PAIN MANAGEMENT ASSOCIATES P.A.
REGISTRATION FORM
PLEASE FILL FORM OUT COMPLETELY TO INSURE PROPER BILLING PURPOSES

Dr. Naveen Korivi

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr.	❑ Miss	Marital status (circle one)
			❑ Mrs.	❑ Ms.	Single / Mar / Div / Sep / Wid

Is this your legal name?		Social Security Number	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Email:	Cell Phone no:	Home phone no.:
	( )	( )

Address:	City:	State:	ZIP Code:

PLEASE FILL OUT EMPLOYER AND PHARMACY INFORMATION

Employer; *MUST HAVE*	Name and Address: *MUST HAVE*	Phone #	Contact

Pharmacy: *MUST HAVE*	Pharmacy Address: *MUST HAVE*	Pharmacy Phone no.:
		( )

Chose clinic because/Referred to clinic by (please check one box):			❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	Online	❑ Other		

INSURANCE INFORMATION

(Insurance Cards and DL must accompany patient) PLEASE FILL OUT FORM COMPLETELY

Work Comp or Car Insurance (if auto claim)	Adjusters name	Claim address:	Adjusters phone no.:
			( )
Claim no.			

Health Insurance Company	Phone no.	ID#	Group no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pain Management Associates P.A. or insurance company to release any information required to process my claims.

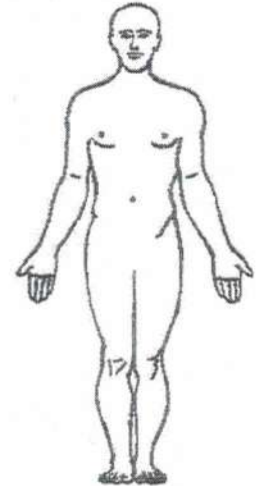
I give consent to Dr. Korivi to diagnose and treat my condition

Patient/Guardian signature	*Date*

Initial Medical Questionnaire - CONFIDENTIAL:

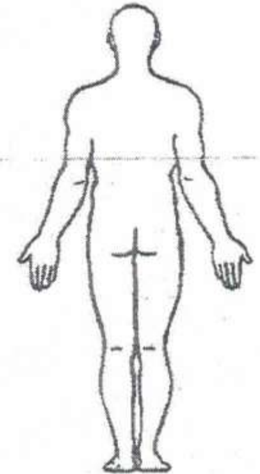
Patient Name: ______________________________ Date: ________________

Have you had: ☐ X-ray ☐ MRI ☐ CT ☐ EMG Height / Weight: ________________



Past Medical History – Do you suffer from any of the following?

	YES	NO		YES	NO
Chronic Headaches	☐	☐	Urine / Stool Leakage (Incontinence)	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐
Heart Rhythm Disorders	☐	☐	Strokes	☐	☐
Heart Attacks	☐	☐	Muscular Dystrophy	☐	☐
Other Heart Disease	☐	☐	Recent Infections	☐	☐
Diabetes	☐	☐	Reactions to Anesthesia	☐	☐
Thyroid Problems	☐	☐	Sickle Cell Anemia	☐	☐
Asthma	☐	☐	Hemophilia / Easy Bleeding	☐	☐
Emphysema / COPD	☐	☐	Recent Weight Loss	☐	☐
Other Lung Disease	☐	☐	Depression	☐	☐
Heartburn or Ulcers	☐	☐	Suicidal Thoughts	☐	☐
Hepatitis	☐	☐	Cancer	☐	☐
Pancreatitis	☐	☐	Type: ________________		
Kidney Stones	☐	☐	Other: ________________		



Past Surgical History

	YES	NO		YES	NO
Spine (Neck or Back)	☐	☐	Tubal Ligation	☐	☐
Tonsillectomy	☐	☐	Bladder/Kidney	☐	☐
Appendectomy	☐	☐	Bowel/Colon/Ulcer	☐	☐
Gallbladder	☐	☐	Shoulder/Knee/Hip/Joint	☐	☐
Lung	☐	☐	Hysterectomy	☐	☐
Heart	☐	☐	Other: ________________		

Family History – Do your parents, siblings, etc. suffer from any of the following?

	YES	NO		YES	NO
Heart Disease	☐	☐	Migraines	☐	☐
Hemophilia/Bleeding Disorder	☐	☐	Anesthetic Reactions	☐	☐
Sickle Cell Anemia	☐	☐	Muscular Disorders	☐	☐
Cancer	☐	☐	Other: ________________		

Social History – Do you, or have you ever used the following?

	YES	NO		YES	NO
Smoking/Tobacco	☐	☐	Cocaine	☐	☐
Alcohol	☐	☐	Other Street Drugs: ________________		
Marijuana	☐	☐	Other: ________________		

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Homemaker ☐ Disabled

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Lawsuits Pending: ☐ Yes ☐ No ☐ Settled

Medications:

Allergies: ______________________________ Iodine: ☐ Yes ☐ No

All current medication you are taking (name, size and frequency)

1. ________________ 4. ________________
2. ________________ 5. ________________
3. ________________ 6. ________________

Name (sign please): ______________________________ Date: ________________

PAIN ILLUSTRATION

Mark the areas on your body where you feel the described symptoms.

Estimate the severity of your pain (choose one number):

0 No Pain
1 Mild Pain
2-3 Moderate Pain
4-5 Moderate to Severe Pain
6-7 Severe Pain
8-9 Intensely Severe Pain
10 Most Severe Pain

Patient Please Initial: ________

Date: ________________

MEDICAL RECORDS RELEASE FORM

To Whom It May Concern:

Patient: ______________________________

DOB: ______________________

Please release medical records for the above mentioned patient for treatment with Dr. Korivi, Pain Management Associates
13636 Breton Ridge Street, Suite D. Houston Texas 77070
Phone: 832-688-9160
Fax: 832-688-9251

EMG	☐	X-RAY	☐
MRI	☐	CT	☐
CLINIC NOTES	☐	BILLING RECORDS	☐

The office has Privacy Practices in place which explains how your medical information will be used and disclosed by the office. A copy is available for review at any time.

Print Name: ______________________________

Signature of Patient: ______________________________

Date: ____________________

Sincerely, Dr. Korivi/Lana Owens

PAIN MEDICATION AGREEMENT

I WILL NOT:

I will not see any other "Pain Management" type physician for my pain management while under the care of this group. All my medication from this clinic cannot be obtained from any other source. In the event of an acute case (dental work or surgical procedure), I must notify my physician in advance.

I will not use alcohol or illegal controlled substances (cocaine, marijuana, etc). I have been made aware of the dangerous side effects of narcotic and tranquilizer use alone or in combination with other substances. Thus, I absolve the physicians and staff of any willful negligence.

I will not share, sell or trade any medication(s) or prescription(s) with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctors unless approved by my physician in advance.

I WILL:

I will provide the physician and staff with all of my medical records pertaining to the past pain treatment. I understand that failure to provide such information gives the clinic the right to refuse to treatment.

I will be responsible for my pain medication, keeping it safe from loss or theft. Lost medications will not be replaced. Stolen medication will not be considered for a refill until a police report is filed and sent to the doctor's attention. I will use my medicines at the rate they are prescribed. If I use my medicines in a greater rate, it will result in my being without my medication for a period of time. Physicians will not authorize any early refills under any circumstances.

I will use only one pharmacy to fill all my prescriptions. I agree to use ______________________________

Pharmacy, located at: ____

Telephone number ______________________ for filling prescriptions for all my pain medications.

I will agree that no refills will be available during evenings or weekends.

I will agree to authorize the doctor and the pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state Board or Pharmacy, in the investigation of any possible misuse or sale, etc. of my pain medications. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

I will submit to a blood or urine sample test if requested by my doctor.

I understand all of the policies above and my signature below states my agreement to comply. I am aware that if I breach this agreement, then Pain Management Associations holds the absolute right to discharge me as a patient.

Print Name: ______________________________

Signature: ______________________________ Date: ______________________

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws care complicated, but we must provide you with the following information.

Use and Disclosure of your Health Information in certain special circumstances:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a few law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including Veterans) if required by the appropriate authorities.
6. To federal officials for intellingence and national security activities authorized by law.
7. To correctional institutions or law enforcement agencies if you are an inmate or under custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. You can request that our practice communicate with you about your health and related issues in particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use and disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or payment of you care, such as family members and friends. We are to agree to your request: however, if we do agree we are bound by our agreement except otherwise required by law: emgencies, or when the information is necessary to you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you including patient medical records, but not including psychotherapy notes. You must submit your request in writing to Medical Records: 13636 Breton Ridge Street, Suite D, Houston, Texas 77070
4. You may ask us to amend your health information if you believed it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing a submitted to Medical Records: 13636 Breton Ridge Street, Suite D, Houston, Texas 77070. You must also provide us with the reason that supports your request for amendment.
5. You are entitled to receive a copy of the Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time. To obtain a copy of the notice, please contact our front desk personnel.
6. If you believe your privacy right has been violated, you may file a complaint with our practice; contact 13636 Breton Ridge Street, Houston, Texas 77070. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, Please contact Dr. Korivi.

I hereby acknowledge that I have been presented with a copy of Pain Management Associates, PA's Notice of Privacy Practice.

Signature: ______________________________ Date: ____________________

Printed Name: ____