



Annu H. Navani, M.D., Q.M.E. & Associates

Board Certified in Pain Management & Anesthesia

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www.cpainmc.com

COMPREHENSIVE

Pain Management Center

Defining Excellence in Pain Management

Demographic Intake Form

Today's Date: _____

Name: _____ M F Birth date: _____ SS#: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail address: _____

Is English your first language? Yes No If no, what language? _____

Current Marital Status: S M W D

Primary Care Physician: _____ Phone: _____

Referred by: _____ Phone: _____

Other physicians or health care providers that you have seen or are currently seeing, including chiropractors, therapists, etc.

Name: _____ Specialty: _____

Address: _____ Phone: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

INSURANCE INFORMATION (*Non Worker's Compensation*)

Primary Insurance Subscriber: Self Spouse Parent Employer Name: _____

Subscriber's Name: _____ SS/ID#: _____ D.O.B.: _____

Name of Insurance: _____ ID#: _____ Group#: _____

Address to submit claims: _____ Telephone: _____

Secondary Insurance

Subscriber's Name: _____ SS/ID#: _____ D.O.B.: _____

Name of Insurance: _____ ID#: _____ Group#: _____

Address to submit claims: _____ Telephone: _____

MEDICARE/MEDI-CAL

Do you subscribe to Medicare? Yes No If yes, Subscriber #: _____

Do you subscribe to MEDI-Cal? Yes No If yes, Subscriber #: _____



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EMPLOYMENT INFORMATION

Current Employer: _____ Phone: _____

Address: _____ Date of Hire: _____

Occupation & Job Title: _____

Current Work Status: working full-time part-time regular work modified work not working

Hours worked per week: _____ Hours worked per day: _____

Describe your job duties: _____

I am: right handed left handed ambidextrous

WORK INJURIES

Is your pain related to a work injury: Yes No Date of Injury: _____

Job title at time of injury: _____

Have you filed a Workers' Compensation claim with this employer for this injury? Yes No

If yes, claim#: _____ Insurance Carrier: _____

Have you ever had a Workers' Compensation claim before? Yes No

If yes, please list separately all work injuries and body parts injured: _____

List any other jobs or income source at the time of your injury: _____

Are you currently in litigation (lawsuit)? Yes No

Contact Person/Adjuster: _____ Phone: _____ Fax: _____

Address: _____

Employer at time of Injury: _____ Phone: _____ Fax: _____

Address: _____

Nurse Case Manager: _____ Phone: _____ Fax: _____

Address: _____

Patient's Attorney: _____ Phone: _____ Fax: _____

Address: _____

Employer's Attorney: _____ Phone: _____ Fax: _____

Address: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

I authorize the release of any medical information necessary to process this claim to the insurance company, attorney, or other physicians. I understand that I am responsible for all charges incurred. I further authorize my insurance to make direct payment to the Comprehensive Pain Management Center for all medical benefits.

 Patient Signature

 Date



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PAIN HISTORY

What is the purpose of your visit? _____

Who has referred you? _____

Where is the pain located? _____

When did the pain start? _____

How did the pain first start? (Circle one)

- o Suddenly Gradually Cumulative
- o Accident Trauma Fall Injured at work Sports

Is this a Workers Compensation injury? Yes No

What is the level of pain today if 0 is no pain and 10 is worst pain: ____/10

Is your pain constant or intermittent?

Nature of pain: dull achy sharp shooting burning pins/needles

What makes you pain worse?

What makes your pain better?

In the last 12 months how many times have you visited the ER for treatment of your Pain?

Is there a personal injury claim or litigation in relation to the current pain?

Have these activities been effected because of your pain: list yes or no

Household chores		Depression	
Office Work		Anxiety	
Drive		Mood	
Walk/Run		Appetite	
Sports		Sleep	
Concentration		Relationships	

What treatments have you tried in the past? List if it was effective.

CURRENT MEDICATIONS

Name of Medication	Date Started	Prescribing Physician	Strength	Number of pills/day	Does it help? (yes/no)

ALLERGIES: _____

PAST SURGICAL HISTORY:

Type	Date	Surgeon



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PAST MEDICAL, FAMILY HISTORY AND REVIEW OF SYSTEMS: (check box)

	You	Family		You	Family		You	Family
Stroke			Diabetes			Suicide ideation/attempts		
Seizures			High Blood Pressure			Depression/Bipolar		
Heart			Thyroid			Mental Disorders		
Lungs			Bleeding/Anemia			Alcohol/Drug problems		
Liver			Stomach/Bowel			State/ SS disability		
Kidney/Bladder			Fibromyalgia			Other		
Cancer			Gout					
Migraines			Arthritis					

PERSONAL AND SOCIAL HISTORY: Circle Yes/No. Please offer detailed answer if yes.

Do you work? Yes/No; Occupation: _____ Employer: _____

What is your highest level of education? _____

Are you () Single () Married () Separated () Divorced () Widowed

Do you have children? How many? _____ Ages _____

Who do you live with? _____

Do you smoke? Yes/No; # of packs/day _____

Do you drink alcohol? Yes/No; how much? _____

Do you use recreational drugs? Yes/No; if yes, please elaborate _____

Have you ever abused drugs or alcohol in the past? Yes/No

Have you ever been treated at a drug or alcohol rehabilitation center? Yes/No

PAIN DIAGRAM:





Authorization for Use or Disclosure of Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled

I hereby authorize this medical practice to use and disclose health information related to the personal health, treatment or payment for treatment of (*patient name and address*) _____ as follows:

This request supersedes any prior request for confidential channel communications I may have made.

This health information may be disclosed to:

(Name and address of person to use or receive the health information)

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):

Health information to be used or disclosed:

- Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:



Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Phone _____ Preferred
I want you to contact me by telephone at _____

- Do Do not leave messages on my answering machine.
 Do Do not leave messages with any other person.

Mail _____ Preferred
Address: _____

E-mail _____ Preferred
E-mail address: _____

Fax _____ Preferred
Fax number: _____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient (to the extent minor could not have consented to the care)
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient
- spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)



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CONDITIONS OF ADMISSION / CONSENT FOR SERVICES

Please read and sign the following agreement so that we may proceed with your care and treatment at the Comprehensive Pain Management Center.

CONSENT TO MEDICAL CARE: The undersigned hereby consents to the procedures that may be performed today as well as in the future during outpatient treatment, including emergency services, or other services rendered under the general and special instructions of my physician.

PERSONAL VALUABLES: It is understood and agreed that Comprehensive Pain Management Center maintains a safe environment for personal belongs. The staff shall not be liable for the loss or damage to any money, jewelry, glasses, documents, clothing, electronic devices or other personal articles of unusual value.

FINANCIAL AGREEMENT: The undersigned, whether signing as a patient or representative of the patient, agrees to pay all charges for medical services not otherwise covered by health care benefits, in accordance with the rates and terms of the Comprehensive Pain Management Center. If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney's fees, together with interest at the legal rate.

ASSIGNMENT OF BENEFITS: The undersigned, whether signing as a patient or representative of the patient, authorizes direct payment to the Comprehensive Pain Management Center of any health care coverage benefits otherwise payable to or on behalf of the patient for medical services rendered by us, including emergency services, if any. Health care coverage benefits include Medicare, Medi-Cal, other governmental health care program benefits, as well as coverage under a Workers Compensation, automobile, life/accident, and disability insurance plan. The undersigned authorizes release of medical information necessary to determine the eligibility and benefits payable and to submit and process claims for payment.

AUTHORIZES REPRESENTATIVE: The undersigned hereby authorizes the Comprehensive Pain Management Center, at its election but without obligation, to represent the patient regarding any application and appeal for eligibility and benefits pursuant to the patient's applicable health benefit plan, including Medicare, Medi-Cal, or other governmental program benefits relating to services rendered at Comprehensive Pain Management Center.

ADVANCE DIRECTIVE:

Does the patient have an Advance Directive? Yes No If yes, location: _____

ACKNOWLEDGEMENT OF RECEIPT (For Medicare patients only): My signature below acknowledges my receipt of an Advance Beneficiary Notice (ABN).

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM, HAS RECEIVED A COPY OF IT, AND ACCEPTS AND AGREES TO ABIDE BY ITS TERMS.

Signature: (PATIENT/PARENT/CONSERVATOR/GUARDIAN/AGENT) _____

Relationship: _____

Witness: _____ Date: _____ Time: _____

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative:

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement and Assignment of Benefits provisions above.

Signature: (FINANCIALLY RESPONSIBLE PARTY) _____ Relationship: _____

Witness: _____ Date: _____ Time: _____



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Acknowledgement of Receipt of Notice of Privacy Practices and Patient Bill of Rights

I hereby acknowledge that I have been informed of this medical practice's Notice of Privacy Practices and Patient's Bill of Rights. I further acknowledge that a copy of these forms will be available at the reception area, and that a copy of any amended Notice of Privacy Practices or Patient's Bill of Rights will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices and Patient's Bill of Rights by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

Patient declined signature

CPainMC Representative Receiving Decline _____

CPainMC Signature: _____ Date: _____



Informed Consent for Controlled Substances Prescriptions

Controlled substance medications (for example, opioids, narcotics, sedatives, muscle relaxants and tranquilizers) are very useful, but have a high potential for misuse and are closely controlled by branches of the local, state and federal governments. They are intended to relieve pain, to improve function and/or the ability to work, and not simply to make me feel good. My pain specialist is prescribing such medication to help manage my condition.

Therefore, I understand and agree to the following:

- 1) I will participate fully in all aspects of the treatment plan prescribed by my doctor and, to the greatest extent possible, keep all scheduled appointments. If I am unable to keep an appointment, I agree to notify my healthcare provider with at least 24 hours advanced notice.
- 2) The main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication, I agree to help myself by adopting a healthier lifestyle. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment. Because of this, I agree to establish better health habits, manage other medical conditions I may have, increase exercise (unless directed otherwise), control my weight and avoid the use of tobacco and not engage in the use of recreational drugs or alcohol.
- 3) That if I gain minimal functional improvement and/or pain relief after using the controlled substance medication prescribed, my pain specialist may discontinue the medication.
- 4) That the use of opioid and other controlled substance medications may have certain side effects associated with it, including, but not limited to: constipation, nausea, vomiting, dizziness, allergic reactions (such as itching, rash, or difficulty breathing), slowing of breathing rate, physical dependence, addiction, tolerance to analgesia, sleepiness or drowsiness, and slowing of reflexes or reaction time. I understand the possibility that the medicine may not provide complete pain relief. I understand that if I have significant side effects, which are not manageable, my doctor will discontinue my use of opioids and other controlled substance medications. I agree to tell my doctor if I experience any of the above side effects or other reactions that might be related to taking opioids and other controlled substance medications.
- 5) I understand that opioid and other controlled substance medications are addictive in nature and also I may get dependent and tolerant to these medications and experience withdrawal symptoms upon cessation of the opioid and other controlled substance medications.
- 6) I will inform my practitioner if I have had any problems with addiction in the past, or if I experience a “compulsive use of my medication resulting in physical, psychological or social harm to myself or others.”
- 7) That I agree not to be involved in any activities that may be dangerous to me or someone else should I experience unusual side effects of my medications. These activities include, but are not limited to:



Patient Rules & Regulations for Comprehensive Pain Management Center

Our goal at Comprehensive Pain Management Center (CPMC) is to provide top quality care to our patients in a compassionate and professional environment. We do our best to stay on time with our schedule and give you our undivided attention.

As a patient of the CPMC, we appreciate you following the rules and regulations of the practice which help us maintain our goals.

1. If you are unable to keep an appointment, kindly call our office at least 24 hours prior to your appointment. We can then reschedule your appointment to a more convenient time.
2. A \$25 fee will be applied to all appointments not canceled within the 24 hour period or if you fail to keep your appointment.
3. Please arrive 15 minutes prior to your appointment time. It is important to have your questionnaire and registration forms completed. If the forms are not complete at the time of your appointment, or you are more than 5 minutes late, you may need to be rescheduled for a later date.
4. Cash payments and co-pays must be paid at the time of check in.
5. We do not accept checks for the initial consultation.
6. If you have recently moved, had a change to your insurance, claims adjustor, attorney, primary treating physician information, or had any other change to your personal information, please supply us with the new information. Please provide the new information within 10 days of the change so we can keep up-to-date records.
7. You are responsible for knowing the coverage & benefits of your particular insurance company. If you are not sure of the requirements of your insurance company, please check with them prior to obtaining medical services. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

Signature: _____ Date: _____

Print Name: _____

Witnessed: _____ Date: _____



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Directions to the Comprehensive Pain Management Center

Located at
10430 S DeAnza Blvd. Ste 110
Cupertino, CA 95014

San Francisco / North Bay

Take Hwy 101 South to 85 South toward Santa Cruz/Cupertino.
Take Hwy 280 South toward San Jose.
Take the De Anza Blvd. exit.
Turn right at N De Anza Blvd.
Make a U-turn at McClellan Rd./Pacifica Dr.
The office will be on your right.

Oakland / East Bay

Take Hwy 880 South to Hwy 17 (880 becomes 17).
Take Hwy 280 N toward San Francisco.
Take the De Anza Blvd exit.
Turn left at N De Anza Blvd.
Make a U-turn at McClellan Rd./Pacifica Dr.
The office will be on your right.

Concord

Take Hwy 680 South to San Jose.
Hwy 680 becomes Hwy 280 in San Jose.
Continue on Hwy 280 North.
Take the De Anza Blvd exit.
Turn left at N De Anza Blvd.
Make a U-turn at McClellan Rd./Pacifica Dr.
The office will be on your right.

Gilroy / Salinas Areas

Take Hwy 101 North to 85 North towards Mountain View.
Take the De Anza Blvd. exit.
Turn right on S De Anza Blvd.
The office will be on your right.