



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?

<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Prior heart attack	<input type="checkbox"/> Irregular heart beats	<input type="checkbox"/> Palpitations	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Murmur	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Angina
<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Gall Bladder Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Prior Back Problems	<input type="checkbox"/> Prior Neck Problems	<input type="checkbox"/> Arthritis
Other _____				

Are you currently experiencing any of the following medical conditions?

<input type="checkbox"/> Fever	<input type="checkbox"/> Chills	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Earache	<input type="checkbox"/> Postnasal Drip
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Anemia	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Loss of Sensation	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Cough	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/> Frequency	<input type="checkbox"/> 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?

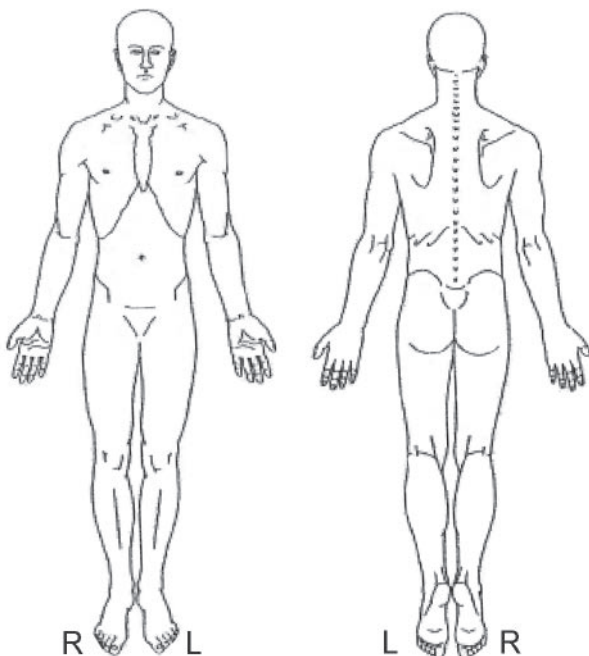
1 2 3 4 5 6 7 8 9 10 more than 10

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) _____

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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 _____