JOHN F. DOMBROWSKI, MD, PC

The Washington Pain Center

3301 New Mexico Avenue NW, Suite 346

Washington, DC 20016

(202) 362-4787

PATIENT REGISTRATION

Name_____ Social Security Number_____

Date of Birth (MM/DD/YY)_____ Male/Female_____ Marital Status_____

Home Phone_____ Work/Alternate Phone_____

Address: City, State, Zip Code_____

Responsible party to bill_____

Billing address_____

Employer/school_____ Occupation_____

Employer/school address_____

Living Will (Yes/No)_____

What is the main problem for which you are seeking treatment?_____

_____

Symptom's cause_____ How long have you had your current pain problem?_____

Date of onset_____ Date of prior symptoms_____

Referring Physician_____ Other Physicians currently involved in care_____

Primary insurance company_____ Secondary insurance company_____

Address_____ Address_____

ID & group numbers_____ ID & group numbers_____

Subscriber_____ Subscriber_____

Subscriber's birthday_____(Male/Female) Subscriber's birthday _____(Male/Female)

How do you intend to pay for today's visit? Cash/Check/Credit card/Insurance _____

Payment is due on the date of service. Disputes regarding payment of claims are between you and your insurance company. We will be happy to assist you any way we can, but we cannot assume responsibility for your insurance contract. We do participate with some health plans; however, we need the proper information at the time of registration to accept assignment. When a referral from your insurance company/primary physician is required but not available at the time of your visit, you will be responsible for the charges incurred.

I hereby authorize John F. Dombrowski, MD to apply for benefits on my behalf for covered services rendered. I request payment to be made directly to him on my behalf. I certify that the above information is correct and further release any necessary information, including medical information for this or any related claim.

_____

Patient's signature and date

Name_____Age_____Height_____Weight_____

Reason for visit_____

Symptom's cause_____

Date of onset_____Date of prior symptoms_____

Please list drug allergies _____

Please list all drugs/medications you are taking or have taken in the past one month, including dosage.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

10._____ 11._____ 12._____

SMOKING HISTORY: ❑ Currently Smoking ❑ Never Smoked ❑ Quit (date) _____

ALCOHOLIC BEVERAGES: ❑ Yes ❑ No If yes, number per day ____ PREGNANT: ❑ Yes ❑ No

MEDICAL HISTORY:

Have you ever experienced any of the following medical conditions?

❑ Easy bruising	❑ Asthma	❑ Emphysema	❑ Bronchitis	❑ Wheezing
❑ Prior heart attack	❑ Irregular heart beats	❑ Palpitations	❑ High blood pressure	❑ Stroke
❑ Low blood pressure	❑ Murmur	❑ Mitral valve prolapse	❑ Heart failure	❑ Angina
❑ Hiatal Hernia	❑ Gall Bladder Disease	❑ Hepatitis	❑ HIV	❑ Tuberculosis
❑ Ulcer	❑ Heartburn	❑ Jaundice	❑ Cirrhosis	❑ Diabetes
❑ Bleeding Disorder	❑ Thyroid Disease	❑ Kidney Stones	❑ Depression	❑ Hypogycemia
❑ Anxiety	❑ Convulsions	❑ Prior Back Problems	❑ Prior Neck Problems	❑ Arthritis

Other _____

Are you currently experiencing any of the following medical conditions?

❑ Fever	❑ Chills	❑ Night Sweats	❑ Loss of Appetite	❑ Earache	❑ Postnasal Drip
❑ Sore Throat	❑ Anemia	❑ Shortness of Breath	❑ Loss of Sensation	❑ Chest Pain	❑ Bleeding Gums
❑ Cough	❑ Joint Swelling	❑ Bladder Infection	❑ Frequency	❑ Painful Urination	

Other _____

Past Operations _____

_____

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

___No ___Yes

If so, what activities? _____

_____

_____

Did you take all of your pain medicine according to instructions today?

___No ___Yes

Even though you took your pain medicine for persistent pain on schedule, were there times during the day that you experienced unrelieved breakthrough pain?

___No ___Yes

How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain?

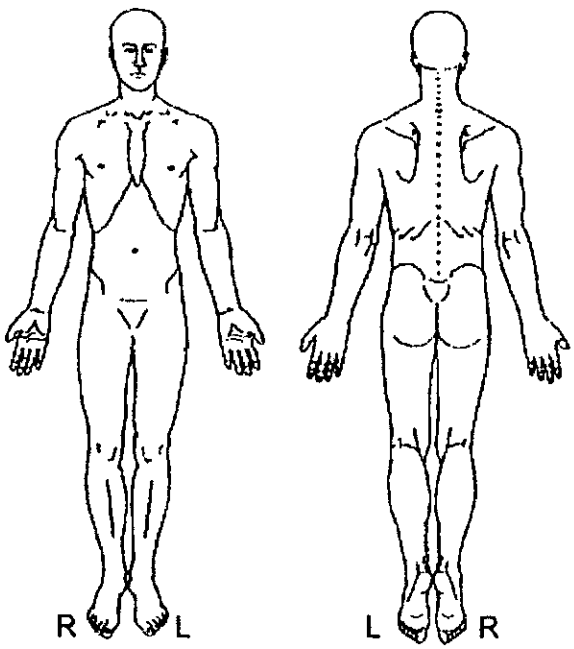
___No ___Yes

If so, what activities? _____

_____

_____

Location: Please mark the location (5) of your pain on the diagram below with an "X"



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

Severity of Pain: ***In general, over the past month, the intensity of pain has been:*** (please circle one)

Mild Moderate Moderate-Severe Severe

Timing of Pain: ***How often do you have pain?*** (please circle one)

Constantly (100%)
Nearly Constantly (60-95% of the time)
Intermittently (30-60% of the time)
Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst? (please circle one)

Morning Afternoon Evening Night
No typical pattern

Pain/Symptoms Quality: ***How would you describe your pain?*** (please circle all that apply)

Burning Cramping Shooting Sharp
Dull/aching Cutting Pressure-like Throbbing
Other (describe) _____

Other than prescription medicine, do you do anything else to relieve the pain? ___No ___Yes (check below)

___ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
___ Herbal remedies
___ Hot or cold pack
___ Exercise
___ Changing position (such as lying down or elevating your legs)
___ Physical therapy
___ Massage
___ Acupuncture
___ Rest
___ Psychological counseling
___ Talk to trusted friend, family, clergy
___ Prayer, meditation, guided imagery
___ Relaxation technique (hypnosis, biofeedback)
___ Creative technique (art or music therapy)
___ Other (describe) _____

Check any of these common side effects that you've noticed after taking your pain medicine.

___ drowsiness, sleepiness ___ nausea,vomiting
___ constipation ___ lack of appetite ___ upset stomach
___ other (describe) _____

John F. Dombrowski, MD, PC

Anesthesiology / Pain Medicine
3301 New Mexico Avenue, NW
Washington, DC 20016
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Effective Date: _____

1. John F. Dombrowski, MD may use and disclose protected health information for treatment, payment and Healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but is not limited to, internal quality control and assurance including auditing of records.
2. John F. Dombrowski, MD is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. John F. Dombrowski, MD will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. John F. Dombrowski, MD may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.
5. John F. Dombrowski, MD will abide by the terms of this notice currently in effect at the time of the disclosure.
6. John F. Dombrowski MD reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.
7. John F. Dombrowski, MD will provide each patient with a copy of any revisions of the Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
8. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact Dr. Dombrowski at the following address and/or phone number: 3301 New Mexico Avenue, NW, Suite 346, Washington, DC 20016.
9. It is John F. Dombrowski, MD 's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

10. Patient's Name (please print) _____

11. Date _____

12. Signature of Patient or Legal Guardian _____