817-268-0104
(fax) 817-268-6102
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Welcome to Metroplex Pain Management, P.A.

At Metroplex Pain Management, we appreciate the impact that pain has on the quality of your life. Pain is rarely treated effectively by any single mode of treatment alone. We utilize a team approach to accomplish pain reduction, pain management and return to activity.

Our team includes:

- **J. Michael Stanton, D.O., F.A.O.C.A.**
- Martin Simpson, C.R.N.A.
- Lonnie Adian, C.R.N.A.
- **Patrick K. Stanton, D.O., F.A.O.C.A.**
- Wray Walcott, C.R.N.A.

At Metroplex Pain Management, our patients come first. We are staffed with Board Certified physicians who specialize in Interventional Pain Management. Our medical team is dedicated to improving the quality of your life. Our overall goal is to assist patients in returning to the most functional and productive lifestyle possible.

Our medical teams of highly skilled specialists are professional, knowledgeable and committed to your well being. Our office is staffed with insurance experts who will help verify, preauthorize and bill your medical claims for you. We accept most insurance plans and look forward to helping you achieve pain relief.

You have received the following information in order to complete your records on becoming an established patient of Metroplex Pain Management. It is important that you complete this packet and bring it to your appointment.

When you attend your first appointment you must bring this following: All of your completed paperwork (attached), your insurance card, a valid photo identification card (driver's license, etc.), a detailed list of all of your medications (including any over-the-counter medication(s) you are currently taking as well as herbal supplements) and your co-pay (if your insurance plan requires one).

Patient Name: _____ DOB: _____

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NEW PATIENT REGISTRATION FORM

Metroplex Pain Management. P.A.
(*PLEASE PRINT- use blue or black ink)*

PATIENT INFORMATION:

Name: _____ Today's Date: _____

SSN: _____ -_____ -_____ Sex: _____ DOB: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

May we leave a message at these numbers? _____ If yes, which number: _____

Email Address: _____

CELL PHONE: _____ ** This number will be used for text messages regarding appointment reminders**

Spouse Name: _____ Daytime Ph#:_____

Referring Physician: _____ Ph#: _____

Primary Care Physician (PCP): _____ Ph#: _____

When did you last see your PCP doctor? _____

Employer Information: Employment Status: Employed Unemployed Disabled Retired

Occupation: _____ Employer: _____

Employer Address: _____ Ph#: _____

If Retired, Date Retired: _____ If Disabled or unemployed, date last worked: _____

School Information, if applicable:

Are you currently in school? (please circle) Y / N Full-time / Part-time

School Name: _____ Grade: _____

GUARANTOR INFORMATION (the person responsible for the patient's account)

What is the patient's relationship to the guarantor? Self Spouse Child Other: _____

Guarantor Name: _____ DOB: _____ SSN: _____ -_____ -_____

Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Employer Name and Address: _____

_____

Patient Name: _____ DOB: _____

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INSURANCE INFORMATION:

Do you have Medicare Part A? ___ Part B? ___ Medicare ID Number _____

If you have Medicare, do you also have a Medigap policy or other supplemental coverage? Yes / No

Do you have MEDICAID? Yes / No Medicaid Policy Number _____

Is this a Worker's Compensation, Auto Accident, Other accident/Injury Claim? (Circle if applicable)

If Yes, Date of Accident/Injury: _____

Are you currently involved in or pursuing litigation over these injuries? Yes / No (Circle if applicable)

If Yes, Attorney Name: _____ Law Firm: _____

Attorney Ph#: _____ Claim/Case #: _____

PRIMARY INSURANCE INFORMATION – Insurance card must be provided to front desk

Insurance Company Name: _____

Claims Mailing Address: _____

Contact Name: _____ Ph#: _____

Policy Holder's Name: _____ Policy Holder's SS#: _____

Policy Holder's DOB: _____ Relationship: _____

Policy Number/ID#: _____ Group #: _____

Group Name/Employer Name: _____

SECONDARY INSURANCE INFORMATION – Insurance card must be provided to front desk

*If Medicare is your primary insurance, is this second policy a former employer's group plan? Yes / No

Secondary Insurance Company Name: _____

Claims Mailing Address: _____

Contact Name: _____ Ph#: _____

Policy Holder's Name: _____ Policy Holder's SS#: _____

Policy Holder's DOB: _____ Relationship: _____

Policy Number/ID#: _____ Group #: _____

Group Name/Employer Name: _____

OTHER INSURANCE INFORMATION – info must be provided to front desk, if applicable

Insurance Company or Worker's Compensation Carrier Name: _____

Claims Mailing Address: _____

Contact Name: _____ Ph#: _____

Policy Holder's Name: _____ Policy Holder's SS#: _____

Patient Name: _____ DOB: _____

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Policy Holder's DOB: _____ Relationship: _____

Policy Number/Claim ID#: _____ Group #:_____

Group Name/Employer Name: _____

"The answers to the following 3 questions are REQUIRED by your insurance carrier. Metroplex Pain Management, P.A. will file claims to your insurance carrier as a courtesy to you. If this information is NOT provided there is a possibility that your claims could be denied and the charges become your responsibility."

Was your injury due to employment, auto, or other accident? _____

If auto, in which state did the accident occur? _____

Date of accident: (mo/day/yr): _____/_____/_____

Date of first symptom or illness: (mo/day/yr): _____/_____/_____

Have you been treated for the same condition or similar illness? _____ If yes, when?_____/_____/_____ and by whom? _____
(Name of doctor or hospital)

By My Signature Below, I Hereby Understand That Charges From Metroplex Pain Management, P.A. are Separate From All Other Providers' Charges, Including But Not Limited To Other Physicians, Anesthetists, Radiology, Lab, Pathology, Facility, Hospital, Surgery Center, Etc. I further understand that anytime my insurance changes it is my responsibility to notify Metroplex Pain Management, P.A. before a scheduled appointment.

X Signature: _____ Date: _____/_____/_____

Patient Name: _____ DOB: _____

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PATIENT CONSENT & AUTHORIZATION

Metroplex Pain Management, P.A. is committed to fulfilling all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Section A: CONSENT

Must be completed for all authorizations. The patient or the patient's representative must read the following statements:

1. I authorize Metroplex Pain Management, P.A, to release any of my medical, billing or insurance information necessary to process my medical, disability or other claims and coordinate or manage my health care.
2. I understand that I may revoke this authorization at any time by notifying Metroplex Pain Management, P.A. in writing. But, if I do revoke this authorization, my revocation will not have an affect on any actions Metroplex Pain Management, P.A. took before they receipt of my revocation.
3. You may revoke this authorization by signing a Revocation of Authorization form and returning it to Metroplex Pain Management, P.A. To request a Revocation of Authorization form, you may ask the reception desk or contact our business office at: Attn: Privacy Contact, Metroplex Pain Management 1600 Central Drive, Suite 160, Bedford, Texas 76022, (817) 268-0104.
4. For additional information regarding disclosure of uses of my health information, I acknowledge I may obtain a copy of Metroplex Pain Management, P.A. ***"Notice of Privacy Practices"*** at any time from the reception desk or by contacting the business office above.

Section B: AUTHORIZATION

In the event a family member or caregiver attends my office visit and is in the exam room at the time of evaluation and/or treatment, I give Metroplex Pain Management, P.A. and its physicians or employees my permission to discuss freely my condition, treatment or diagnosis or insurance/payment issues with that person.

I hereby AUTHORIZE Metroplex Pain Management, P.A. to disclose my protected health information (medical or financial) in the form of written and verbal communications, to the following relatives/friends/caregivers/organizations that I have specifically listed below. Any entity outside of my treatment, payment, or healthcare operations NOT listed below will be denied access to my protected health information. I may revoke this authorization at any time in writing, by requesting an authorization restriction form. (MPM Form 122)

Name: _____ Phone: _____Date of Birth: ___/___/___ Relationship: _____

Name: _____ Phone: _____Date of Birth: ___/___/___ Relationship: _____

Name: _____ Phone: _____Date of Birth: ___/___/___ Relationship: _____

EMERGENCY CONTACT

Please list the name and phone number of **someone other than your spouse** that we may contact in case of an emergency.

Name: _____ Phone: _____ Relationship: _____

Section C: AUTHORIZATION RESTRICTION

I hereby **DENY** disclosure of my protected health information (medical or financial) maintained by Metroplex Pain Management, P.A. without my written authorization to the persons/organizations specified below. I understand that if a person or organization listed below, requests to receive my information and is not a health plan or health care provider, that my health information may not be disclosed without my written authorization. I may revoke this restriction in writing at any time, by requesting a patient authorization, consent, and assignment of benefits. (MPM Form 041)

To whom do you want the restriction to apply:

Persons/Organizations_____Relationship_____
Persons/Organizations_____Relationship_____
Persons/Organizations_____Relationship_____

Patient's Date of Birth _____ Patient's Social Security Number _____

Patient's Printed Name _____

Patient's Signature: _____ Date: _____/_____/_____

Patient Name: _____ DOB:_____

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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

NAME OF PATIENT: **(please print)**_____DATE: _____

PATIENT DATE OF BIRTH: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

Patient Name: _____ DOB:_____

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I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, potential lifelong opioid use disorder and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

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I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

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- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my physician liable for problems caused by the discontinuance of medication(s).

- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for alcohol, illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.
- I must not use alcohol at any time

I certify and agree to the following:

1) I am **not currently using illegal drugs, alcohol or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

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4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____

Patient Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

Name and contact information for pharmacy

_____

_____

_____

Patient Name: _____ DOB: _____

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Patient Pain History

Metroplex Pain Management, P. A.

HISTORY of PRESENT ILLNESS:

Patient Name (please print): _____ M/F Age _____

Last name, First Name, Middle Initial

Have you ever been to another Pain Center? Yes / No If Yes, where: _____

Have you had Physical Therapy before? Yes/No If Yes, where/when: _____

When was your last Physical Therapy Appointment? _____

How many PHYSICAL THERAPY visits have you had **this** year? _____

What is the chief complaint that brings you to the doctor today? _____

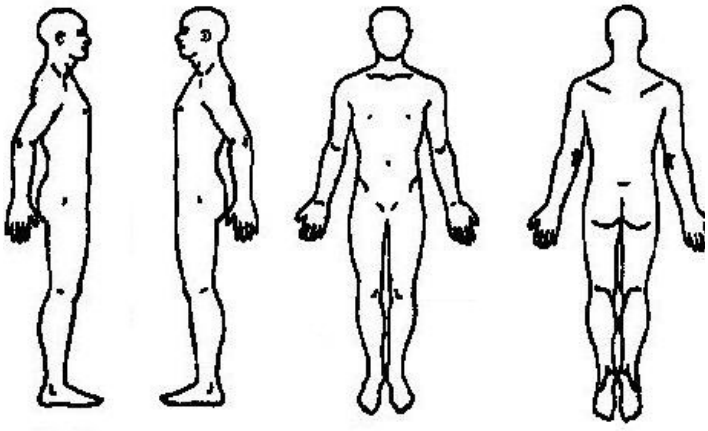
_____

How did these symptoms begin? _____

When did you first start experiencing these symptoms? MM/DD/YY _____

When did the symptoms progress to the current level of severity? _____

Please mark on the drawings below all areas where you are feeling pain:



Location: _____

Severity: mild moderate severe

Quality: dull-aching stabbing cramping
shooting burning throbbing

Duration: Intermittent (stops & starts) or
Persistent (all the time)

Pain worse in: morning afternoon evening

Modifying Factors

What makes it better: _____

What makes it worse: _____

Associated Symptoms: _____

Please circle any of and all of the following you are experiencing:

Sadness Depression Less Interest in Pleasurable Activities Appetite/Weight Change
Worthlessness Felling Agitated or Slowed Down Fatigue Suicidal Thoughts Poor Concentration
Excessive Worry or anxiety/Nervousness Irritability/Moodiness Restlessness or Feeling "Keyed Up"
Repeated Distressing Recollections of a Traumatic Event (PTSD)

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Please circle the number that reflects your current level of pain AT REST:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

Please circle the number that reflects your current level of pain PERFORMING EVERYDAY ACTIVITIES:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

Please circle the number that reflects your current level of pain WHEN PERFORMING YOUR JOB:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

On the average over the past 4 weeks my pain at the **best** was a:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

On the average over the past 4 weeks my pain at the **worst** was a:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

When I take my pain medication as prescribed by my physician, my pain on average is:
None 0 1 2 3 4 5 6 7 8 9 10 unbearable

HISTORY:

I am: Left-handed Right-handed Ambidextrous

Height: _____ Current Weight: _____ Weight one year ago: _____

ALLERGIES:

Do you have a Latex allergy? Yes/No

Please list all allergies and reactions you have: _____

_____

FAMILY HISTORY: (please circle any of the following that are present in your family members)

Adverse reaction to anesthesia Cancer Chronic Pain Diabetes Mellitus Fibromyalgia
Heart Disease Hypertension Lung disease Lupus Mental illness Migraines
Multiple Sclerosis Rheumatoid Arthritis Seizure Disorder Stroke

Please complete the following:

	Age of Living	State of Health of Living			Age at Death	Current Illness or Cause of Death
Father		Good	Fair	Poor		
Mother		Good	Fair	Poor		

Siblings: Number Living: _____ Number Deceased: _____

Patient Name: _____ DOB: _____

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PAST MEDICAL: (please circle any of the following for which "you have" ever received treatment)

Alcohol Abuse	Drug Dependence	Liver Disease
Anemia	Gastric Ulcer	Obstructive Sleep Apnea
Anxiety Disorder	General Anesthesia Complications	Postmenopausal Osteoporosis
Arthritis	Head Injury	Psoriasis
Asthma	Heart Disease	Psychological Trauma
Bleeding Disorders	Hepatitis B	Seizure Disorder
Cancer (Type :_____)	Hepatitis C	Self Catheterization
Coagulopathy	Hiatal Hernia	Sexually Transmitted Disease
Colostomy Bag	HIV	Spinal Cord Injury
Congestive Heart Failure	Hypercholesterolemia	Spinal Fusion
COPD	Hypercoagulopathy	Thrombophlebitis
Coronary Artery Disease	Hypertension	Transient Cerebral Ischemia
CVA (Stroke)	Hyperthyroidism	Tuberculosis
Depression	Hypothyroidism	Urinary Tract Infection
Diabetes	Kidney Disease	OTHER: _____

Are you currently taking any of the following medications? Yes / No
(If yes, please circle which ones)

Aspirin	Coumadin (Warafarin)	Fish Oil	Heparin	Lovenox	Eliquis
Omega Supplements	Plavix	Prodaxa	Vitamin E	Xarelto	

Have you (or a family member) ever had a problem under anesthesia? Yes / No
(If yes, please circle which ones)

Malignant Hyperthermia Prolonged Awareness Prolonged Paralysis Other: _____

Immunizations: (date received) Tetanus: _____ Hepatitis: _____ TB Test: _____

Females: Last Menstrual Period _____ Are you or could you be pregnant? Yes / No
Are your periods regular? Yes / No / N.A. Hysterectomy? Yes / No Birth Control? Yes / No
(Type): _____

Males: Sexual or erectile Dysfunction? Yes / No

Hospitalizations: (please list all major illnesses with diagnosis and year)
1._____ 2. _____
3._____ 4. _____
5._____ 6. _____

Surgeries:(please list all surgeries and type along with year performed)
1._____ 2. _____
3._____ 4. _____
5._____ 6. _____
When and where have you had any of the following MRI(s): _____
CT's: _____ X-rays: _____

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SOCIAL HISTORY: (please circle)

Race: White African American Hispanic Indian Asian Other:_____

Language: English Spanish Other:_____

Marital Status: Single Married Divorced Widowed

I currently live in: House Apartment Mobile Home Retirement Center

Education: Some High School (Grade_____) High School Graduate Some College
College Graduate Masters Doctorate

Employment History: Unemployed
Employed 20-40 hrs/Week
Retired
Applying for Disability
Employed Less Than 20hrs/Week
Employed 40hrs or More/Week
On Disability

Have you missed work due to pain? Y / N If yes, how much? _____

EMPLOYMENT STATUS:

Current Job Title: _____ Years in current position: _____

Prior Job: _____ Years in that position: _____

Has the pain problem that brought you to MPM caused you to change jobs? Y / N
If you are currently NOT WORKING, what was the exact date you last worked? _____
If you are disabled, what year were you declared disabled? _____ Disabling Physician? _____

If appropriate, please circle the level of work your job demands:

Physical Demands:	Sedentary	Light	Medium	Medium Heavy	Heavy	Very Heavy
Occasional (0-33%)	10 lbs.	20 lbs.	50 lbs.	75 lbs.	100 lbs.	Over 100 lbs.
Frequent (34-66%)	0 lbs.	10 lbs.	20 lbs.	35 lbs.	50 lbs.	Over 50 lbs.
Constant (67-100%)	0 lbs.	0 lbs.	10 lbs.	15 lbs.	20 lbs.	Over 20 lbs.

Tobacco Use: Do you smoke? Yes / No If yes, how many packs per day? _____
Did you ever smoke? Yes / No If yes, for how many years? _____
Do any of your immediate relatives smoke? Yes / No

Alcohol Use: How many drinks do you have per week? _____
Have you ever been treated for alcohol dependency? Yes / No
Do any of your immediate relatives have or had an alcohol problem? Yes / No

Substance Abuse: Do you currently use: Marijuana, Cocaine, Crack, Ecstasy, Methamphetamines
any other: _____ drugs off the street? Yes / No
If yes, please specify: _____
Have you in the past used any of the above? Yes / No
Do any of your family members have a substance abuse problem? Yes / No
Have you ever been treated for substance abuse? Yes / No

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Caffeine Use: How many caffeinated beverages do you drink per day? _____

MEDICATION HISTORY:

Please list all current pain medication with mg doses and frequency (times taken per day):

1._____ 2. _____
3._____ 4. _____
5._____ 6. _____

Please list all other medication taken including over the counter, weight loss and nutritional supplements:

1._____ 2. _____
3._____ 4. _____
5._____ 6. _____

Please identify which of the following medications have been tried in the past by checking the appropriate box,

****Do not check any drug never taken****

	Helpful?			Helpful?			Helpful?	
NSAID	Y	N	**Muscle Relaxant**	Y	N	**Anticonvulsant**	Y	N
Motrin			Skelaxin			Neurontin		
Lodine			Norflex			Lamictal		
Naprosyn			Soma			Topamax		
Relafen			Robaxin			Depakote		
Indocin			Flexeril			Tegretol		
Celebrex			Zanaflex			Dilantin		
Mobic			Valium			Lyrica		
Opioid (narcotic)			**Others**			**Antidepressant**		
Darvocet			Stadol			Elavil		
Percocet			Talwin			Pamelor		
Lortab/Vicodin			Fioricet			Doxepin		
Norco/Zydone			Ultram			Tofranil		
Duragesic			Zostrix			Desyrel		
Dilaudid			Ketamine Gel			Wellbutrin		
Oxycontin			Lidoderm			Anafranil		
MS Contin			Imitrex			Luvox		
MS IR			Amerge			Zoloft		
Kadian			DHEA			Remeron		
Levorphanol			Guaifenesin			Paxil		
Methadone			Dextromethorhan			Prozac		
Actiq			Steroids			Serzone		
			Suboxone			Effexor		
						Respiradol		
						Zyprexa		
						Cymbalta		

Patient Name: _____ DOB: _____

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REVIEW OF SYSTEMS – (please indicate if you have any of the following conditions or symptoms, Circle all that apply)

General Health:	Chills	Fatigue	Night Sweats	Weight Gain >10lbs
	Weight Loss >10lbs			
Skin:	Change in Wart/Mole	Dryness	Excessive Sweating	Hair Loss
	Nail Changes	New Lesions	Rash	Skin Color Changes
HEENT:	Blurred Vision	Head Injury	Double Vision	Visual Loss
	Hearing Loss	Ringing in Ears	Vertigo	Nose Bleed
	Sinus Pain	Bleeding Gums	Hoarseness	
Neck:	Neck Mass	Neck Stiffness	Swollen Glands	
Respiratory:	Cough	Decreased Exercise Tolerance	Snoring	Difficulty Breathing
	Hemoptysis	Wheezing		
Breast:	Breast Mass	Breast Pain	Nipple Discharge	Skin Changes
Cardiovascular:	Chest Pain	Calf Cramps	Fainting/Blacking Out	Irregular Heart Beat
	Difficulty Breathing Lying Down	Shortness of Breath	Swelling of Extremities	Hurt Murmur/Valve problem
Gastrointestinal:	Abdominal Pain	Black Tarry Stool	Bloody Stool	Change in bowel Habits
	Constipation	Diarrhea	Difficulty Swallowing	Heartburn
	Jaundice	Nausea	Rectal Bleeding	Vomiting
	Vomiting Blood			
Musculoskeletal:	Joint Pain	Joint Stiffness	Joint Swelling	Muscle Atrophy
	Muscle Weakness	Restless Leg Syndrome		
Neurological:	Decreased Memory	Difficulty Speaking	Dizziness	Headaches
	Incontinence Stool	Incoordination	Loss of Consciousness	Seizures
	Stroke	Unsteadiness		
Psychiatric:	Anxiety	Change in Sleep Pattern	Depression	Hallucinations
	Mood Changes	Panic Attacks	Suicidal Ideation	History of Abuse
Endocrine:	Cold Intolerance	Excessive Thirst	Excessive Urination	Hair Changes
	Heat Intolerance	Hot Flashes	Libido Change	Sexual Dysfunction
	Thyroid Problems			
Hematology:	Abnormal Bleeding	Anemia	Blood Clots	Easy Bruising
	Prolonged Bleeding			

Other Medical Problems: _____

To be Completed by Metroplex Pain Management, P.A. medical staff: This record of the patient's chief complaint, past medical, surgical, Medication, allergies, social, family history and review of systems has been reviewed by me. This information is an adjunct to any dictated information and is to be considered a permanent part of my consultation and medical record for this patient.
Reviewed by: _____ Date: _____

Patient Name: _____ DOB: _____

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Th	SECTION 1 – PERSONAL CARE		SECTION 8 – STANDING
	I can look after myself without causing extra pain.		I can stand as long as I want without pain.
	I can look after myself normally, but it causes extra pain.		I have some pain on standing but it does not increase with time.
	It is painful to look after myself but I am slow and careful.		I can't stand for longer than 1 hour without increasing pain.
	I need some help but manage most of my personal care.		I can't stand for longer than ½ hour without increasing pain.
	I need help every day in most aspects of self care.		I can't stand for longer than 10 minutes without increasing pain.
	I do not get dressed, I wash with difficulty, and stay in bed.		I avoid standing because it increases my pain immediately.
	SECTION 2 – LIFTING		**SECTION 9 – SLEEPING**
	I can lift heavy weights without extra pain.		I have no trouble sleeping.
	I can lift heavy weights but it causes extra pain.		My sleep is slightly disturbed (less than 1 hour sleepless)
	Pain prevents me from lifting heavy weights off the floor but I manage if they are conveniently positioned (i.e. on a table)		My sleep is mildly disturbed (1-2 hours sleepless)
	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.		My sleep is moderately disturbed (2-3 hours sleepless)
	I can only lift very light weights at the most.		My sleep is greatly disturbed (3-5 hours sleepless)
	I cannot lift or carry anything at all.		My sleep is completely disturbed (5-7 hours sleepless)
	SECTION 3 – DRIVING		**SECTION 10– RECREATION**
	I can drive my car without pain.		I can do all of my usual recreational activities with no pain.
	I can drive my car as long as I want with slight pain.		I am able to do all or most of my usual recreational activities with some pain.
	I can drive my car as long as I want with moderate pain.		I am able to do most but not all of my recreational activities.
	I can't drive my car as long as I want because of moderate pain.		I am able to do only a few of my recreational activities.
	I can hardly drive at all because of severe pain.		I can hardly do any recreational activities because of pain.
	I can't drive my car at all.		I cannot do any recreational activities at all because of pain.
	SECTION 4 – WALKING		**SECTION 11 – SEX LIFE (If inactive, estimate how it would be)**
	Pain does not prevent me from walking any distance.		My sex life is normal and causes no extra pain.
	Pain prevents me from walking more than 1 mile.		My sex life is normal but increases the degree of pain.
	Pain prevents me from walking more than ½ mile.		My sex life is nearly normal but is very painful.
	Pain prevents me from walking more than ¼ mile.		My sex life is severely restricted by pain.
	I can only walk using a cane, crutches, or a walker.		My sex life is nearly absent because of pain.
	Pain prevents me from walking at all.		Pain prevents any sex life at all.
	SECTION 5 – READING		**SECTION 12 – HOUSE AND YARD WORK**
	I can read as much as I want with no pain.		I can do house and yard work without extra pain.
	I can read as much as I want with slight pain.		I can do my house and yard work but it causes extra pain.
	I can read as much as I want with moderate pain.		I can do most of my house and yard work but it is very painful.
	I can't read as much as I want because of moderate pain.		I can do most house and yard work with extreme pain.
	I can't read as much as I want because of severe pain.		I can hardly do any house and yard work at all.
	I cannot read at all because of pain.		I cannot do any house and yard work.
	SECTION 6 – SITTING		**SECTION 13 – SOCIAL LIFE**
	I can sit in a chair as long as I like.		My social life is normal and causes me no extra pain.
	I can only sit in my favorite chair as long as I like.		My social life is normal but increases the degree of pain.
	Pain prevents me from sitting more than 1 hour.		Pain has no significant effect except for limiting energetic interests.
	Pain prevents me from sitting more than ½ hour.		Pain has restricted my social life to my home.
	Pain prevents me from sitting more than 10 minutes.		I have hardly any social life because of pain.
	I avoid sitting because it increases my pain.		
	SECTION 7 – WORK		**SECTION 14 – TRAVELING**
	I can do as much work as I want to.		I can travel anywhere without extra pain.
	I can only do my usual work but no more.		I can travel anywhere but it gives me extra pain.
	I can do most of my usual work but no more.		Pain is severe but I manage journeys over two hours.
	I cannot do my usual work.		Pain restricts me to journeys of less than 1 hour.
	I can hardly do any work at all.		Pain restricts me to short necessary journeys under 30 min.
	I can't do any work at all.		Pain prevents me from traveling except to the doctor or hospital.

Patient Name: _____ DOB: _____

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Payment Policy

Patient Name:_____ **DOB:** _____

It is the policy of Metroplex, Pain Management, P.A., for patients to pay for services at the time they are rendered.

We accept Visa, MasterCard, American Express, Discover, personal checks and cash payments. There is a $25 fee on all returned checks.

For those patients with Medicare, we will accept assignment on claims. We file Medicare as well as secondary insurance claims; therefore, it is very important that we obtain all your insurance information. If you do not have secondary coverage, you will be expected to pay 20% of the allowed charges at the time of check-in as well as any unmet deductible.

HMO, PPO, POS and EPO and any other plans that requires a co-pay, patients are expected to pay their co-payments or charges according to their individual plans for each visit.

We require notification of any changes in your insurance coverage, name, address, and/or telephone number. Failure to do so may leave you responsible for charges.

We ask that in the event you are unable to keep your scheduled appointment, you give us at least **24 hours notice**. "No shows" (appointments that are not kept or adequate notice is not given) are not only inconsiderate to our physicians and our staff, they are also an unnecessary expense, in that this time could have been given to another patient. We realize there are instances when emergencies come up; however, if you have "no shows" you will be charged a fee and/or possible termination of the physician/patient relationship may occur.

Due to increasing healthcare costs, we reserve the right to charge a fee per document request. These documents include, but are not limited to, letters written by our office, forms filled out by our physicians/staff, and/or copies of medical records, etc. This could also include any **non-emergent** phone calls made to the office after regular business hours.

These policies help our office to keep charges and expenses as low as possible. Your signature is required below to verify acknowledgement of this policy.

Signature_____Date _____

Patient Name: _____ DOB: _____

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ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS AND MEDICAL AUTHORIZATION: BY MY SIGNATURE BELOW, I HEREBY AUTHORIZE METROPLEX PAIN MANAGEMENT, P.A. (MPM) TO RELEASE ANY AND ALL MEDICAL AND/OR BILLING RECORDS WHICH HAVE BEEN CREATED IN CONNECTION WITH ANY EVALUATION, EXAMINATION, REVIEW, DIAGNOSIS, PROGNOSIS AND/OR TREATMENT RENDERED TO ME AND/OR REGARDING MY MEDICAL INJURY/ILLNESS DIRECTLY TO ME, ANY INSURANCE COMPNAY, ADJUSTER, CASE MANAGER, HEALTH CARE PROVIDER, COVERED ENTITY, REQUESTING PARTY OR ATTORNEY. I FURTHER AUTHORIZE ANY OTHER PROVIDER, SENDER AND/OR COVERED ENDITY TO RELEASE MY RECORDS TO MPM. I UNDERSTAND THAT CHARGES FROM MPM ARE SEPARATE FROM ANY OTHER PHYSICIAN, FACILITY OR PROVIDER. I FURTHER AUTHORIZE AND INSTRUCT MY INSURANCE COMPANY TO PAY MPM DIRECTLY FOR MEDICAL EXPENSES I INCUR. I UNDERSTAND AND AGREE THAT ANY SUM UNPAID IS MY FULL RESPONSIBILITY. I AUTHORIZE MPM TO INITIATE A CLAIM APPEAL TO MY CARRIER OR A COMPLAINT TO THE INSURANCE COMMISSIONER ON MY BEHALF. A PHOTO COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

RELEASE OF MEDICAL RECORDS:

Your signature below indicates we may release your medical records directly to you at any time upon your request. You understand a minimum fee of $25.00 for photocopies may be assessed for preparing and furnishing this information. Medical records may only be released directly to you, to a personal representative by you, or another entity possessing appropriate authorization. Please allow up to 15 days for delivery of this information.

The fee for completion of forms is $25.00

You further authorize any other provider to release your records to Metroplex Pain Management, P.A., in arranging joint treatment of health care activities by physicians and healthcare provider teams who may be directly involved with your treatment. The hospital, surgery care centers and treating physicians participate in what the HIPAA Privacy Rule defines as an organized health care arrangement (OHCA). Thus, we may release protected health information for the joint health care activities of the OHCA.

X Signature: _____ Date: _____/_____/_____

Patient Name: _____ DOB: _____

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CERTIFIED ALLIED HEALTH PROFESSIONALS

Dr. Stanton wants you to know that he employs Certified Allied Health Professionals to assist him in the delivery of medical care.

Certified Allied Health Professionals are not doctors. These individuals have received advanced education and training in the provision of health care. Metroplex Pain Management Allied Health Professionals can diagnose, treat, and monitor routine as well as complex pain disorders. Allied Health Professionals do not perform surgical procedures. If you are seen by an allied health professional, Dr. Stanton will review your case on the day of your visit.

I have read the above and understand that in this practice a "team approach" is used, with my unique problems and/or needs presented and discussed with the appropriate physician in the development of my care plan. I also understand that one doctor will direct my overall care, but that from time to time I may be seen by any of the practitioners in this practice, including Allied Health Professionals. I hereby consent to the services of a Certified Allied Health Professional for my health care needs.

_____ _____
Patient Name Date

_____
Patient Signature

FACILITY

Dr. Stanton wants you to know that to further his commitment to the quality of surgical care for his patients; he has chosen to be an owner in both Baylor Surgicare at Bedford and Baylor Medical Center at Trophy Club. His ownership enhances his ability to direct the manner in which your care is delivered at that facility. If this is a concern to you, he will be happy to answer any questions. Furthermore, he is on the staff at other healthcare facilities and will be happy to discuss your option of choosing an alternative location.

I hereby consent to services being provided at whatever location Dr. Stanton believes is best for my condition.

_____ _____
Patient Name Date

_____
Patient Signature

Patient Name: _____ DOB: _____

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Request for Medical Records

(This form is to be used for METROPLEX PAIN MANAGEMENT, P.A., to request records from other physician offices)

PATIENT NAME _____ DOB _____ SSN _____
Phone number: _____

All requests for medical records must include a signed authorization by the patient.

This authorizes _____ at phone number _____ to release a copy of my medical records or release confidential information as indicated by the check mark(s) √ below:

_____ Complete Record
_____ Records of care from _____ to _____
_____ Records of care concerning the following specific condition(s):_____
_____ Confer with _____ orally about information in my medical record
_____ Other, please specify _____

Release to: Metroplex Pain Management, P.A.
1600 Central Drive # 160
Bedford TX 76022

Please fax information to: 817-685-0153

RELEASE OF MEDICAL RECORDS: *Your signature below indicates your authorization for the release of records referenced above. Metroplex Pain Management is committed to fulfilling all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. A photocopy of this authorization shall be valid as the original. This release will expire one year from the date written below.*

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

Patient Name: _____ DOB: _____

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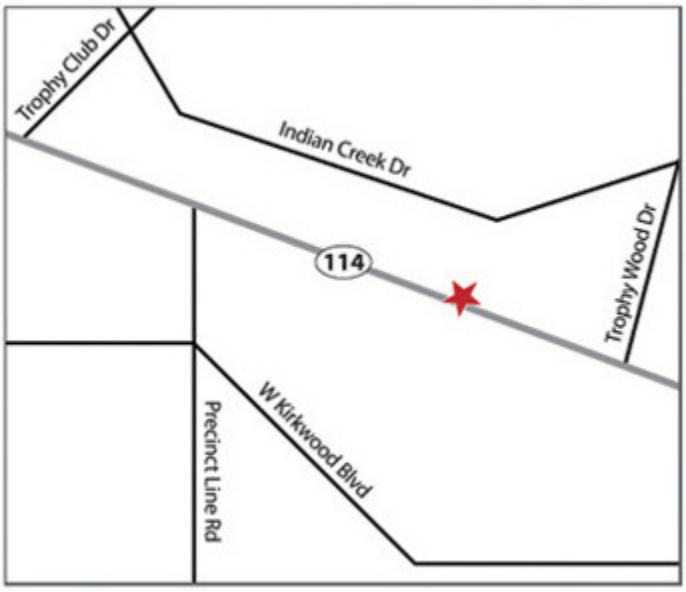
Locations

Directions:
Bedford Clinic
1600 Central Drive, Suite 160
Bedford, TX 76022
Map of 1600 Central Drive, Bedford, TX 76022, US
Directions: Central Drive is located off Highway 183 in Bedford. Exit onto Central Drive and travel south about .3 miles. The clinic is located on the east side of the street (left side) in a strip center called The Oaks.



Trophy Club Clinic
2800 Highway 114, Suite 210
Trophy Club, TX 76262
Map of 2800 Highway 114, Trophy Club, TX 76262, US
Directions: Travel to Highway 114 in Trophy Club and exit Kirkwood Boulevard. Travel west on Highway 114 frontage road about .5 mile to the Trophy Club Professional Building, located next to Baylor Medical Center at Trophy Club. The clinic is in Suite 210 of Trophy Club Professional Building.