The Carrasco Pain Institute and Spa

Pain Management • Rehabilitation • Medical Spa

Arnulfo Tarín Carrasco, M.D.
Diplomate American Academy of Pain Management
Medical Director – Anesthesiologist - Algologist

Patient Registration/Demographic/Insurance Form

Personal Demographic Information *Today's Date:_____/_____/_____*

Name:_____Acct #:_____DOB:_____/_____/_____Age:_____

Address:_____Hm Phone:( )_____SS#_____/_____/_____

City:_____State:_____Zip:_____E-Mail:_____

Cell: ( )_____ Work: ( )_____Other: ( )_____

Employer (at time of injury if workers' comp.):_____Phone ( )_____

Address:_____ City:_____State:_____Zip:_____

License State/#:_____Marital Status: S D W M Spouse Name:_____

How were you referred?: Self Newsletter Physician Phone book Friend Website Other:_____

Emergency Contact (other than spouse)

Name:_____Relationship:_____Phone ( )_____

Address:_____ City:_____State:_____Zip:_____

Referring Physician:

Physician's Name:_____ MD / DO / DPM / DC Phone ( )_____

Address:_____ City:_____State:_____Zip:_____

UPIN #:_____NPI #:_____Lic #:_____Fax # ( )_____

Family Physician:

Physician's Name:_____ MD / DO / DPM / DC Phone ( )_____

Address:_____ City:_____State:_____Zip:_____

UPIN #:_____NPI #:_____Lic #:_____Fax # ( )_____

Workers' Compensation Information:

Insurance Carrier:_____Adjustor:_____Ext #:_____

Address:_____ City:_____State:_____Zip:_____

Claim #:_____DOI:_____/_____/_____ Phone ( )_____

Allowed Conditions:_____ Fax # ( )_____

Preauth Co:_____ Phone ( )_____ Fax # ( )_____

Patient Financial Responsibility Form

Primary Insurance Co:_____Phone ( )_____

*Address:*_____ *City:*_____*State:*_____*Zip:*_____

*Policy Holder's Name:*_____*Relation:*_____

*ID #:*_____*Group #:*_____*Policy #:*_____

Secondary Insurance Co:_____Phone ( )_____

*Address:*_____ *City:*_____*State:*_____*Zip:*_____

*Policy Holder's Name:*_____*Relation:*_____

*ID #:*_____*Group #:*_____*Policy #:*_____

Note: If a patient is a dependent or spouse of the "insured" please complete responsible party information below. Please present your insurance cards and a form of identification.

Insured / Responsible Party

*Name:*_____*DOB:*____/____/_____ *SS#*____/____/____

*Address:*_____*City:*_____*State:*_____*Zip:*_____

*Phone:( )*_____*Relationship:*_____

*Employer:*_____ *Phone:( )*_____

*Address:*_____*City:*_____*State:*_____*Zip:*_____

Attorney

*Name:*_____*Phone: ( )*_____

*Address:*_____*City:*_____*State:*_____*Zip:*_____

In order to control our cost of billing, we request that office visits and treatment be paid at the time service is rendered. We would rather control our billing costs than be forced to increase our fees.

Authorization: I hereby authorize ***Carrasco Pain Institute, its physicians, and other ancillary services.*** *to release information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.*

*Patient Signature:*_____*Date:*_____

The Carrasco Pain Institute and Spa

Pain Management • Rehabilitation • Medical Spa

Arnulfo Tarín Carrasco, M.D.
Diplomate American Academy of Pain Management
Medical Director – Anesthesiologist - Algologist

Permission to Release Information

I (we) hereby authorize and request _____
to release confidential, professional information, including personal, psychological, psychiatric, and medical records and opinions, resulting from any contacts with them, to Carrasco Pain Institute (A.T. Carrasco, M.D.). The specific information requested is as follows:

- *Dating back 3 years: spine x-rays, MRI, CT scan, Mylogram, Discogram, EMG, and Bone Scans*
- *Dating back 6 months: Any Blood work*
- *Other:* _____

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing any of the above noted individual of my wish.

In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

Signature: _____ *Date:* _____

Please Print Name: _____

Date of Birth: _____ *SS#:* _____

Arnulfo Tarín Carrasco, M.D.
Diplomate American Academy of Pain Management
Medical Director – Anesthesiologist - Algologist

Permission for Photograph to be taken

I hereby authorize Carrasco Pain Institute to photograph all or parts of my body (clothed) for the purpose of documenting my medical condition(s).

_____

Patient Signature

_____

Date of Signature

_____

Witness

Arnulfo Tarín Carrasco, M.D.
Diplomate American Academy of Pain Management
Medical Director – Anesthesiologist - Algologist

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my health care, Carrasco Pain Institute originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for further care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payor can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *notice of information practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Carrasco Pain Institute is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Carrasco Pain Institute reserves the right to change their notice and practices and prior to implementation, I accordance with Section 164.520 of the Code of Federal Regulations. Should Carrasco Pain Institute change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and, **( )ACCEPT / ( ) DECLINE** the terms of this consent,

_____
PATIENT SIGNATURE

_____
DATE

Carrasco Pain Institute and Spa
Pain Management • Rehabilitation • Medical Spa

A.T. Carrasco, MD

Pain Management New Patient Questionnaire

Name:_____Age:_____DOB:_____/_____/_____Sex:_____

MEDICAL HISTORY: (please circle all that apply)

Hypertension	Heart Condition	Stroke	Muscular Dystrophy	Sickle Cell
Lung Problems	Thyroid (high / low)	Cancer	Multiple Sclerosis	Hepatitis
Anemia	Asthma	Arthritis	Diabetes (insulin dependent / non-insulin dependent)	

SURGERIES: (please list all surgeries and dates)

_____

_____

_____

CHRONIC/SERIES ILLNESS: (please list, i.e., arthritis, kidney disease, fibromyalgia, osteoarthritis)

_____

HAVE YOU SEEN A PHYCHOLOGIST/PSYCHIATRIST FOR YOUR PAIN? (state last visit and Dr.'s name)

_____

CURRENT MEDICATIONS: (include over the counter medications)

Name of Medication	Dosage	How much & how often

ALLERGIES: (list medication and your reaction)

_____

ANESTHESIA: (please list any reactions you have had)

_____

Patient Name:_____ **ACCT #:**_____ **Date:**_____

CHILDHOOD ILLNESSES (please circle): Chicken pox Measles Mumps Polio

IMMUNIZATIONS: Have you had a tetanus booster within the past 10 years? ☐ Yes ☐ No

FAMILY HISTORY:

Father: ☐ Living ☐ Deceased Health Problems:_____ Cause of Death:_____

Mother: ☐ Living ☐ Deceased Health Problems:_____ Cause of Death:_____

Brothers: # Living:_____ Health Problems:_____

Deceased:_____ Health Problems:_____

Sisters: # Living:_____ Health Problems:_____

Deceased:_____ Health Problems:_____

Children: # Living:_____ Health Problems:_____

Decased:_____ Health Problems:_____

SOCIAL HISTORY:

Do you smoke or use tobacco products? ☐ Yes ☐ No

If yes, How much a day?_____ How many years?_____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much a month? Beer:_____ Wine:_____ Liquor:_____

Caffeine: How many cups of coffee, soda, or tea do you drink a day?_____

Do you use illicit substances, if so describe_____

What is your highest level of education?_____

What is your occupational title?_____

How many hours a week do you work?_____ Please list any restrictions:_____

Marital Status:_____ Length of Marriage:_____

INJECTIONS FOR PAIN: (please list any injections you have received for pain, including dates and the doctor's name)

_____

_____

_____

Patient Name:_____ **ACCT #:**_____ **Date:**_____

DIAGNOSTIC TESTING:

Type of Study	Date	Part of Body Evaluated	Ordering Physician	Place of Service
Bone Scan				
Discogram				
CT Scan				
MRI				
EMG				
X-Ray				
Blood Test				
Myelogram				

Have you attended physical therapy for your current condition: ☐ Yes ☐ No

_____times a week for _____weeks. Date last attended:_____

Please list any physicians you have seen for your current condition:

Name: **Phone:**

_____ _____

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS

Please indicate if you currently have any of the following

SKIN (INTEGUMENT)	YES	NO	COMMENTS
Growths			
Itching			
Lesions			
Prolonged Healing			
Color Changes in the Skin			

EYES	YES	NO	COMMENTS
Last Eye Exam			
Corrective Lenses (glasses/contacts)			
Infections			
Injuries			
Glaucoma			
Cataracts			
Visual Disturbances			
Seeing Double			
Seeing Spots			

EARS	YES	NO	COMMENTS
Pain			
Infection			
Ringing			
Dizziness			
Hearing Loss			

NOSE & THROAT	YES	NO	COMMENTS
Last Dental Exam			
Dental Prosthesis (bridge, dentures)			
Bleeding Gums			
Sore Throats			
Difficulty Swallowing			
Hoarseness			
Swelling of the Glands			
Nasal Congestion			
Nose Bleeds			
Allergies			

GASTROINTESTINAL	YES	NO	COMMENTS
Constipation			
Diarrhea			
Changes in Bowel Habits			
Dark Stools			
Blood in Stools			

REVIEW OF SYSTEMS, Cont.

GENITOURINARY	YES	NO	COMMENTS
Increased Urination			
Increased Urination at Night			
Difficulty Urinating			
Blood in Urine			
Difficulty Holding Your Urine			
Hesitancy			
Urgency			
Diminished Stream			
Frequent Urinary Tract Infections			
Kidney Stones			
Incontinence			

MALE REPRODUCTIVE	YES	NO	COMMENTS
Self Testicular Exams			
Prostate Exam/Date			
Scrotal Pain or Swelling			
Impotence			
Abnormal Discharge from Penis			
Hernia			
Sexually Transmitted Disease			

FEMALE REPRODUCTIVE	YES	NO	COMMENTS
# of Pregnancies			
# of Abortions			
# of miscarriages			
# of deliveries			
Last Menstrual Cycle			
Last Pelvic Exam/Pap Smear			
Menstrual Difficulties			
Sexually Transmitted Disease			
Post-menopausal Problems			
Largest Infant Weight			

BREASTS	YES	NO	COMMENTS
Self-breast Exam			
Mammogram (If yes, date?)			
Pain to Breasts			
Lumps to Breasts			
Discharge from Breasts			

CARDIOPULMONARY	YES	NO	COMMENTS
Chronic Cough			
Shortness of Breath			
Difficulty Breathing on Exertion			
Waking Up Short of Breath			
Night Sweats			
Difficulty Breathing Lying on Back			
Unusual Fatigue			
Chest Pain or Pressure			
Edema to the Chest			
Abnormal Heart Rate			

REVIEW OF SYSTEMS, Cont.

VASCULAR	YES	NO	COMMENTS
Inflammation of Leg Veins			
Varicose Veins			
Severe Pain to the Calf while Walking			
Peripheral Vascular Disease			

ENDOCRINE	YES	NO	COMMENTS
Fatigue			
Weakness			
Increased Urination			
Increased Thirst			
Increased Hunger			
Temperature Intolerance			

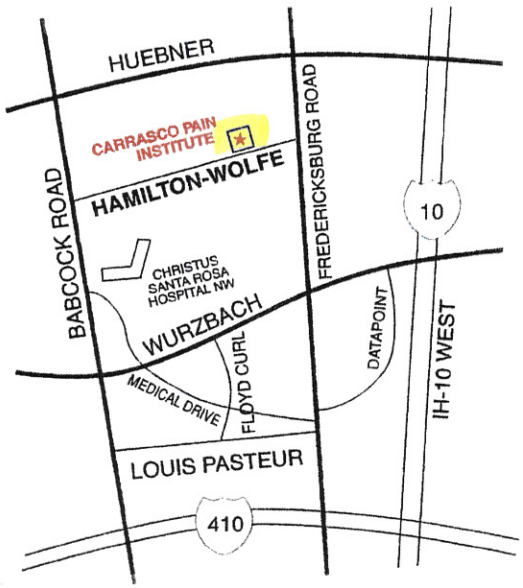
GASTROINTESTINAL	YES	NO	COMMENTS
Weight or Appetite Change			
Abdominal Pain			
Nausea			
Vomiting			
Gallbladder Disease			
Liver Disease			
Pancreatic Disease			
Hiatal Hernia			
Ulcer			
Diverticulitis			
Colitis			
Hemorrhoids			

MUSCULOSKELETAL	YES	NO	COMMENTS
Arthritis			
Neck or Back Injury			
Broken Bones			
Joint Pain			
Edema to Joints			
Redness to Joints			
Warmth to Joints			
Weakness			
Prosthesis			
Ambulation Aids			
Muscle Cramping			

NEUROPSYCH	YES	NO	COMMENTS
Headaches			
Fainting			
Dizziness			
Lightheadedness			
Head Injury			
Seizure			
Movement Disorders			
Sensory Disorders			
Memory Loss			
Numbness			
Tingling			
Difficulty Speaking			

The Carrasco Pain Institute and Spa

Pain Management • Rehabilitation • Medical Spa



4763 Hamilton-Wolfe Road

San Antonio, Texas 78229

Tel. (210) 614-4825 ◇ Fax (210) 614-4525

CarrascoPainInstitute.com

DrCarrascoShow.com