TuftsMedicine
Lowell General Hospital

Pain Management Center
2 Hospital Drive, 2nd Floor
Lowell, MA 1852
T **978.937.6460**
lowellgeneralhospital.org

Dear New Patient:

Welcome to the Lowell General Hospital-Pain Management Center. Please take time to review and complete the enclosed paperwork prior to your upcoming appointment. Accurate information on these forms is extremely important, so please take the time to complete **ALL** sections**. Incomplete information may require us to RESCHEDULE your initial appointment.**

It is important for you to call our **Pre-Registration Department** before your upcoming Pain Management Center appointment. **You may reach Pre-Registration at 978-937-6429**. Please have your insurance card, auto accident or workman's compensation information ready before calling*. If this is a result of an automobile accident or workman's comp injury, the registration department will ask for the date of injury, insurance company's phone and fax numbers, claim number and adjuster's name*.

Please remember, if your health insurance requires an **insurance referral** to the see the specialists at Lowell General Hospital Pain Center, this must be generated by your Primary Care physician and be in place prior to your appointment.

All co-payments are due at the time of service.

Finally, we ask that you **arrive 30 minutes earlier than your appointment time** so that we may have time to process this paperwork.

For more information about our Pain Management services please visit our website www.lowellgeneral.org/paincenter

We look forward to assisting you with your healthcare needs.

Sincerely,

The Pain Management Center Staff

TuftsMedicine
Lowell General Hospital

Pain Management Questionnaire

Name:_____ Date:_____

My PRIMARY pain complaint is (choose only ONE):

☐ Neck pain	☐ Headache	☐ Left arm pain
☐ Mid-back pain	☐ Facial pain	☐ Right arm pain
☐ Low back pain	☐ Chest wall pain	☐ Left leg pain
☐ Buttock pain	☐ Abdominal pain	☐ Right leg pain
☐ Tailbone pain	☐ Groin pain	☐ Other: _____

Additional pain areas:

When did the pain start?

What makes the pain better?

What makes the pain worse?

What does the pain feel like?

☐Intermittent ☐Constant ☐Aching ☐Burning ☐Numb ☐Sharp ☐Shooting ☐_____

Any other symptoms (choose ALL that apply):

☐ Numbness	☐ Weight loss	☐ Constipation	☐ Depression
☐ Tingling	☐ Fever	☐ Muscle spasm	☐ Anxiety/PTSD
☐ Weakness	☐ Rash	☐ Urinary incontinence	☐ _____

Past treatments/therapies:	Dates	Helpful?
☐ Physical/aquatic therapy	_____	Yes / No
☐ Injections	_____	Yes / No
☐ Surgery	_____	Yes / No
☐ Chiropractor	_____	Yes / No
☐ Acupuncture or massage	_____	Yes / No
☐ Other _____	_____	Yes / No

Have you seen a pain or spine doctor? ☐ Yes ☐ No

Name: _____ Dates: _____ Treatments: _____

Name:_____ Dates: _____ Treatments: _____

Have you had any diagnostic tests for your pain? ***

☐ MRI/CT Date:_____ ☐ EMG Date: _____ ☐ X-ray Date_____ ☐Other:_____

	Dose	Dates of Use	Currently taking?	Helpful: Y or N
Tylenol and anti-Inflammatories:				
Acetaminophen (Tylenol)				
Ibuprofen (Advil)				
Celecoxib (Celebrex)				
Diclofenac (Voltaren/Zorvolex)				
Etodolac (Lodine)				
Meloxicam (Mobic/Vivlodex)				
Nabumetone (Relafen)				
Naprosyn (Naproxen/Aleve)				
Steroid (prednisone/Medrol pack)				
Neuropathic Pain Medications:				
Amitriptyline (Elavil)				
Duloxetine (Cymbalta)				
Milnacipran (Savella)				
Nortriptyline (Pamelor)				
Gabapentin (Neurontin)				
Pregabalin (Lyrica)				
Carbamazepine (Tegretol)				
Valproic Acid (Depakote)				
Sumatriptan/Rizatriptan (Imitrex/Maxalt)				
Topiramate (Topamax)				
Muscle Relaxants:				
Baclofen (Lioresal)				
Carisoprodol (Soma)				
Cyclobenzaprine (Flexeril)				
Metaxalone (Skelaxin)				
Methocarbamol (Robaxin)				
Tizanidine (Zanaflex)				
Opioids:				
Buprenorphine (Belbuca/Butrans/Suboxone)				
Hydrocodone (Norco/Vicodin/Hysingla)				
Hydromorphone (Dilaudid)				
Methadone				
Morphine				
Morphine ER (MS Contin/Kadian)				
Oxycodone				
Oxycodone ER (OxyContin/Xtampza)				
Tapentadol (Nucynta)				
Tylenol with Codeine				
Tramadol (Ultram)				
Other:				

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Insurance Form

PATIENT NAME:_____
(FIRST (M.I.) (LAST)

DATE OF BIRTH _____/_____/_____ PHONE NUMBER_____

Please sign the following statement:

I certify that this visit is not an active work-related injury, an auto accident or a pending lawsuit: I am aware my health insurance will be billed.

***Signature*:** _____

TO BE COMPLETED *ONLY* IF THIS IS AN ACTIVE WORKERS COMPENSATION INJURY, AUTO CLAIM OR A LEGAL CASE

Is injury Work Related**? Y / N** Auto Accident**? Y /** N Lawsuit Pending**? Y/**N Currently Working**? Y / N**

We need the following information about your accident/injury in order to process a claim for services.

IF THIS FORM IS NOT COMPLETED -YOUR HEALTH CARE INSURANCE OR YOU WILL BE BILLED FOR ALL CHARGES.* *Without this information we won't know who to bill or where to send the bill

INSURANCE COMPANY:_____ DATE OF INJURY/ACCIDENT___/___/___
INSURANCE ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

INSURANCE TELEPHONE #_____FAX #_____
INSURED'S EMPLOYER:_____TEL #_____
EMPLOYER ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

CLAIM #_____GROUP NAME/NUMBER_____
(CANNOT PROCESS WITHOUT NUMBER

Proceed to page 2.

ATTORNEY NAME:_____**TELEPHONE NUMBER**_____

ADDRESS_____
(STREET) (CITY) (STATE) (ZIP)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: ***PLEASE COMPLETE***

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN THE PLACE OF THE ORIGINAL. I HEREBY AUTHORIZE BENJAMIN HENKLE M D LLC & LOWELL GENERAL HOSPITAL TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIS/HER ORDER, I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO BENJAMIN HENKLE M D LLC & LOWELL GENERAL HOSPITAL.
THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE:_____ SIGNATURE:_____
PATIENT, PARENT, OR GUARDIAN RELATIONSHIP