BRENT BELVIN, M.D.
1101 RAINTREE CIRCLE, SUITE 240
ALLEN, TX 75013

_____ NEW PATIENT

_____ INFO CHANGE

PATIENT INFORMATION

NAME: _____ SEX: M F (circle one) DATE OF BIRTH: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

SOCIAL SECURITY: _____ MARTIAL STATUS: S M D W (circle one) SPOUSE NAME: _____

E-MAIL: _____ EMPLOYER: _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

FAMILY PHYSICIAN: _____ PHONE: _____ REFERRING PHYSICIAN: _____PHONE: _____

RESPONSIBLE INSURED

PATIENT'S RELATIONSHIP TO POLICY HOLDER: _____SELF _____SPOUSE _____CHILD _____ OTHER

INSURED NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

SOCIAL SECURITY : _____ EMPLOYER: _____ PHONE: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ CIRCLE ONE: HMO PPO POS PHONE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURANCE: _____ PHONE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

IF WORKER'S COMP: YES OR NO (CIRLCE ONE) DATE OF INJURY: _____ EMPLOYER: _____

INSURANCE: _____ ADJUSTER NAME: _____ PHONE: _____

CLAIMS ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CONSENT: I hereby authorize direct payment of my insurance benefits to MICRO PAIN INSTITUTE for services rendered to myself or dependents. I understand it is my responsibility to know my insurance benefits and whether or not the service I am to receive are covered benefits. I understand I am responsible for any co-pay or balance due that is determined by my insurance carrier for any reason. I authorize release of information that may be necessary for medical evaluation, treatment, consultations or processing of insurance benefits. I hereby consent to evaluation, testing and treatment.

PATIENT SIGNATURE: _____ DATE: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for Brent Belvin, M.D. to furnish medical care and treatment to considered necessary and proper in diagnosing or treating his/her physical condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to Brent Belvin, M.D. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

FINANCIAL POLICY STATEMENT

I understand that all co-pays, deductibles, and/or services that are not covered by my insurance company are my responsibility. I understand that payment plans are available I agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies paid, including court costs, collection agency fees, and attorney fees.

PATIENT PRIVACY PRACTICES

I have read and understand the Patient Privacy Practices provided to me by Brent Belvin Pain Management. I understand that my personal health information will be used in treatment, payment and operations; including those activities which are performed in order to improve the quality of care. I acknowledge my receipt of this information.

I give authorization for the release of "Medical Records/Privacy Information" to the following:

Name **Relationship to Patient**

Name **Relationship to Patient**

I wish to be contacted in the following manner (check all that apply):

	Home Telephone	
	O.K. to leave message with detailed information	
	Leave a message with call-back number only	
	O.K. to fax to this number	
	Work Telephone	
	Written Communication	
	O.K. to mail to my home address	
	O.K. to mail to my work/office address	
	Other	

Print Patient's Name

Patients Signature **Date**

Clinic Representative / Witness **Date**

1101 RAINTREE CIRCLE, SUITE 240

ALLEN, TX 75013

PAIN QUESTIONNAIRE

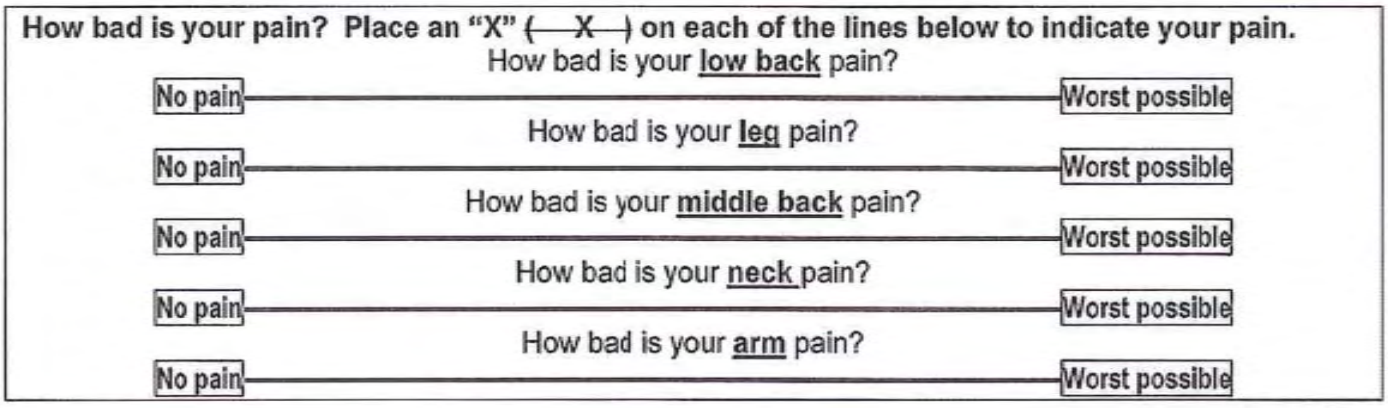
NAME	SEX	DOB	Referring Physician	TODAY'S DATE

HISTORY OF PRESENT ILLNESS:

1. **WHERE** DO YOU HURT? _____
2. APPROXIMATELY **WHEN** DID YOUR PRESENT PAIN START? _____
3. **WHAT** EVENT CAUSED THE PAIN? PLEASE DESCRIBE: _____
   _____
   _____
4. HAVE YOU HAD ANY OF THESE **TESTS**? PLEASE LIST PLACE/ DATE OF TEST:
   EMG/NCV_____ MYELOGRAM _____
   CT SCAN _____ XRAYS _____
   MRI_____ DISCOGRAM _____
5. HAVE YOU BEEN **HOSPITALIZED** FOR YOUR CONDITION? _____
6. HAVE YOU HAD **SURGERY** FOR THIS PROBLEM? If so, please describe the type of surgery, and your results:
   _____
7. HAVE YOU HAD **INJECTIONS** OR OTHER PROCEDURES FOR THIS PAIN? If so, please describe your results with each:
   _____
8. ANY PREVIOUS **PHYSICAL THERAPY** OR CHIROPRACTIC? If so, please describe your results with each:
   _____
9. HAVE YOU BEEN PLACED ON ANY **MEDICATIONS** FOR THIS PAIN? If so, please describe your results with each:
   _____

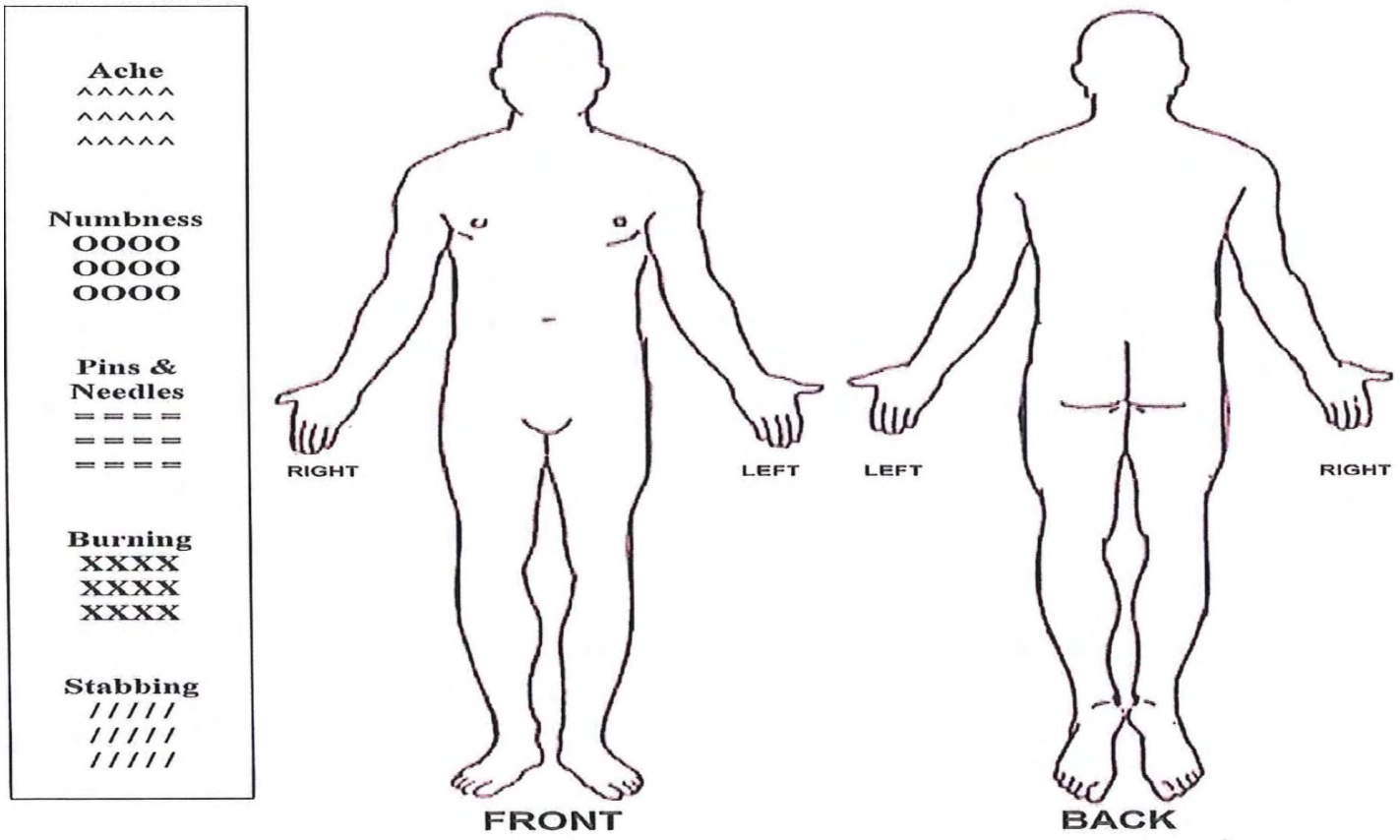
PAIN PATTERN:

1. DESCRIBE THE DEGREE OF PAIN YOU EXPERIENCE (on a scale of 0-10)_____
2. WHAT WORDS WOULD YOU USE TO **DESCRIBE** YOUR PAIN?
   ☐Aching ☐ Burning ☐ Stabbing ☐Stinging ☐ Throbbing ☐Squeezing ☐Electrical ☐ Knife-like
   ☐Other:_____
3. WHAT MAKE THE PAIN **WORSE**?
   ☐Exercise ☐ Sitting ☐ Standing ☐Walking ☐ Bending forward ☐Bending backward ☐Coughing ☐Sneezing
   ☐Other: _____
4. WHAT **REDUCES** YOUR PAIN?
   ☐ Lying flat ☐Lying on your side ☐Sitting ☐Standing ☐Walking ☐ Bending forward ☐Bending backward ☐ Physical Therapy
   ☐Other: _____
5. DO YOU HAVE ANY **NUMBNESS OR TINGLING** IN YOUR ARMS/HANDS OR LEGS/FEET? ☐ YES ☐ NO
   Where? _____
6. OTHER SYMPTOMS RELATED TO YOUR PAIN (i.e. Nausea, Dizziness, Fatigue, Headaches, etc…) _____
   _____
7. WHAT **ACTIVITIES** IN YOUR DAILY LIFE DOES YOUR PAIN IMPAIR?
   _____



PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.



PAST MEDICAL HISTORY:

1. GENERAL MEDICAL PROBLEMS:
   ☐Stomach or Digestive Problems ☐Diabetes ☐Osteoarthritis ☐Rheumatoid Arthritis ☐Gout ☐Lung Diseases
   ☐Bowel or Bladder Incontinence ☐Fibromyalgia ☐Cancer (Type) _____ ☐ Heart Disease ☐Epilepsy
   ☐Depression or Anxiety ☐Unexplained Loss of Weight ☐High Blood Pressure ☐Other
   _____
2. PRIOR SURGERIES (Unrelated to present problem) TYPE/DATE: _____
   _____
3. LIST **ALL** YOUR CURRENT MEDICATIONS (over the counter & prescribed) INCLUDING DOSES AND QUANTITIES TAKEN EACH DAY:_____
   _____
   _____
   _____
   _____

FAMILY HISTORY:

1. HISTORY OF DISEASE IN FAMILY MEMBERS:
   MOTHER: ☐ Alive ☐ Deceased Medical Problems: _____
   FATHER: ☐ Alive ☐ Deceased Medical Problems: _____
   SIBLINGS ☐ Alive ☐ Deceased Medical Problems: _____

MEDICATION ALLERGIES:

Medication: _____ Describe Reaction: _____
Medication: _____ Describe Reaction: _____
Medication: _____ Describe Reaction: _____
Medication: _____ Describe Reaction: _____

PATIENT NAME: _____ **DATE:** _____

DR. INTIALS: _____

SOCIAL HISTORY:

1. DO YOU SMOKE OR USE TOBACCO PRODUCTS? ☐ Yes ☐ No If so, how much?_____
2. DO YOU DRINK ALCOHOLIC BEVERAGES? ☐ Yes ☐ No If so, please describe your use:_____
3. DO YOU USE RECREATIONAL DRUGS? ☐ Yes ☐ No Please describe your use:_____
4. MARITAL STATUS: ☐ Married ☐Divorced ☐Separated ☐Single ☐Committed Relationship ☐Other _____
5. HIGHEST LEVEL OF EDUCATION_____ SEXUAL ACTIVITY: _____

EMPLOYMENT HISTORY:

1. ARE YOU **EMPLOYED** AT PRESENT? ☐ Yes ☐ No Job/Career: _____
   IF YOU ARE **NOT** WORKING WHICH APPLIES TO YOU?
   ☐ Off by Medical Advice ☐ Quit ☐ Downsized ☐ Retired ☐ Terminated
   ☐ Other _____
2. HAS THE PAIN AFFECTED YOUR **ABILITY TO WORK**? ☐ Yes ☐ No If yes, how? _____
3. DO YOU HAVE WORK **RESTRICTIONS**? ☐ Yes ☐ No List: _____

REVIEW OF SYSTEMS

Do you have any allergies other than to medications (such as to latex, shellfish, etc.)?
☐yes ☐no If YES, describe._____

Do you have any of the following?

General:
Recent weight loss of more than 10 pounds? ☐yes ☐no
Recent weight gain of more than 10 pounds? ☐yes ☐no
Fever? ☐yes ☐no
Chills? ☐yes ☐no
Night sweats? ☐yes ☐no

Have you seen your primary care physician in the past year? ☐yes ☐no

Cardiac:
Chest pain ☐yes ☐no
Shortness of Breath ☐yes ☐no

Respiratory:
Wheezing ☐yes ☐no
Pneumonia ☐yes ☐no
Chronic cough ☐yes ☐no

Gastrointestinal:
Abdominal pain ☐yes ☐no
Nausea ☐yes ☐no
Vomiting ☐yes ☐no
Diarrhea ☐yes ☐no
Liver problems ☐yes ☐no

Skin:
Open sores ☐yes ☐no
New moles ☐yes ☐no
Poor healing ☐yes ☐no
Skin infection ☐yes ☐no

Hematologic/Oncologic:
Easy bruising ☐yes ☐no
Blood thinning medications ☐yes ☐no
Blood transfusion ☐yes ☐no
Organ transplant ☐yes ☐no

Bones/Joints:
Shoulder pain ☐yes ☐no
Wrist/hand pain ☐yes ☐no
Hip pain ☐yes ☐no
Knee pain ☐yes ☐no
Lupus ☐yes ☐no
Muscle weakness ☐yes ☐no
Fibromyalgia ☐yes ☐no

Genitourinary:
Abnormal kidney function ☐yes ☐no
Pain with urination ☐yes ☐no
Frequent urinary infections ☐yes ☐no

Mental Health:
Sleep disturbances ☐yes ☐no
Feeling of hopelessness ☐yes ☐no

Nervous System:
Headaches ☐yes ☐no
Tremors ☐yes ☐no
Poor speech ☐yes ☐no
Changes in vision ☐yes ☐no

Endocrine:
Thyroid problems ☐yes ☐no

Notes:

_____

_____

_____

_____

PATIENT NAME: _____ **DATE:** _____

DR. INTIALS: _____

Patient responsibility agreement for controlled substance prescriptions from

Brent B. Belvin, M.D. or Micro-Pain Institute

Controlled substance medications are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, and improve function and/or ability to work. Because my physician may prescribe controlled substance medications to help manage pain, I agree to the following conditions:

1. I am responsible for the controlled substance medications prescribed to me. **If my prescription is lost, misplaced, stolen, spilled, flushed, etc. or if I "run out early"**, I understand that it may not be replaced.
2. Refills of controlled substance medications:
    a. Will be made only during regular office hours, Monday through Friday, in person, during a scheduled office visit. Refills will not be made at night, on weekends or during holidays. **NO REFILLS BY PHONE**
    b. Will not be made if I "run out early" "lose a Prescription", or "spill or misplace my medication". I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
    c. Will not be made as an "emergency", such as on a Friday afternoon, because I suddenly realize I will "run out tomorrow".
3. **It may be deemed necessary by my doctor that I see a psychiatrist, psychologist, or addiction specialist at any time while I am receiving controlled substance medications.** I understand that if I do not attend such an appointment, my medication may be discontinued. I understand that if the specialist feels that I have psychological dependence (addiction) my medications may no longer be refilled.
4. **I agree to comply with random urine, blood, saliva, or breath testing, pills counts, pharmacy screens, evaluation of medication fills via the Texas DPS Prescriptions Across Texas website, or other documentation of the proper use of my medications, as well as confirming compliance with the prescribed regimen.**
5. I understand that driving a motor vehicle or operating heavy machinery may not be safe while taking controlled substance medications, and that it is my responsibility to comply with the laws of the state while taking the prescribed medications. Common adverse reactions in patients taking opioids for pain relief include nausea/vomiting, itching, dry mouth, sedation, and constipation. Other less common, but more dangerous, effects could include (but are not limited to) respiratory depression and death. **I should never increase my dosing regimen without first discussing with my doctor.**
6. I understand that **if I violate any of the above conditions**, my prescription for controlled substance medications **may be terminated immediately.** If the violation involves obtaining controlled substance medications from another individual, **"doctor shopping," or the concomitant use of illicit (illegal) drugs**, I may also be reported to all my physicians, medical facilities, and appropriate authorities.
7. I understand that the main treatment goal is to reduce pain and improve any ability to function and/or work. In consideration of this goal and the fact that I am being given a potent medication to help me reach my goal, **I agree to help myself by the following better health habits: exercise, weight control and avoidance of tobacco and alcohol use.** I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
8. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined, and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances.
9. I have been fully informed by Brent B. Belvin, M.D. and staff regarding psychological dependence (addiction) of controlled substance medication. I know that some individuals may develop a tolerance, a physical reaction which makes the body less responsive to analgesic and other effects of opiates, possibly necessitating a dose increase to achieve the desired effect. I know that there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I know I should slowly decrease the dose or I may have withdrawal symptoms.
10. I understand the above conditions were created for my own safety, and for the safety of the community at large.

I have read this agreement and the same has been explained to me by Dr. Brent Belvin. In addition, I fully understand the consequences of violating this agreement.

Patients Signature	**Date**
Clinic Representative / Witness	**Date**

Updated 08/2014