



NEW PATIENT PACKAGE – INFORMATION, INSTRUCTIONS, QUESTIONNAIRE

Dear New Patient:

Welcome to our practice! We look forward to becoming a part of your healthcare team. Enclosed are some specific details, instructions, and a general questionnaire. We appreciate that you take the time to carefully read and understand the instructions, as well as complete the questionnaire. Doing so allows us to provide the most appropriate treatment. Should you have any questions, comments, or concerns, please feel free to contact the office at 231-592-1360 or 616-975-1186.

YOUR APPOINTMENT
DATE
TIME
LOCATION

YOUR APPOINTMENT

We will contact you prior to your appointment to confirm the date, time, and place of your appointment. If you are unable to be reached during regular business hours, please contact the office at 231-592-1360 or 616-975-1186.

- to confirm your appointment.
- If for any reason you wish to reschedule or cancel your appointment, please contact our office with at least **48 hours notice**.
- Please arrive **15 minutes early** for office registration.

• **If you are currently involved in litigation (the suing process) with regard to AUTO or WORKERS' COMPENSATION claims, please contact our office prior to your visit. Please bring your adjustor's name, telephone number, and claim number to your appointment.**

- **Prior to your appointment**, please complete the enclosed forms to the best of your ability. Please bring the completed forms with you to your appointment.

DIRECTIONS TO OUR LOCATIONS

<u>West Michigan Pain – Big Rapids</u>	<u>West Michigan Pain – Grand Rapids</u>
20095 Gilbert Road, Suite B, Big Rapids, MI 49307	4024 Park East Court SE, Suite C, Grand Rapids, MI 49546
US-131 exit 139 – Perry Street. Turn East onto Perry St and continue past Wal-Mart to State Street (2 Miles). Turn South on State Street, drive 1 mile and turn left (West) onto Gilbert Road. The office is on the left-hand side.	I-96 exit 40 – Cascade Road West. Drive for .5 miles. Turn South onto East Paris. Drive 1.5 miles on East Paris. Turn left onto Park East Court. Our office is located in the same building as Chemical Bank.

CONSENT TO BILL INSURANCE

Please read the following information and sign below. If you have any questions, please ask a customer care specialist.

Assignment of Insurance Benefit

I hereby authorize payment directly to Michigan Primary Care Partners, PC the benefits payable to me, but not to exceed the balance of the charges for this event. All co-pays and deductibles are due prior to the time of treatment. I agree that the information presented on this form is true and accurate.

Financial Responsibility

I understand that I am financially responsible to Michigan Primary Care Partners, PC for any amount not covered by this authorization. The insurance policy is a contract between my insurance company and me. A claim will be filed with my insurance carrier within 45 days. If payment is not made by the insurance carrier within 45 days of filing, the balance will automatically transfer to the responsible party account. Payment by the responsible party is expected within 10 business days of notice of insurance non-payment. In the event that this account is placed with an attorney or collection agency, the undersigned is responsible for collection fees, reasonable attorney's fees, and court costs.

Authorization

I hereby authorize release of my medical record information necessary to process insurance claims. I authorize Michigan Primary Care Partners, PC to issue a complaint to the insurance commissioner for any reason. I further authorize the release of medical information to those healthcare facilities and/or physicians who may be responsible for the patient's care. I understand that it may be necessary to test the patient's blood to protect against possible transmission of blood-borne diseases such as Hepatitis B or Acquired Immune Deficiency Syndrome (AIDS) if, for example, an employee or physician is stuck by a needle or sustains a scalpel injury during the performance of care. I understand and consent that the patient's, as well as the employee's or physician's blood, will be tested as is appropriate. I further understand that routinely tested blood results and tests for those diseases mentioned will be kept confidential in accordance with state law.

Date

Patient's Printed Name

Signature (Patient or Legal Guardian)

Date

Witness Signature

Witness Relationship

Receipt of Privacy Notice

I acknowledge that I have received notification in regards to the Health Insurance Portability and Accountability Act (HIPAA) and have access to a copy of the written Joint Notice of Privacy Practices.

Date

Patient's Printed Name

Signature (Patient or Legal Guardian)

DEMOGRAPHIC INFORMATION

Please answer the following questions completely. If a question does not apply, please write not applicable.

_____/_____/_____
 First Name Last Name Date of Birth

 Address

_____/_____/_____
 City State Zip

 Home Phone Initial

 Cell Phone Initial

 Work Phone Initial

 E-mail Address Initial

 Emergency Contact Details – Full Name, Telephone Number(s)

In some cases, it may be necessary to leave messages that may contain your medical or personal information. Please initial above after any number where we may leave messages.

Primary Care Physician

 Physician Name Phone

Referring Physician

 Physician Name Phone

Insurance Information

 Primary Insurance Name ID #

 Insured Name and Date of Birth

 Relationship to Patient

 Secondary Insurance Name ID #

 Insured Name and Date of Birth

 Relationship to Patient

Auto or Work Injury

Auto Injury? Yes No
 If yes, date of accident: _____

Work Injury? Yes No
 If yes, date of accident: _____

Is your claim in litigation?
 Yes No

 Adjustor Name

 Adjustor Phone Number

Printed Patient Name: _____ **Date:** _____

AUTO INJURY FORM

If you are seeing us for an injury arising from an automobile accident, please complete the form below.

Accident Details

Date of automobile accident: _____ I was wearing a seatbelt: Yes No

I was the: Driver Front Passenger Rear Passenger Pedestrian
 Other _____

I was in a: Car Truck Van Motorcycle Other _____

Please describe the accident (in detail): _____

The accident occurred: _____ am/pm Location: _____

Other vehicle: Car Truck Van Motorcycle Other _____

The weather was: Clear Foggy Raining Snowing Other _____

The road conditions were: Dry Wet Icy Other _____

During the accident, I was: Looking Forward Looking Backward Looking to the Side
 Using the Rearview Mirror Other _____

I was prepared / braced for the accident: Yes No

During the accident, I struck the following objects inside the vehicle: None Chest – Steering Wheel
 Knee – Dashboard Head – Windshield Shoulder – Door Other _____

Following the accident, I was: Fine Dazed Dizzy Unconscious Angry
 Other _____

For how long? _____

My vehicle was damaged: Front Rear Driver Side Passenger Side

Approximate damage in dollar amount: _____ dollars

My vehicle was drivable after the accident: Yes No

I left the scene of the accident by: Ambulance My Vehicle Other _____

My occupational title and job duties at the time of injury were: _____

I am currently working: Yes No With restrictions: Yes No

Please describe any current restrictions: _____

I am doing the same job duties as before the injury: Yes No

The last date that I worked was: _____ Still working? Yes No

I lost time from work: Yes No From _____ to _____ due to my injury

I am working for a different employer: Yes No

Name of new employer: _____

Printed Patient Name: _____ Date: _____

WORK INJURY FORM

If you are seeing us for a **WORK-RELATED** injury or illness, please complete the form below.

Date of work-related injury: _____

My employer at the time of injury was: _____

I reported my injury to: _____

Please describe what happened: _____

My occupational title and job duties at the time of the injury/illness were: (please describe in detail)

The heaviest weight that I lifted was: _____ pounds _____ times per day

I began working for this employer: _____ (month) _____ (year)

An employment physical was done at the time I was hired: **Yes** **No**

Did you like the job you were doing? _____

Did you like your work environment? _____

At the time you got hurt were you doing your usual work? (please describe if you were doing a different job)

I began this work with restrictions: **Yes** **No** **Type:** _____

I am currently working: **Yes** **No** With restrictions: **Yes** **No**

Please describe any current restrictions: _____

I am doing the same job duties as before the injury: **Yes** **No**

The last date that I worked was: _____ Still working? **Yes** **No**

I lost time from work: **Yes** **No** From _____ to _____ due to my injury

I am working for a different employer: **Yes** **No**

Name of new employer: _____

Describe your new job: _____

Do you want to return to the same job? **Yes** **No** If "no", then why? _____

Are you able to do any type of job right now? **Yes** **No**

Printed Patient Name: _____ **Date:** _____



PATIENT'S CHIEF COMPLAINT

Please tell us about your chief complaint – the issue for which you are seeking health care.

Chief Complaint / Location of Pain

example: Low back pain

History of Present Illness

Please describe how long you have been having pain or discomfort and if you can recall any injury to the area.

Is your pain getting worse over time? Yes No If yes, how long has it been getting worse? _____

Present Complaints

Where is the pain located? _____

Does your pain radiate to anywhere else in your body? Yes No If yes, to where? _____

Is your pain Occasional Frequent Constant

How would you describe your pain? Aching Sharp Dull Stabbing
 Cramping Throbbing Shooting Burning

Would you consider your pain Mild Moderate Severe

Do you experience any numbness and/or tingling? Yes No If yes, to where? _____

What makes your pain better? Rest Medication Heat Ice

What makes your pain worse? _____

Past / Current Treatment

Have you had any of the following treatments or diagnostics in relation to your pain? If so, please tell us where and when.

TYPES OF TREATMENT	DATE(S)	DOCTOR OR LOCATION
<input type="checkbox"/> Surgery		
<input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Chiropractic Treatment		
<input type="checkbox"/> Injections		
DIAGNOSTIC STUDIES / IMAGING	DATE(S)	DOCTOR OR LOCATION
<input type="checkbox"/> EMG		
<input type="checkbox"/> Bone Scan		
<input type="checkbox"/> MRI		
<input type="checkbox"/> CT Scan		
<input type="checkbox"/> X-RAYS		
<input type="checkbox"/> Other _____		

My current treatment includes:

Medication Physical Therapy Chiropractic Treatments Injections Surgery Considered

Are any of these helping? Yes No If yes, which ones? _____

Printed Patient Name: _____ Date: _____

MEDICATIONS AND ALLERGIES

Please tell us about any medications that you take and any allergies that you have:

Medications

Name	Strength	Directions
example: L A S I X	40 mg	1 tablet daily

Allergies

Allergies	Allergies
example: S H E L L F I S H	example: I O D I N E

Are you taking any of the following: Aggrenox Aspirin Coumadin Plavix NSAIDs

Printed Patient Name: _____ **Date:** _____

DAST-10

Please answer the following questions:

Have you used drugs other than those required for a medical reason? YES NO

If YES please list drug types _____

Do you abuse more than one drug at a time? YES NO N/A

If YES please list drug types _____

Are you unable to stop abusing drugs when you want to? YES NO N/A

Have you ever had black-outs as a result of your drug use? YES NO N/A

Do you ever feel bad / guilty about your drug use? YES NO N/A

Do your spouse or other family members complain about your drug use? YES NO N/A

Have you neglected your family because of your drug use? YES NO N/A

Have you experienced withdrawal symptoms on stopping drugs? YES NO N/A

Do you have medical problems as a result of taking drugs? YES NO N/A

Additional comments related to your drug use that you wish to share:

Printed Patient Name: _____

Date: _____



Patient History Fill out as accurately as possible and please ask for assistance if you have questions.

Print Name: _____

Birthdate: ___/___/___ Age: _____

	Yes	No
Anemia (Type: _____)		
Blood clotting problems		
Asthma		
Apnea (Heavy Snoring)		
Are you on CPAP at home?		
Are you on Oxygen at home?		
Emphysema / COPD		
High blood pressure		
Chest pain		
Irregular heart beat		
Heart attack		
Colon/bowel problems		
Diabetes Type 1 ___ Type 2 ___		
Ear/nose/throat issues		
Cancer		
Arthritis		
Kidney/Bladder issues or infections		
Gout		
Thyroid		
Migraine headaches		
Seizures		
Stroke		
Rheumatic fever		
Skin disease		
Depression / Anxiety		
MEN: Prostate problems		
WOMEN: GYN problems		
Smoking History Packs/Day ___ Years ___		
Alcohol History		
Drinks/Week _____		
Recreational drug usage: Types _____		

Social History

Single Married Divorced Widowed

Number of Children: _____

Current Occupation: _____

Retired

Legally Disability

Family Health History

Major Conditions (I.e. Cancer, COPD, etc.)	
Father	
Mother	
Sister (s)	
Brother (s)	

Past Surgical History

Procedure	Date / Comments / Complications
Tonsillectomy	
Appendectomy	
Thyroid	
Gall bladder	
Heart- bypass	
Any joint?	
Spinal Surgery	
Other Surgery	

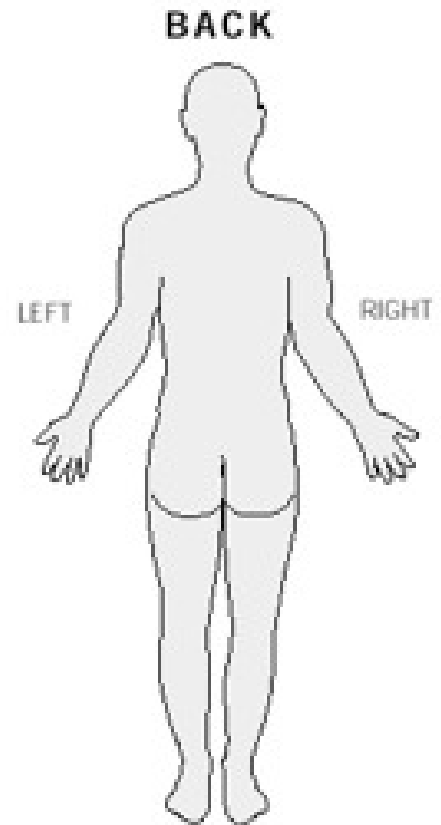
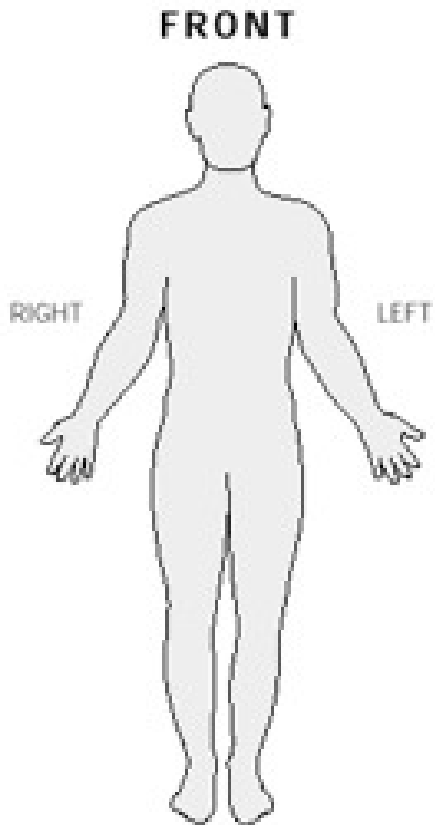
Comments / Additional Information:

Patient or Authorized Representative Signature ➔ _____ **Date** _____

PAIN PROFILE

Where is your pain right now? Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation; be sure to include all affected areas.

<u>Aching</u> A A A	<u>Numbness</u> = = =	<u>Pins and Needles</u> O O O	<u>Burning</u> X X X	<u>Stabbing</u> / / /
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Please mark a **W** on your body where the pain is worst right now.

Please circle the number below that best represents your pain. 0 is the least pain, 10 is the most pain.

0 1 2 3 4 5 6 7 8 9 10

Physician: I have reviewed this new patient information. _____

Printed Patient Name: _____ Date: _____

Patient Signature: _____



PAIN PROFILE – ODI QUESTIONNAIRE

Please complete the following questions by circling the number that corresponds to your condition.

<p><u>PAIN INTENSITY</u></p> <p>(0) I have no pain at the moment (1) The pain is very mild at the moment (2) The pain is moderate at the moment (3) The pain is fairly severe at the moment (4) The pain is very severe at the moment (5) The pain is the worst imaginable at the moment</p>	<p><u>STANDING</u></p> <p>(0) I can stand as long as I want without extra pain (1) I can stand as long as I want but it gives me extra pain (2) Pain prevents me from standing for more than 1 hour (3) Pain prevents me from standing for more than ½ hour (4) Pain prevents me from standing for more than 10 minutes (5) Pain prevents me from standing at all</p>
<p><u>PERSONAL CARE (WASHING, DRESSING, ETC)</u></p> <p>(0) I can look after myself normally without causing extra pain (1) I can look after myself normally but it is very painful (2) It is painful to look after myself and I am slow and careful (3) I need some help but manage most of my personal care (4) I need help every day in most aspects of self care (5) I do not get dressed, wash with difficulty and stay in bed</p>	<p><u>SLEEPING</u></p> <p>(0) My sleep is never disturbed by pain (1) My sleep is occasionally disturbed by pain (2) Because of pain I have less than 6 hours of sleep (3) Because of pain I have less than 4 hours of sleep (4) Because of pain I have less than 2 hours of sleep (5) Pain prevents me from sleeping at all</p>
<p><u>LIFTING</u></p> <p>(0) I can lift heavy weights without extra pain (1) I can lift heavy weights but it gives extra pain (2) Pain prevents me from lifting heavy weights off the floor; but I can manage if they are conveniently positioned, e.g. on a table (3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned (4) I can lift only very light weights (5) I cannot lift or carry anything at all</p>	<p><u>SEX LIFE (IF APPLICABLE)</u></p> <p>(0) My sex life is normal and causes no extra pain (1) My sex life is normal but causes some extra pain (2) My sex life is nearly normal but is very painful (3) My sex life is severely restricted by pain (4) My sex life is nearly absent because of pain (5) Pain prevents any sex life at all</p>
<p><u>WALKING</u></p> <p>(0) Pain does not prevent me walking any distance (1) Pain prevents me walking more than one mile (2) Pain prevents me walking more than ¼ mile (3) Pain prevents me walking more than 100 yards (4) I can only walk using a stick or crutches (5) I am in bed most of the time and have to crawl to the toilet</p>	<p><u>SOCIAL LIFE</u></p> <p>(0) My social life is normal and causes me no extra pain (1) My social life is normal but increases the degree of pain (2) Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc (3) Pain has restricted my social life and I do not go out as often (4) Pain has restricted social life to my home (5) I have no social life because of pain</p>
<p><u>SITTING</u></p> <p>(0) I can sit in any chair as long as I like (1) I can sit in my favorite chair as long as I like (2) Pain prevents me from sitting for more than 1 hour (3) Pain prevents me from sitting for more than ½ hour (4) Pain prevents me from sitting for more than 10 minutes (5) Pain prevents me from sitting at all</p>	<p><u>TRAVELLING</u></p> <p>(0) I can travel anywhere without pain (1) I can travel anywhere but it gives me extra pain (2) Pain is bad but I manage journeys over two hours (3) Pain restricts me to journeys of less than one hour (4) Pain restricts me to short necessary journeys less than 30 minutes (5) Pain prevents me from traveling except to receive treatment</p>

ODI = _____ %

Printed Patient Name: _____ **Date:** _____



Girish Juneja, MD
Board Certified Pain Management

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Mark Clark, MD
Board Certified Pain Management

Doug Tuttle, PA-C
Pain Management

www.westmichiganpain.com

Dear Valued Patient,

We are honored that you have chosen us as your healthcare provider. Today we have exciting news regarding your health management!

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The "Patient Portal" enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents.

The Patient Portal makes it **Easy** for you to:

- **Ask your doctor, nurse, or a staff member a question**
- **Request prescription refills***
- **Request NON-URGENT appointments and view upcoming appointments**
- **Receive appointment reminders**
- **Verify and / or update current medication list**
- **View your personal health record**
- **Examine your current and past billing statements**
- **Receive our monthly e-newsletter**

This can all be done from the comfort and convenience of your home!

Begin today and take an active role in managing your healthcare!

To get signed up today, please fill out the following information and hand to the receptionist when checking in. They will then provide you with a username, password, and website info.

Patient Name: _____ D.O.B. _____

Email Address _____

*Medication refills will be addressed within 1-4 business days.

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