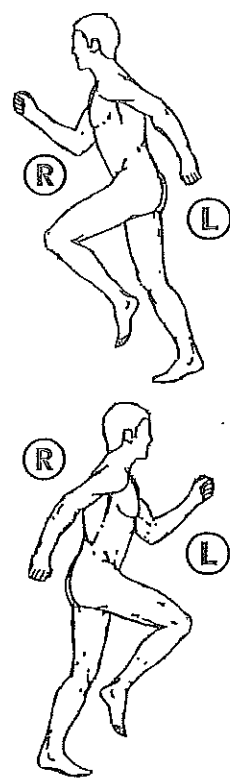


MARK YOUR LEVEL OF PAIN ON THE SCALE



CIRCLE A FEW WORDS THAT BEST DESCRIBE YOUR PAIN

- | | | | | | |
|------------|------------|----------|-------------|-------------|-----------|
| FLICKERING | PRICKING | PINCHING | TUGGING | HOT | TINGLING |
| QUIVERING | BORING | PRESSING | PULLING | BURNING | ITCHY |
| PULSING | DRILLING | GNAWING | WRENCHING | SCALDING | SMARTING |
| POUNDING | STABBING | CRAMPING | | SEARING | STINGING |
| | | CRUSHING | | | |
| DULL | TENDER | COOL | ANNOYING | SPREADING | TIGHT |
| SORE | TIRING | COLD | TROUBLESOME | RADIATING | NUMB |
| HURTING | EXHAUSTING | FREEZING | MISERABLE | PENETRATING | DRAWING |
| ACHING | NAGGING | | INTENSE | PIERCING | SQUEEZING |
| | | | UNBEARABLE | | |

Patient Name: _____ Date: ____/____/____



**PAIN
SPECIALISTS**
OF SOUTHERN OREGON
PAIN SPECIALISTS.COM

PAST MEDICAL HISTORY:

Arthritis	YES	NO
Back Trouble	YES	NO
Asthma	YES	NO
High Blood Pressure	YES	NO
Heart Disease	YES	NO
Hepatitis	YES	NO
Diabetes	YES	NO
Thyroid Trouble	YES	NO

Other: _____

MEDICATION ALLERGIES:

Tetanus Antitoxin	YES	NO
Penicillin	YES	NO
Sulfa	YES	NO
Others	YES	NO

List: _____

SURGERIES:

Tonsils	YES	NO	YEAR: _____
Appendix	YES	NO	YEAR: _____
Gallbladder	YES	NO	YEAR: _____
Stomach	YES	NO	YEAR: _____
Breast	YES	NO	YEAR: _____
Uterus/Ovary	YES	NO	YEAR: _____
Hernia	YES	NO	YEAR: _____

Thyroid	YES	NO	YEAR: _____
Heart	YES	NO	YEAR: _____
Hernia	YES	NO	YEAR: _____
Back	YES	NO	YEAR: _____
Neck	YES	NO	YEAR: _____

Other: _____

HOSPITALIZATIONS (Other than for surgeries):

List: _____

FAMILY HISTORY:

Leukemia:	YES	NO
Heart Disease:	YES	NO
Lung Disease:	YES	NO
Tuberculosis:	YES	NO
High Blood Pressure:	YES	NO
Diabetes:	YES	NO

Thyroid Trouble:	YES	NO
Cancer:	YES	NO

Other: _____

SOCIAL HISTORY:

Do you drink alcohol?	YES	NO	Amount per day: _____
Do you smoke cigarettes?	YES	NO	Amount per day: _____

History of substance abuse/addiction?	YES	NO
Have you ever been through Detox?	YES	NO

Explain: _____

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Have you recently experienced any of the following? (Please circle YES or NO):

GENERAL

Tire easily, weakness	YES	NO
Marked weight change	YES	NO
Night sweats	YES	NO
Persistent fever	YES	NO

CARDIO/RESPIRATORY

Chest Pain	YES	NO
Palpitations	YES	NO
Shortness of breath	YES	NO

DIGESTIVE SYSTEM

Nausea	YES	NO
Vomiting	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO

GENITOURINARY SYSTEM

Increased frequency	YES	NO
Feel the need to urinate	YES	NO
Incontinence	YES	NO
Pain with urination	YES	NO

ENDOCRINE

Thyroid trouble	YES	NO
Adrenal trouble	YES	NO
Diabetes	YES	NO

HEMATOLOGY

Abnormal bleeding	YES	NO
Abnormal bruising	YES	NO

NEUROLOGIC

Numbness	YES	NO
Weakness	YES	NO
Headaches	YES	NO

EYES

Trouble seeing	YES	NO
Eye Pain	YES	NO
Inflamed eyes	YES	NO
Double vision	YES	NO

EARS

Loss of hearing	YES	NO
Ringing	YES	NO

SKIN

Rash	YES	NO
Change in color	YES	NO
Change in hair	YES	NO
Change in nails	YES	NO

PSYCHIATRIC

Anxiety	YES	NO
Depression	YES	NO
Bipolar Disorder	YES	NO

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Patient Name: _____ Today's Date: ____/____/____
Last First M.I.

Address: _____ E-mail address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Ok to leave message?: Y or N Marital Status: _____

DOB: ____/____/____ Soc Sec #: _____ - _____ - _____ Drivers Lic #: _____

Employer Name: _____ Phone Number: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Referring MD: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Address: _____ Phone: _____

Subscriber Name: _____ Date Of Birth: ____/____/____

Subscriber ID: _____ Group Number: _____

Secondary Insurance: _____

Address: _____ Phone: _____

Subscriber Name: _____ Date Of Birth: ____/____/____

Subscriber ID: _____ Group Number: _____

Work Comp Insurance / MVA Insurance: (circle one) _____

Name & Address: _____

Employer at Time of Injury: _____

Claim# _____ Date of Injury: ____/____/____

Adjustor: _____ Phone: _____

SIGNATURE: _____ DATE: ____/____/____

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I, _____, hereby authorize
Patient Name

Pain Specialists of Southern Oregon to release information about my:

Medical Information

Billing Information

Appointment Information

Other _____

if requested by:

*Primary Care Physician**

Name Relationship Phone number

Name Relationship Phone number

Name Relationship Phone number

Patient Signature Date

Representative Signature Relation to patient Date

* NOTE: Primary Care Physician release is required by our office

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The following is our financial policy that all patients are required to read and sign prior to seeing the physician. Please let us know if you need any clarification on our payment policies.

The patient's portion of payment is due at the time of service unless prior arrangements have been made with the business office. Payment may be made by cash, check, Visa or Mastercard.

We accept assignment with most major insurance companies and participating provider plans. However, please note:

1. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not (to the extent of insurance contractual obligation).
3. Co-payments, co-insurances and/or deductibles are due at the time of service.
4. Returned checks will be subject to any bank fees charged to our office and will be billed to you.
5. Unpaid balances are subject to collections process.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to enable us to assist you in managing your account. Patients turned over to a collection agency will also cease to be patients of Pain Specialists.

Scheduled appointments that are missed without prior cancellation notice will result in a ____ fee and may also result in discharge from the practice.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photocopy or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Pain Specialists of Southern Oregon the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims until I choose to revoke it in writing.

Patient Signature/Authorized Signature

Date

Printed Name of Patient

Relationship to patient if not patient

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I understand that Pain Specialists of Southern Oregon (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information created and received by the practice; may be in the form of written, electronic records or spoken words; and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of this Notice of Privacy Practices (if I have requested a copy).

By: _____
(Patient)

Date: _____

OR

By: _____
(Patient Representative)

Date: _____

Description of Representative's Authority _____

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Consent to Obtain External Prescription History

By signing below, I authorize Pain Specialists of Southern Oregon and its affiliated providers to view my external prescription history.

I understand that prescription history from other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff at Pain Specialists of Southern Oregon, and it may include prescriptions over several years.

My signature certifies that I have read and understood the scope of my consent and that I authorize the access to my prescription history.

Patient Signature

Date

Printed Patient Name

Date of Birth

Witness

Date

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