Patient Name:_____DOB:_____

OMEGA PAIN MANAGEMENT

IGOR SMELYANSKY, MD

Board Certified Interventional Pain Management Physician

6348 Lonas Spring Dr, Knoxville, TN 37909

Ph: (865) 337-5137

Fax: (865) 312-8350

TO OUR PATIENTS

Thank you for choosing Omega Pain Management. Please complete the entire packet **PRIOR** to arrival for your appointment. This information is vital to our plan of care for you. You may return this packet to our office any time before your appointment or at your appointment. If you need any assistance completing these forms, please arrive 45 minutes prior to your appointment and promptly notify our staff for assistance.

YOU MUST BRING THE FOLLOWING ITEMS WITH YOU TO YOUR APPOINTMENT:

- **Photo Identification (must be valid and current)**
- **Insurance Cards**
- **Completed New Patient Packet**
- **Current List of Medications**
- **Most Recent Imaging (NO DISCS, MUST BE PAPER REPORT)**

Failure to bring any of the items WILL result in your appointment being rescheduled.

Note: All patients are subject to random urine drug screens in the office at any time. (**NOT OPTIONAL**)

This practice utilizes the services of specially trained NURSE PRACTITIONERS. Most of your follow ups will be scheduled with one of them.

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PATIENT REGISTRATION FORM

Patient Name:_____Date:_____

Date of Birth:_____Age:_____SS#:_____-_____-_____

Marital Status: □Single □ Married □ Divorced □ Widowed □ Separated

Address:_____City:_____State:_____Zip:_____

Home#:_____Cell#:_____Email:_____

Preferred Contact: □ Home □ Cell May we contact you by text/email/portal: □ Yes □ No

Race:_____Ethnicity:_____Preferred Language:_____

Occupation:_____Employer Name:_____

Employer Address:_____Employer Phone:_____

Primary Physician:_____Phone:_____

Emergency Contact:_____Relation:_____

Address:_____Phone:_____

INSURANCE INFORMATION

Primary Insurance:_____ID#:_____

Policyholder's Name:_____SS#:_____-_____-_____DOB:_____

Name of Employer:_____

Employer Address:_____

Secondary Insurance:_____ID#:_____

Policyholder's Name:_____SS#:_____-_____-_____DOB:_____

Patient Signature:_____Date:_____

OMEGA PAIN MANAGEMENT

Initial Medical History Questionnaire

Your Name: _____ DOB _____/_____/_____

PCP:_____ Referring MD:_____

CHIEF COMPLAINT:

1) Where is your pain? (neck, lower back, etc.) _____

Please describe how your pain began: ~ date/ year of onset, what caused it and events until now.

_____

_____

_____

_____

_____

_____

_____

_____

_____

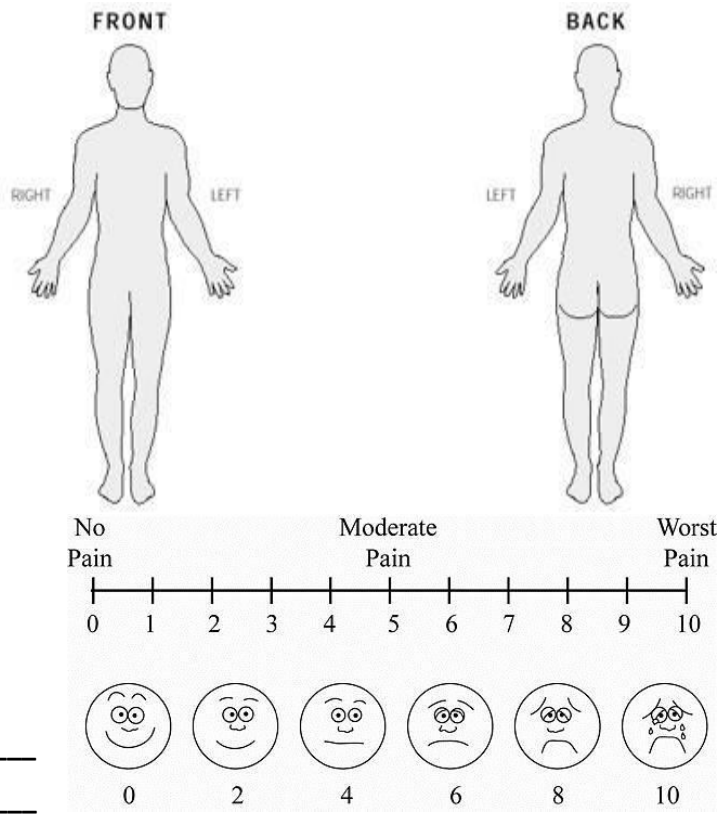
_____

_____

_____

_____

Please indicate, on the diagram below, the location of your pain



2) Describe the pain: ❑ Throbbing ❑ Shooting ❑ Sharp ❑ Dull ❑ Aching ❑ Tingling ❑ Burning

3) What number on the pain scale (0-10) describes your WORST pain? _____

4) What number on the pain scale (0-10) describes your CURRENT pain? _____

5) Have you tried Physical Therapy? if yes: when was the last time and did it help you?_____

PREVIOUSLY TRIED MEDICATIONS:

	Helped?		Never taken		Helped?		Never taken		Helped?		Never taken
Opiates	**Y**	**N**		**NSAID**	**Y**	**N**		**Muscle Relaxant**	**Y**	**N**	
Vicodin (Hydrocodone)				Motrin (Ibuprofen)				Flexeril (Cyclobenzaprine)			
Percocet (Oxycodone)				Aleve (Naproxen)				Baclofen			
OxyContin				Relafen (Nabumetone)				Robaxin (Methocarbamol)			
Morphine ER MS Contin				Mobic (Meloxicam)				Zanaflex (Tizanidine)			
Oxymorphone/ Opana ER				Celebrex				Skelaxin (Metaxolone)			
Hydromorphone/ Exalgo ER				Diclofenac (Voltaren)							
Fentanyl/ Duragesic patch				Etodolac							
Butrans patches				Tylenol							
Ultram/Tramadol				**OTHER**							
Nucynta				Gabapentin/ Neurontin							
				Lyrica							
				Cymbalta							
				Savella							
				Lidoderm patches							
				Fioricet							

REVIEW OF SYSTEMS:

Do you currently have any of these symptoms? (Please circle all that apply)

General: fever, chills, night sweats, anorexia, fatigue, weight loss, weight gain
Eyes: pain, redness, blurred vision, loss of vision
Ears/Nose/Throat: ear pain, ringing in ears, hearing loss, sore throat, hoarseness
Cardiovascular: chest pain, irregular heartbeat, shortness of breath, syncope/fainting
Respiratory: cough, wheezing, excessive mucous
Gastrointestinal: nausea, vomiting, diarrhea, constipation, abdominal pain, bloody stools, indigestion.
Genitourinary: painful urination, blood in urine, urinary frequency, incontinence, decreased sex drive
Musculoskeletal: joint pain, joint swelling, muscle cramps, muscle aches, muscle weakness
Skin: rash, itching, dry skin
Neurologic: weakness, seizures, tremors, vertigo, headaches, tingling, numbness, visual disturbance
Psychiatric: sleep problems, mood swings, depressed mood, confusion, anxiety/panic attacks.
Endocrine: heat intolerance, cold intolerance, excessive thirst, excessive urination, constipation, diarrhea, dry skin, tremor, changing menstrual patterns
Heme/ Lymphatic: bleeding, easy bruising, leg swelling (edema)

PAST MEDICAL HISTORY: (please circle)

❑ Alcoholism
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Atrial fibrillation
❑ Cardiac pacemaker
❑ Congestive heart failure
❑ COPD
❑ Coronary Artery Disease
❑ Depression
❑ Diabetes
❑ DVT-blood clots
❑ Fibromyalgia
❑ GI bleeding
❑ Glaucoma
❑ Headache
❑ Hearing loss
❑ Heart attack
❑ Heartburn - GERD
❑ Hepatitis B
❑ Hepatitis C
❑ High blood pressure
❑ High cholesterol
❑ HIV-AIDS
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Irritable Bowel Syndrome
❑ Kidney failure- Dialysis
❑ Kidney stones
❑ Liver cirrhosis
❑ Multiple sclerosis
❑ Osteoporosis
❑ Pancreatitis
❑ Polyneuropathy
❑ RSD / CRPS
❑ Schizophrenia
❑ Seizures
❑ Stomach ulcer
❑ Stroke
❑ Tuberculosis
❑ Urinary tract infection

Blood clots/ Pulmonary (lung) Embolism? (if yes, date and are you on COUMADIN?)_____

ADDITIONAL MEDICAL HISTORY: _____

_____

PAST SURGICAL HISTORY:

❑ Appendectomy ❑ Cardiac bypass ❑ Cardiac pacemaker ❑ Cardiac stents ❑ Cesarean section ❑ Gall bladder

❑ Hysterectomy ❑ Kidney stones surgery ❑ Thyroidectomy ❑ Tonsillectomy

Please list any additional **surgeries**, **side**, **surgeon's name** and ~ **date: (i.e. Rt total knee replacement, Dr. Smith 2009)**

1_____ 4_____

2_____ 5_____

3_____ 6_____

FAMILY HISTORY:

	Stroke	**Cancer/type**	**Arthritis**	**Heart prob**	**Diabetes**	**High BP**	**Other**
Mother							
Father							

SOCIAL HISTORY:

Cigarette Smoking Y N Packs per day: _____

Alcohol Y N How many alcoholic drinks per week?_____

History of drug abuse: Y N What type of drug?_____ Last used_____

CURRENT MEDICATION LIST:

Medication Name	**Dose**	**Frequency**	**Medication Name**	**Dose**	**Frequency**

Are you taking any blood thinners? Please circle: Coumadin/ Warfarin Plavix Effient Xarelto Pradaxa

ALLERGIES (both to medications and non-medications/ **any IV Dye allergy?**):

_____

_____

Mark all of the following studies you have had in the last 3 yrs that are related to your current pain complaints:

MRI of the: _____ Date: _____ Facility: _____

X Rays of the: _____ Date: _____ Facility: _____

CT scan of the: _____ Date: _____ Facility: _____

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MEDICAL RECORDS RELEASE

Patient Name:_____DOB_____

SS#_____/_____/_____ Daytime Phone Number_____

This is a request that my medical records be forwarded to Omega Pain Management and that my medical health information may be shared with other healthcare providers or pharmacies to ensure continuity of care.

PLEASE LEAVE THIS SECTION BLANK

RECORDS REQUEST FORM

Facility or Physcian_____

Records Needed:_____

Address:_____City:_____State:_____

Phone:_____Fax:_____

_

****Patient Signature:_____ Date:_____**

PATIENT RELEASE OF INFORMATION

In addition to speaking to your referring provider, your primary care provider, your insurance companies, and any outpatient facility we refer you to, this will allow our office to release your information to those you list below.

I_____, give Omega Pain Management and its representatives permission to speak with the following persons listed below regarding my personal information. This is effective until otherwise revoked by the patient.

_____

_____

_____

**Patient Signature_____DOB_____Date_____

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IMPORTANT POLICIES

CANCELLATION AND NO SHOW POLICY

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. In return, it is your responsibility to make every effort to keep your appointment and to arrive promptly at the time you are instructed.

In any event you need to cancel your appointment or procedure, you will need to contact us AT LEAST 24 HOURS PRIOR YOUR APPOINTMENT. Failure to give a 24-hour notice, will result in a cancellation fee. This fee is not covered by your medical insurance policy and MUST be paid prior to being seen in our office again.

Appointment Cancellation/NO show Fee: $35.00
Procedure Cancellation/NO show fee: $50.00

If you fail to show on 3 occasions you will be discharged from the practice for non-compliance and an appropriate note will be sent to your referring provider.

Initial:_____

Financial Policy

It is our desire that payment of your account is easy and convenient as possible. We will assist you in any way we can to facilitate the settling of your account. In order for us to be able to keep billing fees at a minimum, it's absolutely necessary for you to provide us with accurate and up to date insurance information at each of your visits. If your insurance status changes from one visit to the next, it is your responsibility to notify us so that your insurance can be filed correctly.

Initial:_____

Payment Policy

In accordance with the agreement that you have with your insurance company, any deductible or copay is required at the time services are rendered. Required co-pays and deductibles are expected each visit and failure to keep your account current in this regard may prohibit future services until account is made current. Payments may be made by cash, check, money order, or accepted credit cards. For any questions with your account, please call our office at 865-337-5137 and select the billing department option.

Initial:_____

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Patient's Consent to Receive Opioid Therapy

I understand that opioid analgesic medication is recommended by my provider to treat the pain associated with my_____(condition/diagnosis).

I understand that many medications can have interactions with opioids that can either increase or decrease the opioid's effect on me.

I told my provider about all other medications including over the counter and treatments that I am receiving, and I will promptly let my provider know if I take any new medications or have new treatments.

I have informed my provider about my complete personal drug history, including herbal remedies. I understand that some herbal remedies and certain medications such as Valium, Ativan, Xanax, Soma, Fiorinal; antihistamines like Benadryl; alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects. I understand that certain other medicines such as nalbuphine (Nubain ™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the opioid and may cause symptoms like a bad flu, called a withdrawal syndrome.

I understand that I should not use any illicit substances, such as cocaine, marijuana, amphetamines, or legal central nervous system depressants such as alcohol while taking these medications.

It has been explained to me that the initiation of an opioid medication is a trial. Continuation and any changes in dosage of the opioid medication will be determined by my provider based on pain relief, functional improvement, side effects, and my adherence to instructions and other factors. If I do not have significant improvement, or development of harmful side effects, or based on other considerations, my provider may discontinue this treatment or change dosage.

I understand that opioid medication treatment is not the only option to treat my condition or symptoms and the benefits and risks of alternative treatments (including declining treatment) have been explained to me. I have had an opportunity to discuss these options with my provider and to ask questions about them which have all been answered to my satisfaction.

I understand there are risks associated with the use of opioids, including abuse, misuse and diversion (sharing, selling, permitting others to use the medication).

I understand the likelihood of continuing to use opioids increases most dramatically after the 5th and 31st days on therapy; after the second prescription of opioids; and first prescriptions with 10- and 30-day supplies. (CDC, 2017)

It has been explained to me that taking narcotic/opioid medication may pose certain risks and side effects to me. These risks and side effects include, but are not limited to, the following:

- **Allergic reaction (immediately consult your provider)**
- **Addiction – involves compulsive use of a substance for unintended purposes. Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm or consequences, and cravings.**
- **Physical dependence on the properties of the medication. Dependence results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking then I may experience a runny nose, yawning, large pupils, goose bumps, abdominal pain, cramping, diarrhea, irritability, body aches, and flu-like symptoms. These can be very painful but are generally not life-threatening. Physical dependence does not equal addiction.**
- **Tolerance - A state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease in pain.**
- **Overdose (which can result in death)**
- **Slowing of breathing rate**
- **Slowing of reflexes or reaction time**
- **Failure to provide pain relief**
- **Sleepiness, drowsiness, dizziness, and/or confusion**
- **Impaired judgment and inability to operate machines or drive motor vehicles**
- **Nausea, vomiting, and/or constipation**
- **Itching**
- **Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance)**
- **Changes in hormonal levels**
- **Dangers to others. All of these side effects can occur to others if they get access to opioids.**

For Women of Childbearing Age With Reproductive Capacity Only *(under Tennessee law, ages 15 – 44)*:

Risks associated with opioid use during pregnancy

It has been explained to me that the use of narcotic/opioid medication poses special risks to women who are pregnant or may become pregnant. I have been advised, for example, that should I carry a baby to term while taking this medication or illicit opioids such as heroin, the baby may be physically dependent on opioids (called "neonatal abstinence syndrome"), which is very harmful to the baby. Neonatal Abstinence Syndrome is a condition in which a new born baby has withdrawal symptoms after being exposed to opioids while in the womb. I also understand that birth defects can occur to any baby whether or not the mother is on medications and there is always the possibility that my baby will develop a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not fully understood and cannot be predicted, but it could be harmful to the child.

Birth control counseling

I have been informed of the birth control (or contraceptive) options available to me to reduce the chances that I become pregnant while being treated with narcotic/opioid medication. I have been counseled on appropriate and effective forms of birth control. I have also received information about how I can receive free or reduced birth control.

Initials of patient acknowledgement: _____

Signature of parent/legal guardian if parent/legal guardian of a minor patient was given this advisory instead of the minor patient or if parent/legal guardian is otherwise required to provide informed consent for this patient: _____

Note: Nothing prohibits a physician from advising, counseling or providing information directly to a competent and mature minor patient. (TCA 53-11-308).

Patient Consent

Having been informed of the risks and potential benefits of opioid medications and possible alternative treatments, understanding the characteristics, expectations and instructions regarding how opioids should be used and having been given the opportunity to discuss options and ask questions, I agree that any questions that I have raised have been discussed to my satisfaction. Therefore, I voluntarily consent to take opioid medication.

Patient Agreement

If I plan to become pregnant or believe that I have become pregnant while taking an opioid medication(s), I will immediately call my obstetrician and this office to inform them.

I will take this opioid medication only as prescribed and I will not change the amount or dosage frequency without authorization from my provider (except to discontinue the medication in the event of allergic reaction). If my medication is prescribed "PRN", I understand that I should only take it as needed. I further understand that changes may result from my running out of medications early, and early refills may not be allowed.

I will obtain my opioid prescriptions from my provider or, during his or her absence, by the covering provider. Requests for pain medications from the on-call provider (nights and weekends) may not be honored.

I will fill opioid medication prescriptions at only one pharmacy. I will notify my provider if I change pharmacies.

The pharmacy that I have selected is_____.

Pharmacy phone number is:_____.

I will submit to random pill counts and urine and/or blood drug tests as requested by my provider in order to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to dismissal from care by my provider after a 30-day, emergency-only time period.

I will not share, sell, or otherwise permit others to have access to this medication and I will keep it in a secure location.

I have read the above information or it has been read to me. I understand all of it. I have had all of my questions regarding the treatment of pain with opioids answered to my satisfaction. By signing this form, I voluntarily give my consent to opioid medication therapy & acknowledge receipt of this document.

Date: _____

Patient or Parent/Guardian Signature

_____

Printed Name of Consenting Person

_____