Beacon Pain Clinic
Patient Registration Form

Patient Name_____
First Middle Last

Phone (home)_____(cell)_____(work)_____

Email_____

Social Security #_____ DOB_____

Address_____

City_____ State_____ Zip_____

Emergency Contact_____ Phone_____

Emergency Contact Relation_____

Insurance Information

Guarantor (person who holds insurance policy) ____self ____parent ____spouse

Guarantor name_____ DOB_____

Employer_____ SSN_____

Patient Employer_____

Primary Insurance_____ Policy#_____

Group#_____

Secondary Insurance_____ Policy#_____

Group#_____

I authorize payment directly to Rebekah Guy, MD, doing business as Beacon Pain Clinic, for all charges for medical products and services. I understand that I am financially responsible to Dr. Guy for all charges that are billed to the insurance company. I further understand that medical decisions are made between the doctor and the patient. Some insurance companies might call some treatments “medically unnecessary” without regard for what the doctor and patient have decided upon. Some procedures we perform, while proven to be safe and effective and considered “experimental” by insurance companies are not covered. I authorize Dr. Guy to provide information, including my medical information, to the insurance company and to discuss our treatment plan. I understand that I am responsible for these charges if the insurance company denies my claim for any reason. I understand that it is my responsibility to verify if my insurance will cover my procedures or services rendered. If I am a Medicare patient, I will be told in advance if a service or procedure is known not to be covered and will submit payment at the time of service or procedure. I hereby request that the payment of authorized benefits for services rendered or in my behalf by Dr. Guy, be made to the provider. I authorize any holder of medical information about me to release it to the healthcare financing administration, my insurance carrier or its agents, any information (in compliance with HIPPA and other regulations) a required to determine these benefits or the benefits payable for related services.

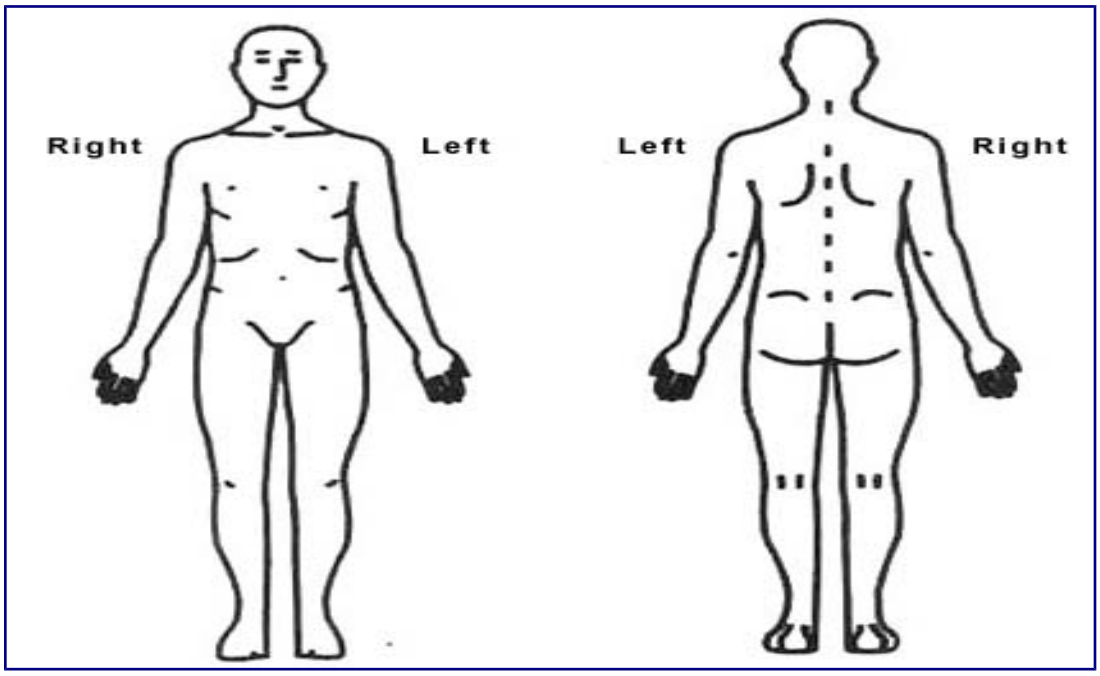
Patient Signature_____ Date_____

Guarantor Signature_____ Date_____

Beacon Pain Clinic
Pain Diagram/Scale

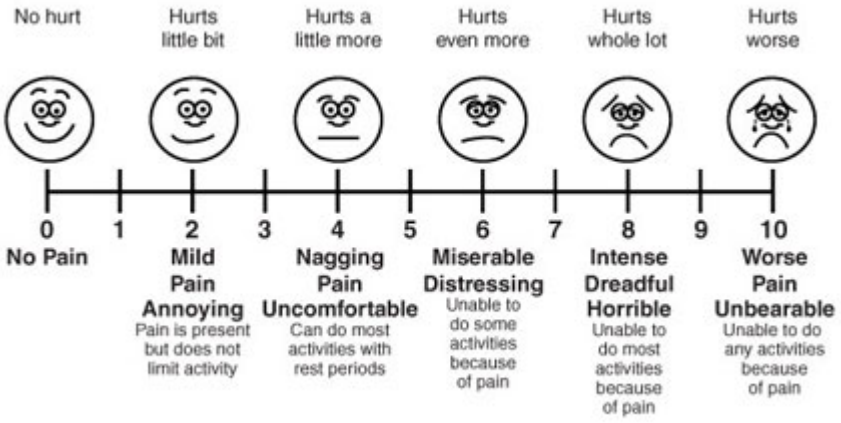
Patient Name:_____ Date:_____

DOB:_____ Height:_____ Weight:_____



Mark the areas of your body where you typically feel your pain. If you are having multiple types of pain please use the provided key:

Aching: ==== Tingling, Pins and Needles: **0000** Burning: xxxx Sharp/stabbing: ////



Name_____ DOB_____

Please List Any Current or previous medical conditions and the treating physician:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

Surgical History

Approx date Surgeon Procedure

1. _____

2. _____

3. _____

4. _____

5._____

6._____

7._____

8._____

9._____

Name_____ DOB_____

Family History

M=Mother F=Father S=sister B=brother

	M	F	S	B		M	F	S	B
Alzheimer/Dementia					Depression				
High Blood Pressure					Cancer				
Stroke					Epilepsy				
High Cholesterol					Diabetes				
Trouble with blood clotting					Heart Trouble				
Muscular Weakness					Arthritis				
Migraine Headaches					Allergic Diseases				

Social History

Are you: single____ married____ widowed____ divorced____ separated____ significant other____

What kind of work do you do?_____

What types of recreational activity/relaxation do you partake in? How often?_____

_____

Do you Drink? No____ Yes____ Drinks per day____ Socially____ Rarely____ Moderately____

Do you Smoke? No____ Yes____ How many a day?_____ Less than a pack a week?_____

Does anyone in your family have a substance abuse history? No____ Yes____ Whom?_____

Do you have a history of street drug abuse? No____ Yes____ Drug?_____

Do you have a history of prescription drug abuse? No____ Yes____ Drug?_____

Have you ever been hospitalized for a psychiatric condition? No____ Yes____

When?_____ Where?_____

Have you used or are you using any illegal substances? No____ Yes____ Which ones?_____

Is there any substance abuse in your household? No____ Yes____ Which kind?_____

Have you ever been treated for, or do you feel you have problems with alcoholism or any type of substance abuse? No____ Yes____ Details_____

Name_____ DOB_____

Please List all current medications that you are taking, including over the counter medications:

Medication	Dose	#per day	Physician	Medication	Dose	#per day	Physician

List your allergies and the reaction:

_____

_____

_____

_____

_____

Name_____ DOB_____

Review of Symptoms

Please circle any of the following problems or symptoms which you may have:

General Health: weakness, fatigue, body aches, headaches, poor appetite, excessive appetite
Other:_____

Skin: Hives, eczema, dryness, itching, rash, changes in moles or skin color, changes in nails
Other:_____

Head: headaches, migraines, fainting/loss of consciousness, dizziness, passing out
Other:_____

Eyes: Blurred vision, double vision, change in vision, pain
Other:_____

Ears: Changes in hearing, pain, ringing, drainage, vertigo
Other:_____

Nose: congestion, runny nose, bloody nose, sinus problems, snoring
Other:_____

Throat and Mouth: Difficulty swallowing, hoarseness, dry mouth, sores in mouth
Other:_____

Respiratory: Shortness of breath, asthma, wheezing, sleep apnea, cough, pneumonia
Other:_____
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Gastrointestinal: abdominal pain, heartburn, nausea/vomiting, blood in stool, IBS, Diarrhea, hernia, constipation, ulcer, jaundice, excessive gas, bloating, colitis
Other:_____

Muscles, Bones and Joints: arthritis, muscle/joint pain, cramps, joint swelling, fractures, gout, osteoporosis, fibromyalgia, polio (Specific joint areas: shoulder, elbow, wrist, hand, fingers, hip, knee, ankle, foot, toes)
Other:_____

Back and Neck: Back pain or stiffness, neck pain or stiffness, restricted motion, disc problems, sciatica, fracture
Other:_____

Psychiatric and Mood: depression, anxiousness, poor energy or motivation, short temper, compulsive behavior, change in mood, problems sleeping, poor concentration
Other:_____

Cardiovascular: pacemaker, chest pain, high blood pressure, blood clots, murmur, heart attack, high cholesterol, leg edema/swelling, rheumatic fever
Other:_____

Other conditions or problems not listed:_____

_____

Beacon Pain Clinic Controlled Substance Agreement

The purpose of this agreement is to protect your access to controlled substances and protect our ability to prescribe to you. Please check the line below or initial by each line 1-13.

____If this line is checked, I do not want controlled prescriptions. However, if I ever get controlled medications I agree to these provisions.

____1. I understand that my provider and I will work together to find the best treatment for my pain. To achieve this goal this office is willing to prescribe controlled substances. The goals of this treatment is to reduce my pain in order to improve my ability to function, but may not completely eliminate my pain.
____2. I understand that I am responsible for my medications. I will take measures to secure them to prevent possible theft. If the medications are lost, stolen, or misplaced, **regardless of the reason.** I understand that my medications will **NOT** be replaced or refilled and I risk being discharged from Beacon Pain Clinic.
____3.I **will not** request or accept pain medications from any other physician or individual while receiving medications from Beacon Pain Clinic. I understand by doing so I could be endangering my health and it is illegal. Exceptions will be made if I have DISCUSSED THEM WITH DR. GUY or while I am admitted to the hospital.
____4. Use of prohibited substances can interfere with my opioid therapy and cause adverse effects. Therefore, I agree to notify my provider of the use of all substances: to include marijuana, alcohol, and illicit drugs. I understand that I should not be using these substances while on opioid therapy and by doing so I risk being discharged.
____5. Medication changes will **NOT** be made over the phone. Changes in my medication will require a doctors visit so I can be re-evaluated. **I will not dispose of unused medications. I will bring in all medications in their original containers to every appointment.**
____6. I will take the medication at the dose and frequency prescribed by my provider. **I understand that I am NOT to increase the dose of my medication.** By doing so I may no longer receive controlled substances from my physician.
____7. I understand that prescriptions may take up to 72 hours to refill. I will be responsible and plan accordingly in order to get my refills on time and will also plan for weekends and holidays so as I will not run out of my medication. Same day requests or walk in requests will NOT be honored or filled.
____8. I understand that opioids have common potential side effects that include: constipation, sweating itching/rash, and allergic reactions. Drowsiness may occur when starting or increasing the dosage. I understand this and agree to refrain from driving a motor vehicle or operating machinery until drowsiness subsides.
____9. I agree to random drug testing by my physician to monitor my compliance with proper medication use. I waive certain privacy rights so that my physician may talk to other healthcare providers, family members, and even law enforcement officials. I also agree to come into the office when asked to and submit to a drug screen or produce unused portions of medications to verify they are being taken correctly.
____10. I understand that I can become dependent on opioid medications, which in a small number can lead to addiction. If addiction occurs my physician will discontinue the medication and I will be referred to a drug treatment program.
____11. I understand that some persons develop tolerance, which is the need to increase the dose of the medication to achieve the same level of pain control. I also understand that I may become physically dependent on the medication and stopping the medication suddenly my cause serious withdrawal symptoms.
____12. I understand that all controlled substances are my responsibility and I am not to give them to any other persons for any reason. If I do my physician may no longer prescribe controlled substances to me and may also lead to discharge from the clinic.
____13. I fully understand that if I violate any of the above conditions that my controlled substance prescriptions and/or the treatment with Beacon Pain Clinic may be immediately terminated and I risk being discharged from the clinic. I also understand that this may result in withdrawal symptoms.

Patient Name:_____ Date:_____

Signature:_____ Reviewed by Physician:_____

Name & location of pharmacy_____ Witness Initials:_____

Opioid Risk Tool (ORT)

Patient Form

Name _____ **Date** _____

Mark each box that applies		Female	Male
1. Family history of substance abuse	■ Alcohol ■ Illegal drugs ■ Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	■ Alcohol ■ Illegal drugs ■ Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark box if 16-45 years)		[ ]	[ ]
4. History of preadolescent sexual abuse		[ ]	[ ]
5. Psychological disease	■ Attention-deficit/ hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia ■ Depression	[ ] [ ]	[ ] [ ]