

**Central Texas Pain  
Center Locations**

**Austin – Central**  
630 West 34th Street  
Suite 303  
Austin, TX 78705  
Office: 512-953-8134  
Fax: 512-614-2735

**Austin – South**  
4316 James Casey Street  
Building B, Suite 200  
Austin, TX 78745  
Office: 512-498-1029  
Fax: 512-369-3366

**Fort Worth**  
7235 Boat Club Road  
Fort Worth, TX 76179  
Office: 817-677-9535  
Fax: 844-809-2247

**New Braunfels**  
213 Hunters Village  
New Braunfels, TX 78132  
Office: 830-627-3800  
Fax: 888-972-1327  
Pharmacy: 830-515-1278

**Round Rock**  
7201 Wyoming Springs Drive  
Suite 400  
Round Rock, TX 78681  
Office: 512-953-8133  
Fax: 737-212-0544

**San Antonio**  
250 East Basse Road  
Suite 207  
San Antonio, TX 78209  
Office: 210-614-9955  
Fax: 210-614-9966

**San Marcos**  
1304 Wonder World Drive  
San Marcos, TX 78666  
Office: 512-953-8121  
Fax: 512-667-9149

**Seguin**  
411 South King Street  
Seguin, TX 78155  
Office: 830-609-9478  
Fax: 803-433-9089

**Waco**  
205 Woodhew Drive  
Suite 203  
Waco, TX 76712  
Office: 254-732-6632  
Fax: 254-732-0947

**Pain Specialists of Austin  
Locations**

**Austin – North**  
4100 Duval Road  
Building 3, Suite 200  
Austin, TX 78759  
Office: 512-485-7200  
Fax: 512-485-7224

**Austin – South**  
2500 W William Cannon Dr  
Suite 206  
Austin, TX 78745  
Office: 512-953-8127  
Fax: 512-609-8020

**Bastrop**  
3101 Highway 71  
Suite 211  
Bastrop, TX 78602  
Office: 512-953-8130  
Fax: 512-265-8742

**Cedar Park**  
1401 Medical Parkway  
Building C, Suite 345  
Cedar Park, TX 78613  
Office: 512-953-8137  
Fax: 512-485-7224

**Gatesville**  
1507 West Main Street  
Gatesville, TX 76528  
Office: 512-485-7200  
Fax: 254-432-5388

**Georgetown**  
3201 South Austin Avenue  
Suite 265  
Georgetown, TX 78628  
Office: 512-953-8120  
Fax: 512-582-8264

**Killeen**  
3202 South W S Young Dr  
Suite 102  
Killeen, TX 76542  
Office: 254-247-3322  
Fax: 254-432-5388

**Temple**  
10252 West Adams Ave  
Suite 104  
Temple, TX 76502  
Office: 254-732-6631  
Fax: 512-582-8617

Even though we are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, opana, and methadone. Prescriptions for these medications will not be given at an initial visit.

- Please bring your driver's license and insurance cards along with your **completed** new patient paperwork to your scheduled appointment. Payment for services are expected at the time of service (co-pays, co-insurance, private pay). We accept cash, check, money order and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain imaging reports and/or films by our staff, please bring them to your appointment. Our office requires these as part of your consultation. If we do not have your films at the time of your appointment, you may be rescheduled.**
- Your initial visit at the Practice is a consultation. If a doctor referred you for an injection, you must be seen for an office visit first. Procedures are scheduled after the initial consultation.
- If English is your second language, please make arrangements for someone to accompany you to your visit who can translate in order to provide you with the best healthcare service. We want you to fully understand your diagnosis and prognosis and have any questions you may have answered.

We wish to make your visit as comfortable as possible, so please do not hesitate to contact us if you have any questions at the numbers listed above.

**Notice of Financial Interest**

This is to serve as legal notice that the physicians at this location providing my care have a financial interest in The Pain Relief SurgiCenter, Ambulatory Surgery Center of Killeen, Pain Specialists of Austin Pharmacy and Hunter's Creek Pharmacy. I understand that I am free to choose any facility for obtaining services or prescriptions that are ordered for me.

Physicians include the following: Hans Bengtson, Daniel Frederick, Genaro Gutierrez, Gary Heath, Vivek Mahendru, Ahmed Mahmoud, Pankaj Mehta, Eric Miller, Rahul Sarna, Samuel Stevens, Steven Sloan, Derrick Wansom, John Wages.

## Patient Acknowledgement Statement

Patient Name & DOB: \_\_\_\_\_

I understand that services or items that I have requested be provided to me by Central Texas Pain Center or Pain Specialists of Austin (as applicable, the “Practice”) may not be covered under my insurance as being reasonable or medically necessary for my care. I understand my health plan determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable or medically necessary for my care.

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### Advanced Practitioner Consent for Treatment

*The Practice has on staff physician assistants, nurse practitioners, or advanced practice nurses to assist in the delivery of medical care of pain management.*

*A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner or advanced practice nurse is not a doctor. A nurse practitioner or advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant, a nurse practitioner, or an advanced practice nurse can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care.*

*“Supervision” does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.*

*A physician assistant, a nurse practitioner, or an advanced practice nurse may provide such medical services that are within his/her education, training and experience.*

I have read the above and hereby consent to the services of an advanced practitioner for my health care needs. I understand that at any time I can refuse to see the advanced practitioner and request to see a physician.

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### Acknowledgment of Urine Testing Policy

I understand that the Practice reserves the right to perform random urine testing on any patient. I have the right to refuse the urine test but may then not be prescribed any medications or given refills of medications.

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### Acknowledgment of External Rx History

I understand that the Practice reserves the right to obtain an external Rx history and randomly verify past medications through the Prescription Drug Monitoring Database in order to be prescribed any medications.

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### Acknowledgment of Late Arrival Policy

If you are unable to make an appointment, please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment, you will be charged a NO SHOW fee of \$25 for an office visit and \$50 for a procedure. Frequent NO SHOWS may result in a release from the Practice.

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### Access to Protected Health Information – HIPAA Privacy Rule’s

I give permission for the Practice to leave appointment information, test results, and/or pre-operative instructions on voice message for the following phone numbers or with the following individuals:

\_\_\_\_\_  
\_\_\_\_\_

**PATIENT SIGNATURE & DATE:** \_\_\_\_\_

## PATIENT'S PERSONAL INFORMATION

Today's Date: \_\_\_\_\_  
 Location of Care: \_\_\_\_\_

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last Name First Name M.I.

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_  
 Marital status  Single  Married  Divorced  Widowed

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # & State: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Preferred Method of Communication?  Home phone  Cell Phone  Work Phone  E-Mail/Patient Portal

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Declined to Specify Preferred Language: \_\_\_\_\_

Race:  American Indian  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  White  Other

Referring Provider: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Other Providers: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_ Phone Type: \_\_\_\_\_

## PATIENT'S RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

## INSURANCE INFORMATION

**Primary** Insurance Name: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary** Insurance Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**\*Please provide card(s) to the front desk**

Is there an ongoing lawsuit related to your visit today?  YES  NO

Are you currently under worker's compensation?  YES  NO

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**PAST MEDICAL HISTORY**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please list and indicate dates.

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**FAMILY HISTORY**

Please list any disease, illness, or ailments in your IMMEDIATE FAMILY (i.e. mother-breast cancer, father-diabetic, paternal grandfather-heart disease, maternal grandmother-hypertension).

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**SOCIAL HISTORY**

Any tobacco use? Yes No      If yes, how many per day? \_\_\_\_\_ Years? \_\_\_\_\_  
 Any alcohol use? Yes No      If yes, how much? \_\_\_\_\_  
 Recreational drug use? Yes No      If yes, which drug? \_\_\_\_\_  
 Do you live alone? Yes No      If no, who do you live with? \_\_\_\_\_

**REPRODUCTIVE HISTORY**

Are you Pregnant: Yes No    If **YES**, how many weeks? \_\_\_\_\_  
 Date of last period? \_\_\_\_\_  
 Date of last Pap smear? \_\_\_\_\_    Date of last mammogram? \_\_\_\_\_

**PHARMACY NAME & LOCATION**

\_\_\_\_\_

**ALLERGIES**

\_\_\_\_\_  
 \_\_\_\_\_

**CURRENT MEDICATIONS**

\*Please list pain medications and blood thinners first

Medication (ex. Ibuprofen)	Dosage (ex. 400 mg)	Frequency (ex. three times a day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

## REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that bears further explanation, please indicate so and explain in the additional notes section.

✓ **CHECK ALL APPLICABLE**

### General:

Chills  Fatigue  Fever  Change of Appetite  Weight Loss

### Allergy/Immunology:

Hay fever  Hives  Frequent infections

### Ophthalmologic:

Blurred Vision  Diminished visual acuity  Double Vision  Eye pain  Light sensitivity

### HENT:

Decreased hearing  Difficulty Swallowing  Ear pain  Hoarseness  Ringing in ears

### Endocrine:

Cold Intolerance  Heat Intolerance  Thyroid problems

### Respiratory:

Cough  Shortness of breath  Wheezing

### Cardiovascular:

Leg Swelling  Palpitations  Swelling in hands/feet

### Genitourinary:

Bladder incontinence  Blood in urine  Frequent urination  Painful urination

### Gastrointestinal:

Blood in stool  Change in bowel habits  Constipation  Heartburn  Nausea  Vomiting

### Musculoskeletal:

Back problems  Joint stiffness  Muscle aches  Painful joints

### Hematology:

Bleeding problems  Easy bruising  Swollen glands

### Skin:

Itching  Rash  Skin lesions

### Neurologic:

Dizziness  Numbness  Seizures  Tingling  Tremor  Weakness

### Psychiatric:

Anxiety  Depression  Insomnia  Substance abuse

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**PAIN EVALUATION**

Location of pain \_\_\_\_\_

Onset of pain \_\_\_\_\_ (days, weeks, months, or years)

Cause of pain \_\_\_\_\_ (accident, unknown)

Your occupation \_\_\_\_\_ Is this work related?  Yes  NoOther physicians/specialties you have seen for this pain, including other pain management clinics:  
\_\_\_\_\_  
\_\_\_\_\_Characteristics of your pain:  Constant  Intermittent Duration \_\_\_\_\_

Pain Intensity from 1 – 10 (where 10 is the worst): \_\_\_\_\_ at its worst; \_\_\_\_\_ at its least

Your pain is:  sharp  shooting  burning  stabbing  electrical shocks  numbness  aching

Other \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Do you have:  numbness  localized weakness  bowel incontinence  bladder incontinence

How many hours per night do you sleep? \_\_\_\_\_

**PREVIOUS TREATMENTS**Which of the prior treatments or tests have you had? Include **date of service, results, & facility**: MRI \_\_\_\_\_ CT/X-rays \_\_\_\_\_ Acupuncture \_\_\_\_\_ Braces (DME) \_\_\_\_\_ Chiropractic Treatment \_\_\_\_\_ EMG/Nerve Testing \_\_\_\_\_ Massage Therapy \_\_\_\_\_ Physical Therapy \_\_\_\_\_ TENS \_\_\_\_\_ **Injections** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

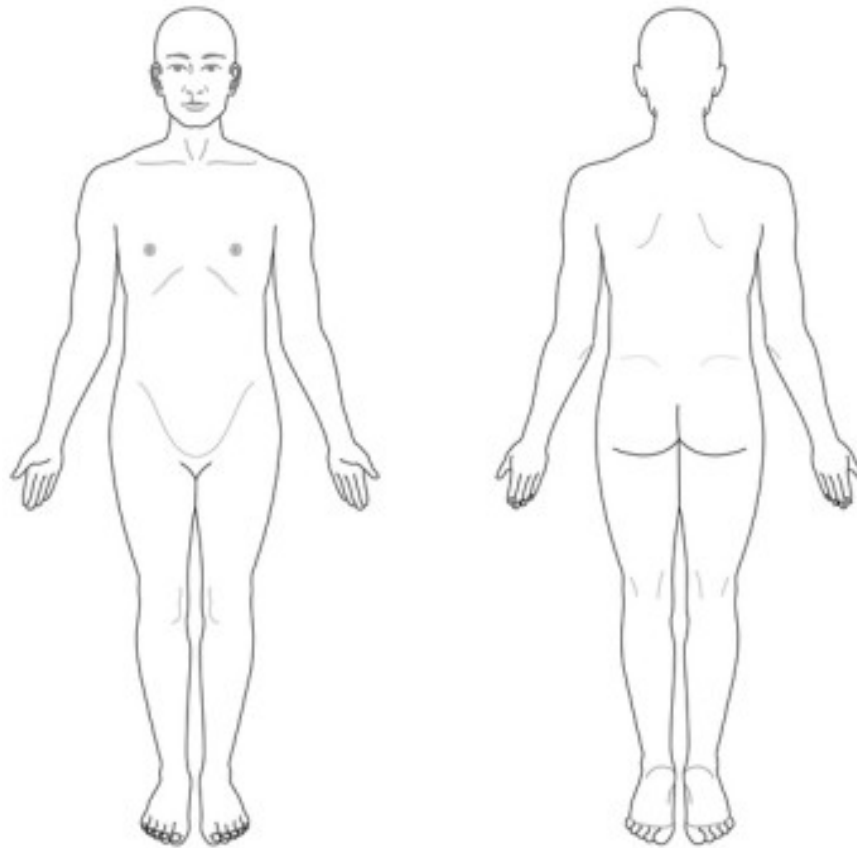
Topical Compounded Pain Creams Yes No **If yes, which cream?** \_\_\_\_\_

Prescribed Medications (circle all that apply): Pain Medications Muscle Relaxers Anti-Inflammatory Steroids

Please **CIRCLE** all tried medications below. Also mark **X** in the box if tried for at least 6 weeks.

<input type="checkbox"/>	Amitriptyline	<input type="checkbox"/>	Baclofen	<input type="checkbox"/>	Celebrex	<input type="checkbox"/>	Cymbalta	<input type="checkbox"/>	Depakote
<input type="checkbox"/>	Effexor/Venlafaxine	<input type="checkbox"/>	Fentanyl Patch	<input type="checkbox"/>	Gabapentin	<input type="checkbox"/>	Ibuprofen	<input type="checkbox"/>	Meloxicam
<input type="checkbox"/>	Morphine Sulfate ER	<input type="checkbox"/>	Nabumetone	<input type="checkbox"/>	Naproxen	<input type="checkbox"/>	Nucynta	<input type="checkbox"/>	Tizanidine
<input type="checkbox"/>	Topamax	<input type="checkbox"/>	Tramadol/Ultram	<input type="checkbox"/>	Tramadol ER	<input type="checkbox"/>	Tylenol #3	<input type="checkbox"/>	Tylenol #4

**Please mark the area(s) on your body where you feel pain.**



Additional Notes:

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