

❑ WHEELER FAMILY MEDICAL
CENTER
**UPMC Somerset Pain
Management**
126 E. Church St, Suite 2400
Second Floor
Somerset, PA, 15501

❑ UPMC Ear, Nose, and
Throat – Johnstown
**UPMC Somerset Pain
Management –
Johnstown**
348 Budfield St
Johnstown, PA 15904

❑ UPMC SPECIALITY OFFICE
**UPMC Somerset Pain
Management –
Greensburg**
410 Pellis Rd, Suite 1B
Lower Level
Greensburg, PA 15601

Welcome to UPMC Somerset Pain Management,

Your healthcare provider had requested a consultation with our office to discuss interventional pain management. Please review and complete all paperwork PRIOR to your scheduled appointment. Allow approximately 45 minutes to complete the paperwork as accurately as possible. **Remember to bring the completed forms to your visit. (Failure to complete your paperwork may result in a rescheduling of your appointment.)**

PLEASE ARRIVE 20 MINUTES PRIOR TO YOUR FIRST SCHEDULED APPOINTMENT TIME.

Please bring the following:

- Completed paperwork
- Current Driver's License/Photo ID
- Current Insurance Card
- Current Medication List with dosage and frequency
- Additional Xray, CT scan, MRI, or EMG reports and disc (ONLY if performed outside of the UPMC or Conemaugh)

The initial patient consultation will include a detailed pain history, physical exam, review of available diagnostic material, and a discussion of possible treatment modalities.

Several treatment modalities will require specific diagnostic testing as well as a detailed discussion regarding possible risks, benefits, and reasonable alternatives. Furthermore, your insurance will require office visit documentation before most treatment plans can be approved. **As such, your initial visit will not typically include performing injections. All UPMC Somerset Pain Management locations do not routinely prescribe narcotic medications for non-cancer related pain.**

Should you need to cancel or change your initial appointment please notify our office **at least 24 hours in advance**, otherwise your rescheduling status will be placed in review.

Should you have any questions, please contact the office at **814-443-5800**



**UPMC Somerset
Somerset Pain Management**

126 East Church Street
Suite 2400
Somerset, PA 15501
T 814-443-5800
F 814-443-5499

TREATMENT DISCLAIMER

UPMC Pain Management does not routinely prescribe narcotic medications for non-cancer related pain as part of an integrative pain management approach at our Outpatient Centers in Greensburg, Johnstown, or Somerset locations. We request you discuss any opiate-based treatments with your primary caregiver. An opiate consultation can be made at the request of your primary care physician through our provider referral form.

**Somerset Health Services
Patient Demographic Collection Sheet**

Patient Name: _____ Patient Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellphone: _____

Sex (*circle one*): Male Female Date of Birth: _____

Marital Status (*circle one*): Single Married Widowed Separated Divorced

Email Address (if over the age of 18): _____

Primary Care Physician/Referring Physician: _____

Employment Status (*circle one*): Disabled Not Employed Retired Full Time Part Time Student

Race (*circle one*): White Asian American Indian/Alaskan Native Black/African American
Native Hawaiian More than One Race Other Pacific Islander Prefer not to Report

Ethnicity (*circle one*): Not Hispanic or Latino Hispanic or Latino Prefer not to Report

Primary Language (*circle one*): English Spanish Other: _____

If patient is under the age of 18, complete this section.

Legal Mother's Name: _____ Legal Mother's Phone: _____

Legal Father's Name: _____ Legal Father's Phone: _____

Guarantor Information (the guarantor is the person responsible for paying the bill)

Guarantor Name (must be a parent or guardian if under age 18): _____

Guarantor Social Security #: _____ Guarantor Date of Birth: _____

Subscriber Information (the subscriber is the person who is the policy holder)

Is the patient the policy holder for the health insurance coverage? Yes / No If yes, skip this section.

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Policy Holder Social Security #: _____

Emergency Contact Information

Name of Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Dear Patient:

We understand that you wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Read this form carefully and then fill it out completely by printing or typing. If printing, use a pen.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient:

- Make appointments for health care services;
- Have discussions with health care providers about routine tests and treatments (that do not require informed consent);
- Access to medical information, as necessary, to have discussions with health care providers about routine tests and treatments. However, unless the personal representative is a licensed physician who is credentialed to provide healthcare services at UPMC, use of UPMC's internal electronic medical record systems to access such medical information is not permitted.

Note that this form is not applicable and cannot be used for UPMC behavioral health patients or for any patient when major health care decisions are involved, including, but not be limited to:

- Procedures/services that require informed consent (and withdrawal of consent if applicable);
- Admissions to and discharges from nursing homes or other long-term care facilities;
- Donation of organs, body parts, or body for medical purposes, including the authorization of an autopsy;
- Continuation or withdrawal of life support; and
- For major health care decisions, a formal power of attorney or living will is required.



This personal representative designation applies to the following UPMC entity/locations:

List all applicable entities: Somerset Health Services - UPMC Somerset Pain Management

REQUIRED INFORMATION:

Patient's Name:	Patient's Date of Birth:	Patient's Phone:
Patient's Address:		
Name of Patient's Personal Representative:		Personal Representative Phone:
Personal Representative Address:		Personal Representative Fax:
Any limitations on issues your personal representative may discuss? If yes, please specify:		Yes ____ No ____
Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at UPMC).		

REQUIRED SIGNATURES:

Personal Representative Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Please return this completed form by mail to: 126 East Church Street
Suite 2400
Somerset, PA 15501

or by fax to: 814-443-5499



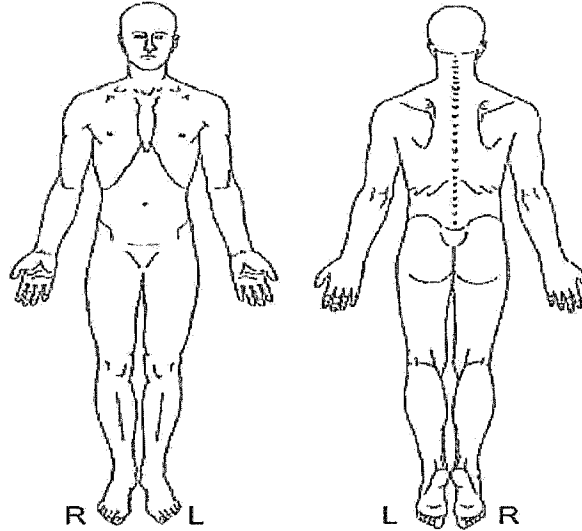
Name _____ DOB: _____ Today's Date: _____

NEW PATIENT QUESTIONNAIRE

PRIMARY AREA OF PAIN: _____

Does your pain radiate? No Yes, it radiates to _____

On the illustration below, please place an "X" on the primary area with arrows for radiation



How long ago did the pain start? More than 1 year More than 3 months Less than 3 months

Do you remember the date when your symptoms began?

No Yes it began on: _____

Was there a trauma or incident you can identify when your symptoms began?

No Yes it began when: _____

Since the pain started, how has it progressed? Improved Worsened Stayed the same

What do your symptoms feel like? Burning Stabbing Stinging Aching Shooting

What is your **CURRENT** pain level? (0—1—2—3—4—5—6—7—8—9—10)

(0= no pain, 10=pain so severe you can't even speak)

In the past 3 months have you had any of the following for your current symptoms?

Physical Therapy Chiropractic Care Exercises directed by your Physician

In the past year have you had any of the following obtained regarding your current symptoms?

X-Ray CT MRI EMG/NCV CT Myelogram

Name _____ DOB: _____ Today's Date: _____

PAST MEDICAL HISTORY (Select all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Von Willebrands's Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Factor V Lieden |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Pulmonary Embolism Spinabifida |
| <input type="checkbox"/> Myocardial Infarction (Heart Attack) | <input type="checkbox"/> DVT |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Thrombocytopenia (Low Platelets) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Other: _____ |

MEDICATION LIST

DRUG ALLERGIES

SURGICAL HISTORY

FAMILY HISTORY (Select all that apply)

Cancer Bleeding Disorder Rheumatological Disease Other: _____

SOCIAL HISTORY

Are you a smoker? NO YES

REVIEW OF SYSTEMS (Please select all that apply)

Constitutional: Chills Fever Weight Loss

Skin: Rash Ulcers Skin Color Changes

HEENT: Ringing in Ears Blurred Vision Double Vision

CV: Chest Pain Palpitations Leg Swelling

MSK: Muscle Pain Joint Pain Falls

GU: Heartburn Diarrhea Constipation

GI: Incontinence Urgency Frequency

Resp: Wheezing Cough Shortness of Breath

Endocrine: Cold Intolerance Heat Intolerance
 Excessive Thirst

Hematology: Swollen Nodes Abnormal
Bleeding Increased Bleeding

Neuro: Seizures Dizziness Lightheadedness

Psychiatric: Memory Loss Depression Sleep Problems

Before Your Visit

Use Pre-Registration to:



Electronically sign documents



Verify insurance information



Complete questionnaires



Make a copy

Have a MyUPMC account? Use the MyUPMC app to let us know you're here by clicking "I've Arrived."

Download the MyUPMC app to manage your health care all in one place.

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LIFE CHANGING MEDICINE

Get Ready For Your Appointment

- 1 Check your email or text messages
- 2 Pre-register for your visit at home **before** your appointment
- 3 Enjoy a faster check-in experience!



Didn't receive an email or text to pre-register?

Make sure your contact information is up-to-date in MyUPMC or contact the office.

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