PLEASE READ ENTIRE PACKET

Thank you for choosing PAWLEYS ISLAND PAIN MANAGEMENT.

You have an appointment with

DR. GRANT

WE MUST RECEIVE YOUR PAPERWORK AT LEAST 24 PROIOR TO YOUR APPOINTMENT TO AVOID BEING RESCHEDULED.

PLEASE ARRIVE 15 MINUTES EARLY OR YOU MAY BE RESCHEDULED

I have attached your paperwork to fill out. Please fill out in BLACK OR BLUE INK and write legibly.

Pawleys Island Pain Management

Patricia R. Grant, MD

Phone (843) 894-0978 Fax (843) 894-1106 313 Commerce Drive Suite B Pawleys Island, SC 29585

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

Home Phone Number: _____ Cell Number: _____

Date Of Birth: _____ Social Security Number: _____

Sex:M/F Martial Status: S/M/W/D Email Address: _____

Employer: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____ Ok to discuss information with Emergency Contact? Y / N

Primary Care Physician: _____ Referring Physician: _____

Other Physicians:	Area of Speciality:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Primary Insurance Carrier: _____ ID Number: _____

Secondary Insurance Carrier: _____ ID Number: _____

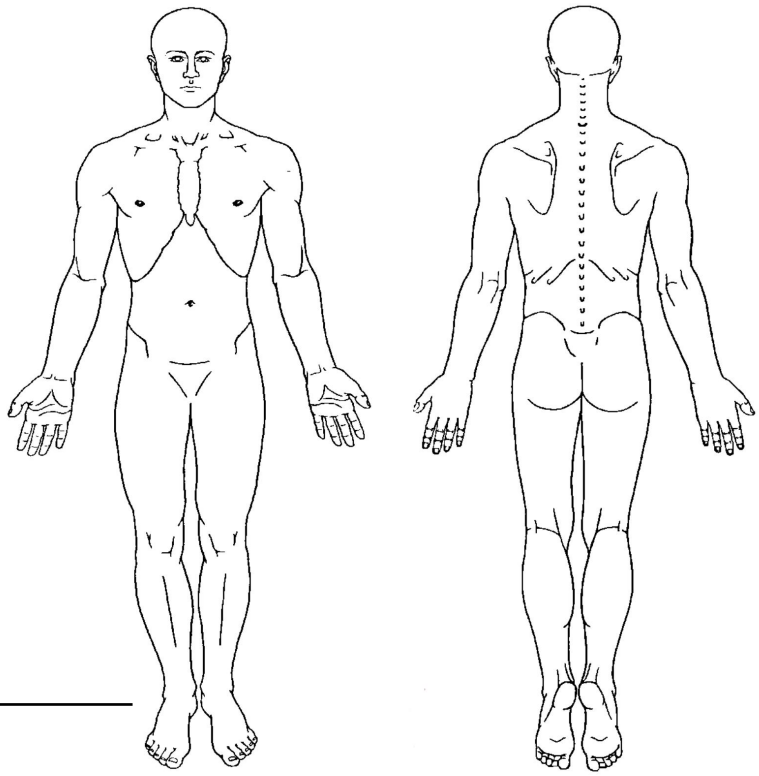
Pawley's Island Pain Management is hereby authorized to release information to healthcare providers that have referred me to this physician or who may benefit from this information as they are for me. I authorize the release of medical information to my insurance carrier, their utilization management company, my employer or any other agency that may be assisting in payment for my care.

Patient Name: Patient Signature: Date:

Patient Name: _____ Today's Date: _____

Date Of Birth: _____ Preferred Pharmacy: _____

Please show the area of pain on the diagram to the right.



On a scale from 0 (no pain) to 10 (worst pain you've ever felt) what is your pain level at its worse.

0 1 2 3 4 5 6 7 8 9 10

Current Chief Complaint

Where is your Pain? _____

When did your pain start? _____

Does your pain radiate to another part of your body? ___Yes ___ No Where? _____

Was there an injury or precipitating event? ___Yes ___No If so, when? _____

Have you had any x-rays, MRI, or CT scan? If so, What? _____When? _____Where? _____

Have you seen any other doctors for this problem? ___Yes ___No Who? _____

Any Numbness? ____Yes ___No Where? _____

Any Weakness? ____Yes ___No Where? _____

Have you had any difficulty with bladder or bowel control? ____Yes ____No

How would you describe your pain? ____Sharp _____Achy ____Throbbing ____Burning ____Cramping ____Dull

____Shooting _____Stiff _____ Sore _____ Stabbing _____Pressure-like

What makes your pain worse? ____Standing____Sitting ___Lying ____Walking ____Housework ___Bending

_____ Rotating/Twisting _____Worse in the AM _____ Worse in the PM Other: _____

What makes your pain better? _____ Rest _____ Walking _____ Stretching _____Standing _____ Sitting

Other: _____

Have you ever tried any of the following? _____Heat/ Ice ____Rest

_____ Over the counter medications? What? _____

_____ Prescription Medications? What? _____

_____ Chiropractor? Who? _____ When? _____

_____ At least 6 weeks of physical therapy withing the last 6 months?
Where? _____ How Long? _____

_____Physician Supervised Home Exercise Program?

_____6 weeks of Daily home exercising within the last 6 months?

_____Any Injections in the past 12 months?

Allergies: (please list below)

Drug/Food: Reaction:

_____

_____

_____

_____

Medications: Dose: Times Per Day:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY: Please circle any that have been and add any not listed.

Anemia Anxiety Arthritis Asthma CAD CHF COPD Cancer Gout

High Cholesterol Dementia Depression Diabetes Epilepsy GERD Glaucoma

HIV Hepatitis Headaches Hypertension Heart Attack Migraine Renal Stone

Stroke TB Thyroid Disease Ulcer

Additional Diagnosis: _____

_____

FAMILY HISTORY:

Mother Illness: _____ Father Illness: _____

Suicide? _____ Suicide? _____

Illegal/Illicit Substance Abuse? _____ Illegal/Illicit Substance Abuse? _____

Deceased ___Yes ___No Deceased ___Yes ___No

Other Family Members and Illness: _____

_____

IMMUNIZATIONS: Have you has any of the following?

Influenza Vaccine Date Administered _____

Pneumonia Vaccine Date Administered _____

Covid Vaccine/s Date Administered _____

SOCIAL HISTORY:

Do you smoke/use tobacco products? ____Yes ____No If so, what type? _____

How much per day? _____ How many Years? _____

Are you a former smoker? ____Yes ____No How much & number of years? _____

Do you drink alcohol? ____Yes ____No If yes, what? _____

History of Illegal/illicit Substance Abuse? ____Yes ____No If yes, what? _____

FALLS:

Have you fallen in the past year? ____Yes ____No

Are you worried about falling? ____Yes ____ No

Do you feel unsteady while standing or walking? ____Yes ____No

SURGICAL HISTORY: Please list any surgeries/ surgical procedures

_____

_____

_____

_____

Do you have a pacemaker? ___Yes ____No Defibrillator? ___Yes ___ No

By signing this medical history form, I am attesting that the following information is accurate to the best of my ability. I understand that I must notify a staff member of Pawley's Island Pain Management if any changes are made to my medical history.

Print Name: _____ Date: _____

Signature: _____

Pawleys Island Pain Management

Patricia R. Grant, MD

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INFORMED AUTHORIZATION AN CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I hereby authorize PAWLEY'S ISLAND PAIN MANAGEMENT to release and/or obtain medical records for the following patient:

_____ Date of Birth: _____

(PRINT PATIENTS NAME VERY CLEARLY)

Releasing To:

_____

_____

_____

_____

Obtaining From:

_____

_____

_____

_____

For the purpose of CONTINUITY of CARE

☐ Medical Notes/Summary

☐ Imaging/X-ray/MRI Reports

☐ Other

☐ Operative/Procedure Reports

☐ Recent Labs

I understand these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entities as stated above. I understand that information disclosed pursuant to this authorization maybe subject to re-disclosure by the recipient and may no longer be protected by federal or states privacy laws. This authorization/consent will remain in effect for a period of one year from the date of service stated below, unless otherwise revoked in writing by the person to which it pertains.

_____ Date: ____/____/_____

(Signature of patient, parent, legal guardian, or legally authorized agent.)

Acknowledge of Receipt of Notice of Privacy Practices

Notice to patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I received a copy of this office's Notice of Privacy Practices

Print Name:

Signature:

Date:

Authorization to release of use information for treatment, payment, or Healthcare operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Pawley's Island Pain Management in order to carry out treatment, payment, or healthcare operations. Please review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of use information, and you have the right to review such notice prior to singing this consent form.

We reserve the right to change the terms of its Notice of Privacy Practice at any time. If we make changes to the terms of the Notice of Privacy, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is relesed or used to carry out treatment, payment, or healthcare operations. Our practice is not required to agree to such requested restirctions: however, if we do not agree to your restriction (s), such restrictions are then binding to the practice.

I agree and consent to releasing information to me in the following manner(s):

		Please Initial
Via Email	OK to email me	_____
Via Mail	OK to mail me	_____
Via Home Phone	OK to leave a detailed message	_____
	Leave callback number only	_____
Via Cell Phone	OK to leave a detailed message	_____
	Leave callback number only	_____

The following persons may speak with Pawley's Island Pain Management regarding my health information:

Name	Relationship	Phone Number

By signing below, I attest that the information provided above is true and accurate.

Signature: _____

Pawleys Island Pain Management
Patricia R. Grant, MD
Phone (843) 894-0978 Fax (843) 894-1106 313 Commerce Drive Suite B Pawleys Island, SC 29585

OFFICE POLICIES AND PROCEDURES FOR OUR PATIENTS

Receipt Acknowledgment Form

By signing below, I acknowledge that I have received, reviewed, understand and will comply with policies and procedures explained in the Paley's Island Pain Management Office Policies and Procedures for Patients form.

_____

Printed Name

_____

Signature

Date: ____/____/_____

Thank You,
Pawley's Island Pain Management

Pawleys Island Pain Management
Patricia R. Grant, MD
Phone (843) 894-0978 Fax (843) 894-1106 313 Commerce Drive Suite B Pawleys Island, SC 29585

NO SHOW POLICY

Pawley's Island Pain Management schedules appointment so that each patient receive the appropriate time to be seen by our physicians. It is very important that you keep your scheduled appointments. Pawley's Island Pain Management sends text message and email reminders prior to appointments.

If your schedule changes are you cannot keep your appointment, please contact the office so that we may reschedule you, and to accommodate those patients who are waiting to schedule an appointment with our physicians. As a courtesy to our office as well as to those patients who are waiting, we will need 24-hour notice.

If you do not cancel or reschedule your appointment within at least a 24-hour period, you will be marked a NO SHOW. Three NO SHOWS in a 12-month period will result in being discharged from the practice.

I UNDERSTAND THE "NO SHOW" POLICY OF PAWLEY'S ISLAND PAIN MANAGEMENT AND I UNDERSTAND THAT I MUST CANCEL OR RESCHEDULE ANY APPOINTMENT AT LEAST 24-HOURS IN ADVANCE IN ORDER TO AVOID A POTENTIAL DISCHARGE FROM THE PRACTICE.

Date: _____

Patients Name(Print): _____

Date of Birth: _____

Patients Signature: _____