pain well enough.

- Opioid medications are to be used to decrease my pain but they will not take away my pain completely.
- Opioid 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 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:__________________