Regenexx Pittsburgh

RAPS Medical (www.regenexxpittsburgh.com)

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Welcome to Regenexx Pittsburgh,

We are pleased that you have chosen Regenexx Pittsburgh as your physiatry and regenerative medicine practice. Regenexx Pittsburgh provides a comprehensive clinical approach to managing your condition and improving your daily functioning and quality of life. Your physician is highly skilled in assessing the cause of your pain and determining appropriate and effective treatment. Please take a few moments to read the enclosed brochure to learn more about your physician.

Effective treatment is the result of a cooperative partnership between you and your physician. To that end there are key responsibilities that our patients are given to assure their needs can be met by the staff in a time efficient manner.

- **Please complete the enclosed forms in their entirety.**
- **Please arrive 15-20 minutes early to your first appointment to allow time to process your forms and obtain additional information.**
- **If you have had any XRAY or MRI films/disc *and* report taken, please bring them with you. If you do not have the report, please call facility and have a report faxed to the number listed above.**
- **If your insurance card states that you have a co-payment for specialist services, please be prepared to pay your co-payment for every office visit. We participate with many insurance carriers; however you will be responsible for any applicable deductibles, co-insurance, and non-covered services at the time of service. If you foresee a financial difficulty with payment of your balance, please call our office immediately to discuss and arrange a payment plan.**
- **Please call the office if you are unable to attend an appointment.**
- **Please bring a photo ID to be copied for your chart for verification.**

We are dedicated to providing you with high quality care. This starts with your first phone call to the office, your experience with our office staff, your visit with the doctor, and all other activities that occur while you are here. We welcome your comments and suggestions so that we can provide you with the high quality of patient care that you deserve.

Sincerely,
Tisha A. Nardozza

Regenexx Pittsburgh

Patient Registration

LAST NAME	FIRST NAME MI
HOME ADDRESS	CITY/STATE/ZIP
DOB:	SOCIAL SECURITY NUMBER
PRIMARY PHONE CELL PHONE	EMAIL ADDRESS
EMERGENCY CONTACT/RELATIONSHIP	PHONE NUMBER
REFERRING PHYSICIAN	OFFICE PHONE NUMBER
PRIMARY CARE DOCTOR	OFFICE PHONE NUMBER

Insurance Information

PRIMARY INSURANCE	SECONDARY INSURANCE
ID#	ID#
SUBSCRIBER NAME: DOB:	SUBSCRIBER NAME: DOB:

Accident Information (if applicable)

DATE OF ACCIDENT	TYPE OF CLAIM: **WORKERS COMP AUTO OTHER**
NAME OF INSURANCE	CLAIM NUMBER
NAME OF CLAIM ADJUSTER	ADJUSTER PHONE #

Communication

Please help us make sure we have the most current information for your account.

By providing your information below, you are agreeing to be contacted via those communication channels. Your information will not be abused and will only be used to contact you regarding your care. Example communications include appointment reminders, reminders to schedule your next appointment and important announcements about our practice.

I prefer to be contacted via **(circle one)**: Phone Call Text

I hereby grant my healthcare provider permission to contact me via an automated phone/text/email. I authorize my healthcare provider to disclose to third parties who answer my phone my limited protected health information, and to leave a message on my voicemail system or answering machine.

I give my permission for RAPS to speak with the following people concerning the evaluation & treatment of my pain condition. **Please complete below to give us consent to speak to the following people regarding your care.**

Name	Name
Phone	Phone
Relationship:	Relationship

Signature: X_____ **Date:**_____

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Patient Name_____ Date_____

Birthdate: _____/_____/_____ Age: _____ Sex: M_____ F_____ Height: _____ Weight:_____

Occupation: _____ How long? _____

How were you referred to RAPS: □ Physician □ family/friend If so, whom? _____
□ magazine/newspaper □ physical therapist □ internet □ insurance company

Referring Physician: _____ PCP: _____

IF YOUR SYMPTOMS ARE THE RESULT OF AN INJURY, COMPLETE THE FOLLOWING:

Type of Injury: Work_____ Auto_____ Home_____ Other (explain)_____

Date of Injury: _____ Where it happened: _____

How it happened: _____

Are you currently off work due to this injury? _____ If yes, since what date? _____

HISTORY OF PRESENT ILLNESS

Date your symptoms began: _____ Describe your symptoms: _____

_____

_____

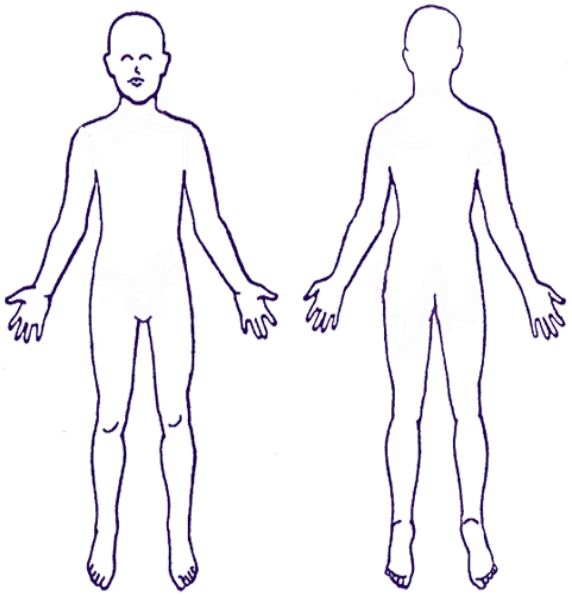
Is your pain (please Circle if applicable): **Sharp Dull Aching Stabbing Burning Tingling Numb**

Severity Rate: 1 (low) to 10 (high): _____ Have you had any loss of bowel/bladder control? _____

When do you have pain? Constantly Daily Weekly Monthly Other _____

Please mark the areas on your body where you feel the following sensations, using the symbols below:

* NUMBNESS : PINS/NEEDLES X BURNING / STABBING



Please circle yes or no to the following questions:

- Do you exercise regularly? Yes No
- Do you feel stressed on a regular basis? Yes No
- Do you describe your diet as healthy? Yes No
- Do you regularly feel fatigued (tired)? Yes No
- Do you sleep well? Yes No
- Do you feel well rested after a night's sleep? Yes No

What makes your pain worse?

_____

_____

What makes it better?

_____

_____

Patient Name _____ Date of Birth: _____

What treatment have you had for your complaints?

_____ Physical Therapy _____ Brace/Collar/Splint

_____ TENS Unit _____ Pain Clinic

_____ Chiropractor _____ Injections/Nerve Blocks

_____ Treatment by Another Physician

_____ Medications for pain (please list) _____

SOCIAL HISTORY

_____ Single _____ Married _____ Divorced _____ Widow(ed) __ ____ Partnered

Children? (number) _____

Smoker? YES NO Smoker in the past? YES NO ____ packs per day for _____ years.

Do you use smokeless tobacco (chew or snuff)? YES NO

Alcohol? YES NO _____ drinks per week Recreational drug use? YES NO

Exercise? YES NO If yes, describe type and frequency _____

_____

FAMILY HISTORY

Do any family members suffer from the following conditions? If so, who?

Blood Clot/Pulmonary Embolism_____

_____ Heart_____ _____ Diabetes _____

_____Cancer_____ _____ Stroke _____

_____Hypertension_____ _____ Aneurysm _____

PAST MEDICAL HISTORY

Do you suffer from any of the following conditions? Circle all that apply:

Cardiac:	Heart Attack	Abnormal Rhythm	Murmur	Other: _____
Pulmonary:	Asthma	COPD	Emphysema	Other: _____
Endocrine:	Diabetes	Hypothyroid	Pituitary tumor	Other: _____
Circulatory:	Hypertension Bleeding disorders	Stroke	Aneurysm	Blood Clot (or Pulmonary Embolism)
Cancer:	Type: _____		Date of Diagnosis: _____	

Other: _____

_____

Patient Name _____ Date of Birth: _____

REVIEW OF SYSTEMS (please circle all that apply)

Neurological:	Headache	Dizziness	Memory	Numbness
Eyes:	Glasses	Contact lenses	Blurriness	Double vision
Ears/Throat:	Deafness	Ringing	Swallowing	Hoarseness
Cardiac:	Chest pain	Skip beats	Rapid beats	Edema
Pulmonary:	Cough	Cough blood	Wheezing	Short of breath
Intestinal:	Constipation	Diarrhea	Incontinence	Bleeding
Urinary:	Frequent	Burning	Incontinence	Bleeding
Musculoskeletal:	Pain	Weakness	Arthritis	Cane/Walker
Endocrine:	Weight loss	Weight gain	Heat/Cold intolerance	
Skin:	Bruising	Lesions	Birthmarks	
Hematological:	Bleeding	Transfusion	Hepatitis	
Psychiatric:	Depression	Fatigue	Insomnia	

PREVIOUS SURGERIES (list type of surgery, date and name of the surgeon that performed it)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES: (list what you are allergic to and the reactions you have) **LATEX (circle) Y or N IODINE (circle) Y or N**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

CURRENT MEDICATIONS (include over-the-counter medications taken on a regular basis)

PHARMACY NAME # _____ **PHONE** #_____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name_____ Dosage_____ Frequency_____

Name_____ Dosage_____ Frequency_____

DIAGNOSTIC STUDIES (list date and place your study was done)

X-rays _____ MRI _____

CT Scan _____ Myelogram _____

Bone Scan _____

Patient Signature Date

(PHYSICIAN USE ONLY): I personally reviewed all of the systems noted on page 3 of this patient history.