REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City: State:	Zip:

Social Security #:	Email address:	Home Phone:	Cell Phone:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

If other, please tell us where:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ BCBS PPPO	❑ United Healthcare	❑ Cigna	❑ Tricare
❑ Aetna	❑ Humana	❑ AARP	❑ Other	❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative to contact:	Relationship to patient:	Phone Number:
___________________________________	______________________	_______________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Crescent Pain Relief or insurance company to release any information required to process my claims.

____ _____________________

Patient/Guardian's Signature **Date**

INFORMATION NEEDED

Crescent Pain Relief would like this information to help them in your medical needs.

1. Languages Spoken:

2. Ethnicity:
   - Hispanic or Latino
   - Not Hispanic or Latino
   - Unknown
   - Decline to answer

3. Race (can mark more than one; if multiracial):
   - Alaskan Native
   - American Indian
   - Asian
   - African American / Black
   - Caucasian / White
   - Indian
   - Native Hawaiian or other Pacific Islander
   - Unknown
   - Decline to answer

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and/or other individuals he/she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical conditions. This consent is valid for each visit I make to Crescent Pain Relief unless revoked by me in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to Crescent Pain Relief infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested, at the expense of Crescent Pain Relief if any of those situations occur during your treatment period.

Patient's Printed Name Date of Birth

Patient/Legal Representative's Signature Today's Date

Relationship to Patient

Witness Today's Date

FINANCIAL POLICY

Thank you for choosing Crescent Pain Relief as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

Patient Name: ____ Date of Birth: _________________________________

All patients must read and sign this form prior to receiving services. Please initial before each section

____**It is your responsibility to provide us with your most current insurance information at time of each visit.**

____All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the estimated cost of the services, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. We have no way of knowing every insurance companies plans and benefits so YOU are responsible for knowing what services are or are not covered. KNOW YOUR BENEFITS.

____We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, **your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your** insurance company.

____We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond to our claim, a statement will be sent to you. You will have to call the insurance company to work out your statement; our office will assist you only after you have contacted your insurance.

____Co-payments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we received from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim-regardless of our estimation.

_____**It is your responsibility to provide us with your most current billing information.** You must provide your most current billing address at each visit, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

_____**Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 90 days of the statement issue date are deemed past due.

_____If your account is past due for an amount more than $200 (two hundred dollars), you will not receive services from any physicians at Crescent Pain Relief and will be dismissed from the practice. Failure to accept the certified letter (and/or to pick it up at the post office) serves as notice of termination of services.

_____In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $35.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

____You will be charged a "No Show" fee of $30 if you fail to cancel or reschedule your appointment at least 24 hours prior your appointment date. Canceling the appointment the same day is not 24 hour notice; and a "no show" fee will still be charged unless emergency reason.

_____ **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

______ Full payment is due at time of service. We accept cash, checks, and credit cards.

______We do understand that temporary financial problems may affect timely payments. We encourage you to communicate any such problems and ask about our "Agreement to Pay for Physician Services" Plan.

By signing this; you are agreeing to the clear understanding of our financial policy and how it is important to the relationship with Crescent Pain Relief. Please ask if you have any questions.

Signature of Responsible Party	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Crescent Pain Relief reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at any of my appointments.

Patient's Printed Name	Date of Birth

Patient/Legal Representative's Signature	Date

Relationship to Patient

Witness	Date

I wish to be contacted in the following manner: **(Please list phone number that is best number for nurses to call)**

Telephone Number: ____

☐ Ok to leave message with detailed information.

☐ Leave message with call-back number only.

Email address: ____

☐ I authorize Crescent Pain Relief to contact me using the email address provided above.

☐ I understand my name, information regarding my account balance could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted.

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Crescent Pain Relief to share my protected health information with:

Name/Relationship	Contact Phone Number
Name/Relationship	Contact Phone Number
Name/Relationship	Contact Phone Number
Name/Relationship	Contact Phone Number

PATIENT PORTAL

☐ Patient does want to receive access to health information.

☐ Patient does **not** want to receive access to health information.

CRESCENT Pain Relief

Welcome to our practice. Please fill out the information below to the best of your ability.

Physician: ____ Date: _____________________________________

Patient Name: ____ Reason for Visit: ____________________________

Personal Medical History			**Previous Surgeries/Serious Injuries (When?)**
Diabetes (Type _____)	N	Y: Date ___________	____
High Blood Pressure	N	Y: Date ___________	____
Cancer (Type_______)	N	Y: Date ___________	____
Stroke	N	Y: Date ___________	____
COPD	N	Y: Date ___________	____
High Cholesterol	N	Y: Date ___________	____
GERD	N	Y: Date ___________	____
Arthritis	N	Y: Date ___________	____
Gout	N	Y: Date ___________	____
Sleep Apnea	N	Y: Date ___________	____
Asthma	N	Y: Date ___________	**Local Pharmacy**______________________________
Thyroid Disorder	N	Y: Date ___________	____
Allergic Rhinitis	N	Y: Date ___________	**Mail Pharmacy**_______________________________
Other	N	Y: Date ___________	____

Patient Social History

Use of Alcohol:	Daily	Weekly	Monthly	Occasionally	Rarely	Never
Use of Tobacco:	Daily	Previously, but Quit	(Age Stopped_______)			Never
Use of Drugs:	Never	Type/Frequency ______________________________				

Family Medical History

	Age	Diseases	If Deceased, Cause of death
Father	_____	________________________________	___________________________
Mother	_____	________________________________	___________________________
Brother(s)	_____	________________________________	___________________________
Sister(s)	_____	________________________________	___________________________
Son	_____	________________________________	___________________________
Daughter	_____	________________________________	___________________________

PAST PAIN TREATMENTS (Check ALL that Apply)

- ❒ Anti-inflammatory Medications
- ❒ Home Exercises
- ❒ Heating Pad
- ❒ Chiropractic Care
- ❒ Narcotic Pain Medications
- ❒ Facet Injections
- ❒ Over the Counter Medications
- ❒ Massage
- ❒ Physical Therapy
- ❒ Acupuncture
- ❒ Nerve Medications (gabapentin, etc)
- ❒ Epidural Steroid Injections
- ❒ RF Neuroanatomy (Rhizotomy)
- ❒ Intrathecal Pump
- ❒ Joint Injections
- ❒ Spinal Cord Stimulator
- ❒ Other

CRESCENT Pain Relief

Patient Name: ____ Date of Birth:__________________________________

ALLERGIES (Medications and Dyes)	
Item(s) that you are *allergic* to:	**Reaction(s) you have had from the *medication*, you are allergic to:**

MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS			
Drug Name (Brand name, or generic name)	**Dosage**	**Times taken within 24 Hours**	**Reason for taking Medication**

CPR CRESCENT Pain Relief

Patient Name: ________________________________ Date of Birth: _________________________________

Do you **currently** have any problems related to the following systems?

REVIEW OF SYSTEMS	
CONSTITUTIONAL: No Yes □ □ Chills □ □ Fatigue □ □ Fever □ □ Weight Gain □ □ Weight Loss	**GENITOURINARY:** No Yes □ □ Dysuria (painful urination) □ □ Hematuria (blood in urine) □ □ Urinary frequency
HEENT: No Yes □ □ Ear pain □ □ Eye pain □ □ Sinus pressure □ □ Sore throat	**INTEGUMENTARY (SKIN):** No Yes □ □ Hair loss □ □ Rash
RESPIRATORY: No Yes □ □ Cough □ □ Shortness of breath □ □ Wheezing	**NEUROLOGICAL:** No Yes □ □ Dizziness □ □ Extremity numbness □ □ Headache
CARDIOVASCULAR: No Yes □ □ Chest Pain □ □ Edema	**PSYCHIATRIC:** No Yes □ □ Anxiety □ □ Depression □ □ Insomnia
GASTROINTESTINAL: No Yes □ □ Abdominal Pain □ □ Blood in stools □ □ Constipation □ □ Diarrhea	**Musculoskeletal:** No Yes □ □ Back pain □ □ Joint pain □ □ Neck pain

CRESCENT Pain Relief

Health Maintenance Flow Record

Patient Name: ________________________________

Date of Birth: _________________________________

Test	Date Performed	Normal or Abnormal?
Bone Density		
Colonoscopy		
Eye Exam		
Foot Exam		
Echocardiogram		
Endoscopy		
EKG		
Spirometry		
Stress Test		

Male Patients Only

PSA Blood Test		

Female Patients Only

Mammogram		
Pap Smear		

Immunizations

Hep A vaccine	
Hep B vaccine	
Twinrix	
HPV vaccine	
Menactra vaccine	
MMR vaccine	
Pneumonia vaccine	
Tetanus vaccine	
Varicella vaccine	
Zostavax vaccine	