

Nova Pain Management, P.A.
1813 S. Glenburnie Rd., New Bern, NC 28562

Phone: (252) 672-0095
Fax: (252) 672-9897

PATIENT INFORMATION:

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: () _____ Work Phone: () _____ Ext: _____
Best time and number to reach you: _____
Sex: () M () F Age: _____ Birth date: _____ SS#: _____
Marital Status: () Single () Married () Widowed () Separated () Divorced
Occupation: _____ Employer: _____
Employer's Address: _____
Employer's Phone #: () _____ Contact Person: _____
Spouses Name: _____ Birth date: _____
SS#: _____ Spouse's Employer: _____
Whom may we thank for referring you? _____
In case of emergency, contact:
Name: _____ Relationship: _____
Home Phone: () _____ Work Phone () _____ Ext: _____

INSURANCE INFORMATION:

Who is responsible for this account? _____ Relationship to patient: _____
Insurance company: _____ Group #: _____
Is patient covered by additional insurance? () Yes () No
Subscriber's Name: _____
Birth date: _____ SS#: _____
Relationship to patient: _____
Insurance Company: _____ Group #: _____

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
and assign directly to Dr. _____ all insurance benefits, if any, otherwise
payable to me for services rendered. I understand that I am financially responsible for all charges whether
or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the
payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

ACCIDENT INFORMATION:

Is condition due to an accident? () Yes () No Date: _____
Type of accident: () Auto () Work () Home () Other
To whom have you made a report of your accident?
() Auto insurance () Employer () Worker Comp. () Other
Attorney Name (if applicable) _____

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(Confidential)

Patient Name: _____ Today's Date: _____

Age: _____ Birth date: _____ Date of last physical examination: _____

What is your reason for visit? _____

Symptoms Check conditions you currently have or have had in the past year.

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

Muscle/ Joint/ Bone

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

Genito-urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Gastrointestinal

- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Excessive hunger
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Cardiovascular

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-flashes
- Vision-halos

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

Men Only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penile discharge
- Sore on penis

Women Only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period _____
 Date of last Pap smear _____
 Have you had a mammogram? _____
 Are you pregnant? _____
 Number of children _____

Conditions Check conditions you currently have or have had in the past year.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorders
- Breast lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Ulcers
- Vaginal Infections
- Venereal Disease

OFFICE USE ONLY

T _____ R _____ P _____ BP _____ HT _____ WT _____ P/S _____

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Family History

<u>Relation</u>	<u>Age</u>	<u>State of Health</u>	<u>Age of Death</u>	<u>Cause of Death</u>	Check if, your blood relatives had any of the following: <u>Disease</u>	<u>Relationship to you</u>
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Father _____	Arthritis, Gout _____
Mother _____	Asthma, Hay Fever _____
Brothers _____	Cancer _____
_____	Chemical Dependency _____
_____	Diabetes _____
_____	Heart Disease, Strokes _____
Sisters _____	High Blood Pressure _____
_____	Kidney Disease _____
_____	Tuberculosis _____
_____	Other _____

Hospitalizations

<u>Year</u>	<u>Hospital</u>	<u>Reason for Hospitalization and outcome</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a blood transfusion? Yes ___ No ___
 If yes, please give approximate dates _____

<u>Serious Illness/ Injuries</u>	<u>Date</u>	<u>Outcome</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pregnancies

<u>Year of Birth</u>	<u>Sex of Birth</u>	<u>Complications if any</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Habits

Check which substances you use and describe how much you use.

Caffeine _____
 Tobacco _____
 Drugs _____
 Other _____

Occupational
 Check if your work exposes you to the following

<u>Stress</u>	<u>Hazardous Substances</u>
<u>Heavy Lifting</u>	<u>Other</u>
<u>Occupation</u>	_____

I certify that the above information is correct to the best of knowledge. I will not hold my doctor or any members of his/her staff responsible if any errors or omissions that I may have made in the completion of this form.

 Signature

 Date

 Reviewed By

 Date

