APC
Advanced Pain Consultants, PA

Kenneth H. Rogers, DO

Stephen S. Boyajian, DO

Date:

Dear Patient:

Welcome from the staff at Advanced Pain Consultants, P.A.

This will confirm your appointment with Dr. Rogers and Dr. Boyajian on _____ at _____, in our _____ office. In order for Dr. Rogers and Dr. Boyajian to perform a comprehensive assessment on this visit, we must have all information pertinent to your condition. **Please bring the actual films and written results of all diagnostic studies (MRI, CT Scans, etc), as well as any lab test results with you.** Please bring a written statement, signed by your doctor, requesting a "pain management consultation" and advising of their reason for this request. We develop an individualized plan of care for each of our patients which may consist of diagnostic testing, interventional care, consultations, and possibly medication. **Please be aware we do not always prescribe pain medication for every patient we see, especially on the first visit.**

Please complete the enclosed registration forms before you arrive, and bring with you at the time of your appointment. Also bring your health insurance cards, two forms of identification (driver's license and social security card) and all referral/pre-certification forms that may be required by your health insurance carrier. **All co-pays will be collected at the time of the office visit. Please be prepared to pay by cash, check made payable to "APC", or credit card (Visa, Mater Card or American Express).** If this is an Auto or Workman's Compensation claim, we will need your Auto or Workman's Compensation case number, as well as the name, address and telephone number of your claims representative. **For Auto and Workman's Compensation, we will require your health insurance information and referral or pre-certification forms, if applicable, in the event that your claim is rejected.**

We have enclosed directions to our office and we look forward to seeing you. If you have any questions, please call. If for any reason you are unable to keep your appointment, please notify our office at least 24 hours prior to the appointment. Your assistance will be appreciated.

Sincerely,

Advanced Pain Consultants, PA

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PAYMENT POLICY

TO OUR PATIENTS

Advanced Pain Consultants will make every effort to bill your insurance carrier for payment. However, we would appreciate your cooperation with the following:

1. All co-pays are due at the time of your visit. We accept cash, checks and credit cards.
2. Referrals must be presented before your visit – payment for services denied by insurance due to lack of referral will become the patent's responsibility and obligations **must be** satisfied before subsequent visits can be scheduled.
3. Those services denied by your insurance as **billable non-covered** are your responsibility.
4. We cannot carry your balance over an extended period of time, nor are we able to extend "credit" to our patients. All balances remaining after insurance payment are payable in full within **thirty days** of billing.
5. To insure the maximum use of our provider's time, and offer the best treatment for our patients, we charge $25 for "late cancellation (less than 24 hours) or no-show appointments.
6. There will be a $25 charge for all checks returned by the bank and for non-sufficient funds. After **two** incidents, the patient will be put on a **"cash only"** status.

We value you as a patient and will continue to act as your advocate in billing your insurance company and hope you will make every effort on your part to assist us in obtaining reimbursement.

Again thank you for your continued cooperation.

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DIRECTION TO THE VOORHEES OFFICE

OFFICE LOCATION : 326 N. ROUT 73, VOORHEES, NJ 08043

TELPHONE#: 856-489-9822

IF YOU ARE TRAVELING NORTH ON ROUTE 73 (FROM BERLIN AREA TOWARDS MARLTON) THE OFFICE WILL BE ON THE RIGHT, SHORTLY AFTER THE DINER AND DIRECTLY AFTER DELONG ELECTRIC.

IF YOU ARE TRAVELING SOUTH ON ROUT 73 (FROM MARLTON AREA TOWARDS BERLIN) THE OFFICE WILL BE ON THE LEFT. YOU WILL HAVE TO PASS THE OFFICE MAKE A U-TURN AT THE LIBERARY RESTAURANT AND TRAVEL BACK TOWARDS MARLTON AREA. THE OFFICE WILL BE ON THE RIGHT SHORTLY AFTER THE DINER AND DIRECTLY AFTER DELONG ELECTRIC.

GPS DIRECTIONS MAY NOT BE ACCURATE IF USING GPS DO NOT PUT NORTH JUST USE 73

PATIENT REGISTRATION

Patient Information (PLEASE PRINT CLEARLY)

First Name_____MI_____ Last _____

Address_____

Zip_____ City_____ State_____

Telephone( )_____Alternate Telephone( )_____Birthdate____/____/_____

Social Security No. _____Sex _____ Marital Status ___S___M___D___W___Separated

Employment Information (ARE YOU CURRENTLY WORKING? _____yes _____no)

Employer's Name_____

Address_____

Zip_____ City_____ State_____ Telephone ( )_____Ext_____

Referring Physician and Primary Care Information

Referring Physician: Last Name_____ First_____ Title_____

Address_____

City_____ State_____ Zip_____ Telephone ( )_____Ext_____

Primary Care Phys: Last Name_____ First_____ Title_____

Address_____

City_____ State_____ Zip_____ Telephone ( )_____Ext_____

Workman's Compensation /Auto Insurance Information

Is this condition related to:

Auto Accident? _____ yes _____no Workman's Compensation? _____yes _____no

Date of Injury or Auto Accident _____

Insurance Co. Name_____ Claim No. _____

Address_____

Zip_____ City_____ State_____ Telephone ( )_____Ext_____

Policy No. _____ Policy Holder's Name _____Birthdate____/____/____Soc. Sec. #_____

Case Manager's Name _____ Phone No. _____

Adjuster's Name _____ Phone No. _____

Attorney Information

Last Name_____ First_____ Title_____

Legal Practice Name_____

Address_____

City_____ State_____ Zip_____ Telephone ( )_____Ext_____

Health Insurance Information

Primary Insurance Name_____

Address_____

Zip_____ City_____ State_____ Telephone ( )_____Ext_____

Subscriber's Name _____ Birthdate____/____/____ Social Security No. _____

Relation to Patient_____ Policy No._____ Group No._____

Secondary Insurance Name_____

Address_____

Zip_____ City_____ State_____ Telephone ( )_____Ext_____

Subscriber's Name _____ Birthdate____/____/____ Social Security No. _____

Relation to Patient_____ Policy No._____ Group No._____

Prescription Information

Do you have a prescription plan? _____yes _____no Name of Plan _____

Name of Pharmacy _____ Telephone ( )_____

Address_____ City_____State_____Zip_____

AUTHORIZATION FOR THE RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize my insurance carrier to make payments directly to ADVANCED PAIN CONSULTANTS, P.A., for any provider services that they may furnish to me. I understand that I am responsible for all charges not paid by my insurance or not covered by assignment. This assignment will remain in effect until revoked by me in writing. I also authorize the release of all records required to act on this request.

I request that payment of authorized medical benefits be made either to me or on my behalf to ADVANCED PAIN CONSULTANTS, P.A. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____ _____

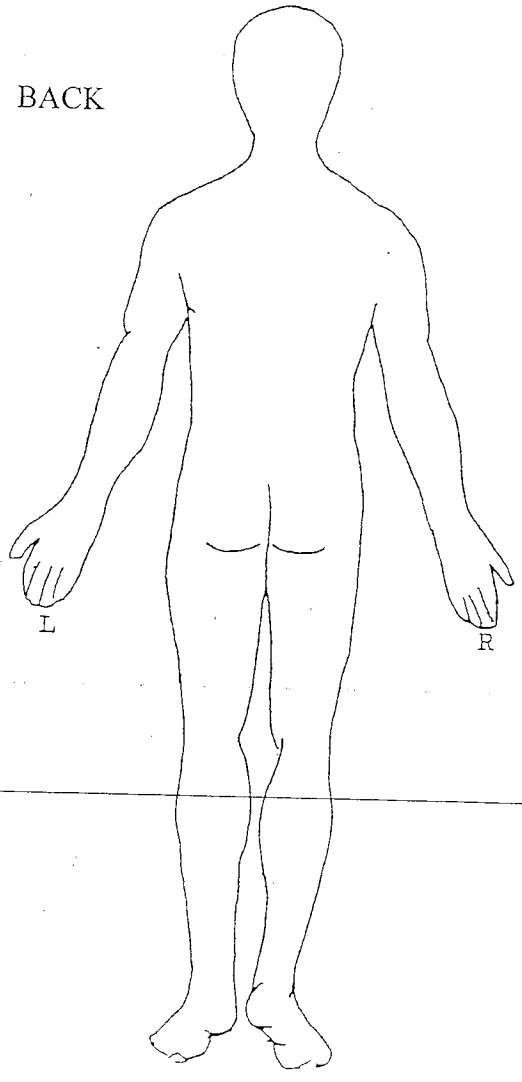
Signature of Patient or Authorized Person Date Relationship to Patient

Patient's Name _____ Date _____

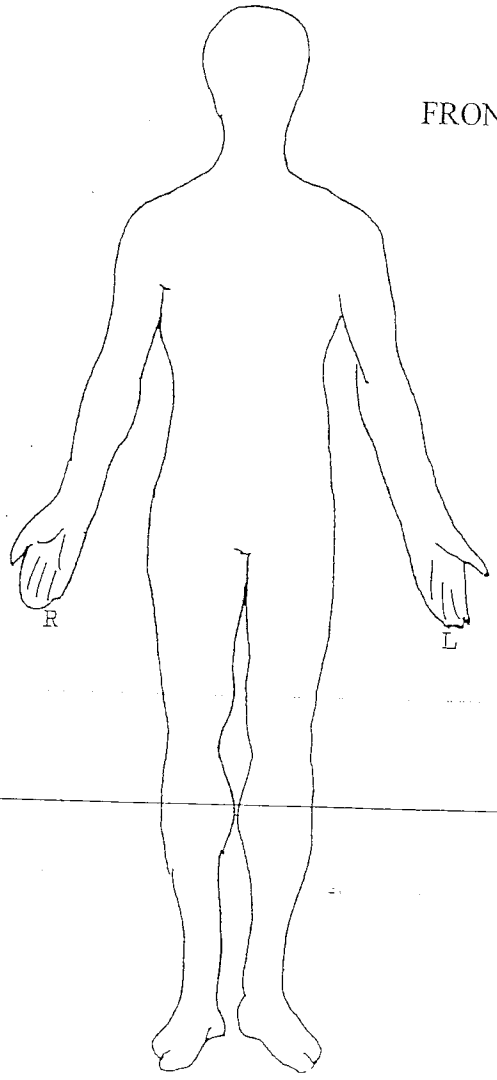
USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS.
INCLUDE ALL AFFECTED AREAS.
JUST TO COMPLETE THE PICTURE, PLEASE DRAW YOUR FACE.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
^^^^^^	==========	oooooooooooo	xxxxxxx	///////	.....

BACK



FRONT



Pain in arm(s) compared with neck _____worse _____same _____less
Pain in leg(s) compared with back _____worse _____same _____less

On the following line, indicate the intensity of your pain, overall:

No pain _____ Worst possible pain

Patient's Name _____ Date _____

HEALTH QUESTIONNAIRE FORM

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ CURRENT AGE: _____

NAME OF INDIVIDUAL COMPLETING THE HEALTH QUESTIONNAIRE FORM:

_____

PLEASE FILL OUT THIS QUESTIONNAIRE IN ITS ENTIRETY.
It will assist us in understanding the full impact that your pain condition has made upon your life, and help us in planning your recovery.

PAIN HISTORY:

Where are you experiencing your pain? _____

_____

When did your pain first appear? _____

_____

What makes your pain better? _____

_____

What makes your pain worse? _____

_____

Please describe the circumstances, if any, in which your pain began. (example: gradual onset, injury, accident, illness): _____

_____

List all of the physicians / clinicians and their specialties that have been involved in the treatment of your pain. List approximate dates of treatment (beginning to end) and check "yes" if you are still treating with them and "no" if you have discontinued treatment with them.

PHYSICIAN	SPECIALTY	PERIOD OF TREATMENT	CURRENTLY TREATING	
_____	_____	_____	( ) YES	( ) NO
_____	_____	_____	( ) YES	( ) NO
_____	_____	_____	( ) YES	( ) NO

Patient's Name _____ Date _____

HEALTH QUESTIONNAIRE FORM

Which statements describe your current employment situation? Circle all that apply.

Currently working	Student
On paid leave	Homemaker
On unpaid leave	Unemployed, unable to find work
Disabled and /or retired because of my pain problem	Unemployed due to pain problem
Disabled due to a health problem not related to my pain	Other – please specify: _____ _____

Are you already on or planning to apply for any of the following programs? (Place an "X" next to any that apply)

	Already on it	Applied for it	Planning to apply for it
SOCIAL SECURITY	_____	_____	_____
PRIVATE DISABILITY	_____	_____	_____
WORKER'S COMPENSATION	_____	_____	_____
OTHER: _____ (please specify)	_____	_____	_____

Do you think that the fault for your pain condition is: (circle all that apply)

Yours Your employer Co-Worker Another person Nobody

Have you hired a lawyer because of your pain condition?

_____ No, I have not hired a lawyer

_____ Yes, I have and the matter is in litigation

_____ Yes, I have and the matter has been settled.

Patient's Name _____ Date_____

HEALTH QUESTIONNAIRE FORM

If not working now, how long has it been since you stopped? (please specify in how many days, weeks, months or years)

_____

What is your primary occupation? If you are not working, what was your primary occupation? (please be as specific as possible)

_____

Is your current job the same one you had when your current pain symptoms started? Please circle the answer that applies:

Occupation:_____
_____

1. Yes, the exact same job
2. Yes, but my job was modified or the hours reduced because of my pain
3. No, I have changed jobs because of my pain
4. No, I have changed jobs but for reasons unrelated to my pain
5. Not working now

Have you ever used alcohol, marijuana or other substances? ( )YES ( )NO
If you ever used the above, please indicate the substance, the amount used and the frequency with which you used it:

_____
_____

Patient's Name _____ Date_____

HEALTH QUESTIONNAIRE FORM

Past Medical History

Hospitalizations/Surgery: (Please include all for illness, injury and/or surgery)

Reason	Date	Location
Reason	Date	Location
Reason	Date	Location
Reason	Date	Location
Reason	Date	Location

Patient's Name _____ **Date** _____

HEALTH QUESTIONNAIRE FORM

Family History

	Age	Alive? Yes	No	Major Illness/Cause of Death
Mother	_____	Y	N	_____
Father	_____	Y	N	_____
Maternal Grandmother	_____	Y	N	_____
Maternal Grandfather	_____	Y	N	_____
Paternal Grandmother	_____	Y	N	_____
Paternal Grandfather	_____	Y	N	_____
Sibling	_____	Y	N	_____
Sibling	_____	Y	N	_____
Children	_____	Y	N	_____
Children	_____	Y	N	_____

Has anyone in your family had...?

	Yes	No	Type?
Cancer	Y	N	_____
Heart Disease	Y	N	_____
Lung Disease	Y	N	_____
Liver Disease	Y	N	_____
Kidney Disease	Y	N	_____
Intestinal / Colon Disease	Y	N	_____
Skin / Connective Tissue Disease	Y	N	_____

Social History

Do you drink alcohol? Y (yes) – amount: _____ N (no)

Do you use tobacco? Y (yes) – amount: _____ N (no)

Are you single? married? widow(er)? divorced?

Do you live alone? live with significant others?

Do you currently see a psychologist, psychiatrist, or other mental health professional?
Y (yes) (Name)_____ N (no)

MEDICAL HISTORY (check answer(s) that apply) PATIENT NAME: _____

1. Constitutional Symptoms [ ] No Problems
   - [ ] weight loss _____lbs., period of time_____
   - [ ] weight gain_____lbs., period of time_____
   - [ ] recurrent fever
   - [ ] general weakness
   - [ ] fatigue
2. Skin [ ] No Problems
   - [ ] dry skin
   - [ ] recurrent rashes
   - [ ] eczema
   - [ ] itching
   - [ ] changes in skin color
   - [ ] changes in hair or nails
3. HEMATOLOGIC / LYMPHATIC [ ] No Problems
   - [ ] swollen glands
   - [ ] low blood count (anemia)
   - [ ] easy bruising
   - [ ] easy bleeding
   - [ ] slow to heal after cuts
   - [ ] history blood transfusion(s)
   - [ ] enlarged glands
   - [ ] phlebitis
   - [ ] HIV positive
   - [ ] on blood thinners
4. Head / Face [ ] No Problems
   - [ ] headaches
   - [ ] history head injury no residual problems
   - [ ] history head injury with residual problems of _____
   - [ ] facial pain
   - [ ] TMJ R L
   - [ ] Tic douloureux R L _____
5. Eyes [ ] No Problems
   - [ ] nearsighted
   - [ ] farsighted
   - [ ] wear glasses
   - [ ] wear contact lenses
   - [ ] cataracts at present time R L
   - [ ] conjunctivitis R L
   - [ ] glaucoma R L
   - [ ] double vision
   - [ ] blurred vision
6. Ear / Nose / Mouth

   Ears [ ] No problems
   - [ ] hard of hearing R L
   - [ ] hearing aids R L
   - [ ] frequent earaches R L
   - [ ] chronic ear discharge R L
   - [ ] vertigo
   - [ ] ringing in ears R L

   Nose / Sinuses [ ] No Problems
   - [ ] sinus discharge
   - [ ] nasal discharge
   - [ ] repeated nosebleeds
   - [ ] deviated nasal septum
   - [ ] chronic sinus problems
   - [ ] chronic stuffy nose
   - [ ] hay fever
   - [ ] nasal polyps

   Mouth / Throat [ ] No Problems
   - [ ] teeth ___loose ___none
   - [ ] dentures ___full ___partial
   - [ ] bleeding gums
   - [ ] dry mouth
   - [ ] sore throat
   - [ ] hoarseness
   - [ ] vocal cord polyps
   - [ ] trouble swallowing
7. Chest / Breasts [ ] No Problems
   - [ ] breast masses
   - [ ] breast surgery
   - [ ] chest surgery
   - [ ] other explain_____ _____
8. Respiratory [ ] No Problems
   - [ ] smoker_____pack(s)per day since_____
   - [ ] recurrent cough
   - [ ] chronic bronchitis
   - [ ] emphysema
   - [ ] chronic obstructive pulmonary disease
   - [ ] bronchial asthma
   - [ ] tuberculosis
   - [ ] wheezing
9. Cardiac / Peripheral – Vascular

   Cardiac [ ] No Problems
   - [ ] heart trouble
   - [ ] swelling of feet
   - [ ] high blood pressure
   - [ ] chest pain
   - [ ] heart attack
   - [ ] bypass surgery
   - [ ] angioplasty
   - [ ] mitral valve prolapse
   - [ ] heart murmur
   - [ ] valvular surgery
   - [ ] heart failure
   - [ ] shortness of breath with walking

   Peripheral – Vascular [ ] No Problems
   - [ ] poor circulation in arm R L
   - [ ] blood clots in arm R L
   - [ ] varicose veins R L
   - [ ] poor circulation in legs R L
   - [ ] blood clots in leg R L
   - [ ] vascular surgery _____
10. Hepatic-Biliary/Gastrointestinal/Abdominal
    - [ ] any liver disease
    - [ ] history hepatitis Active___ Inactive___
    - [ ] history jaundice due to liver disease

PATIENT NAME:_____

[ ] history jaundice due to gallbladder disease
[ ] gallbladder problems

Gastrointestinal [ ] No Problems
[ ] loss of appetite
[ ] abdominal pain
[ ] problems with gas
[ ] heartburn
[ ] recurrent nausea
[ ] recurrent diarrhea
[ ] recurrent constipation
[ ] ulcer
[ ] hiatal hernia
[ ] regurgitation
[ ] reflux
[ ] indigestion
[ ] history vomiting blood
[ ] blood in stools
[ ] loss of control of bowels

11. Urinary [ ] No Problems
[ ] frequent urination
[ ] difficulty with urination
[ ] burning on urination
[ ] inability to control urination
[ ] loss of control
[ ] blood in urine
[ ] kidney stones

12. Genital / Reproductive

Male [ ] No Problems
[ ] discharge
[ ] pain in testicles
[ ] lumps in testicles
[ ] hydrocele
[ ] sexually transmitted disease(s)
[ ] sexual dysfunction

Female [ ] No Problems
[ ] menstruation Regular___Irregular___
first day last menstrual peirod:___/___/___
[ ] premenstrual syndrome, since_____
[ ] recurrent vaginal discharge
[ ] number pregnancies_____miscarriages____
abortions____
[ ] Cesarean section(s),number_____
[ ] on hormones
[ ] history cancer of uterus – ovaries
[ ] sexual dysfunction
[ ] sexually transmitted disease(s)

13. Endocrine [ ] No Problems
[ ] Excessive thirst or urination
[ ] heat intolerance
[ ] cold intolerance
[ ] change in hat or glove size
[ ] thyroid trouble Underactive__ Overactive__
[ ] sugar diabetes- since _____
insulin dependent yes / no
[ ] disease of pituitary gland
[ ] disease of adrenal gland

14. Musculoskeletal [ ] No Problems
[ ] muscle cramps
[ ] stiff joints
[ ] swelling of joints
[ ] generalized arthritis
[ ] rheumatoid arthritis
[ ] fibromyalgia syndrome
[ ] osteoporosis
[ ] neck pain
[ ] upper back pain
[ ] low back pain
[ ] heel spurs
[ ] gout
[ ] difficulty with walking
[ ] cold upper extremities R L
[ ] cold lower extremities R L
[ ] pain in feet

15. Neurological / Psychiatric

Neurological [ ] No Problems
[ ] frequent or recurrent headaches
[ ] fainting
[ ] blackouts
[ ] stroke
[ ] dizzy spells
[ ] gait difficulties
[ ] seizures
[ ] epilepsy
[ ] tremors
[ ] neuropathy
[ ] weakness
[ ] paralysis

Psychiatric
[ ] problems with concentration
[ ] confusion
[ ] problems with thinking or thought process
[ ] problems with memory
[ ] depressed
[ ] anxious
[ ] shaky
[ ] agitated

16. Allergies / Immunologic

Allergies [ ] No Problems
[ ] drug allergies_____
_____
[ ] food allergies_____
_____
[ ] environmental allergies_____
_____

Immunologic [ ] No Problems
[ ] immunologic disorders_____
[ ] AIDS
[ ] lupus

HEALTH SURVEY

Patient Name:	**Date:**
Height: **Weight:**	**Sex:** **Male** **Female**
Home Phone:	**Date Of Birth:**
Work Phone:	**Procedure:**
Physician:	**Procedure Date:**

1. Are you currently taking any medication, supplements herbals or vitamins? Please List Below or Provide List

Medications	Dosages and Frequency

2. Do you have any ALLERGIES to medication	YES	NO	?
OR LATEX			
OR SHELLFISH (IODINE)			

Medication	Reaction

3. Do you take any of the following medications:			
a. Diuretics(Water Pills) or Potassium (KCL)			
b. Blood Thinner (except Aspirin)			
c. Aspirin, NSAIDS			
d.Antibiotics			
~~e.Insulin or Oral Hypoglycemics~~			
f. Digitalis (Digoxin, Lanoxin)			
g. Steriods (Prednisone, Cortisone)			

4. Have you ever had any of the following heart or related problems:			
a. Heart Disease (Blocked arteries)			
b. Blood Vessel Disease			
c. Heart Attack (MI)			
d. Valve Problems (Murmur)			
e. Irregular Heartbeat			
f. Heart Failure			
g. Angina (Chest Pain)			
h. High Blood Pressure			
5. Do you get short of breath when you lie flat			
6. Are you on oxygen all or part of the day			
7. Do you smoke			
a. If yes how much and how long			
8. Do you have any lung problems:			
a. Chronic cough or mucus(Chronic Bronchitis)			

PLACE AN "X" IN THE BOX THAT APPLIES	YES	NO	?
b. Emphysema			
c. Wheezing (Asthma)			
d. Short of breath with activity			
e. Lung Cancer			
f. Do you have sleep apnea			
g.Do you have a C-Pap Machine?			
9. Have you ever had any of the following medical problems:			
a. Recent Cancer			
b. Recent Chemo/Radiation			
c. Thyroid Problems			
d. Kidney Disease			
e. Liver Disease (Hepatitis)			
f. Bleeding Disease			
g. Anemia:			
h. Diabetes			
I. Recreational Drugs			
j. Uncontrolled Heartburn/Reflux			
k. Stroke			
l. Seizure			
m. Active Infections or Open Sores			
10. If you have answered "YES" to # 2-7			
a.Do any of these conditions limit activity?			
b.Any chest pressure with activity?			
c Do you see a Doctor for any of these problems?			
d. If Yes, date of last visit			
~~Doctor's Name:~~			
Doctor's Phone # ( )			
a. Any changes in your health since last visit			
11. Is there a possibility of pregnancy?			
a. Date of last menstrual period			
12. Have you ever had an operation on :			
a. Brain			
b. Heart			
c. Lungs			
d. Blood Vessels			
e. Intestines			
f. Kidneys			
g. Spine			
13. Have you had a problem with anesthesia other than nausea?			
14. Has any blood relative had problems had anesthesia other than nausea?			
15. If yes to # 12 or 13, what problem:			

PATIENT NAME:_____ DATE:_____

Have You Tried The Following For Your Pain?

Intervention	Duration of treatment (Please include dates if known)	% Response
☐ **NSAIDS:**		
☐ Aspirin	_____	_____
☐ Naproxen	_____	_____
☐ Ibuprofen	_____	_____
☐ Tylenol	_____	_____
☐ Mobic	_____	_____
☐ Celebrex	_____	_____
☐ Other:_____	_____	_____
☐ **Opioids:**		
☐ Percocet	_____	_____
☐ Vicodin	_____	_____
☐ Morphine	_____	_____
☐ Oxycodone	_____	_____
☐ Dilaudid	_____	_____
☐ Fentanyl	_____	_____
☐ Oxymorphone	_____	_____
☐ Tramadol	_____	_____
☐ Butrans Patch	_____	_____
☐ Other:_____	_____	_____
☐ **Neuropathic Pain Meds:**		
☐ Lyrica	_____	_____
☐ Cymbalta	_____	_____
☐ Gabapentin	_____	_____
☐ Savella	_____	_____
☐ Other:_____	_____	_____
☐ **Conservative Treatments:**		
☐ Physical Therapy	_____	_____
☐ Home Exercises	_____	_____
☐ Aqua Therapy	_____	_____
☐ Yoga	_____	_____
☐ Therapeutic Massage	_____	_____
☐ Chiropractic	_____	_____
☐ Acupuncture	_____	_____
☐ Other:_____	_____	_____

I affirm that I completed this form to the best of my knowledge and that it is an accurate representation of all therapies/interventions that I have tried to address my pain issues.

PATIENT SIGNATURE:_____ DATE:_____

APC
Advanced Pain Consultants, PA

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Stephen S. Boyajian, DO

New Patient Notification

Date _____

Dear _____,

The physician who referred you for a consultation with Dr. Boyajian and Dr. Rogers would like their opinion about the best way to diagnose and treat your chronic pain. **Please do not assume that they will use the same diagnostic methods or treatments that you have had in the past or are using currently. THERE IS NO GUARANTEE THAT YOU WILL RECEIVE ANY PRESCRIPTIONS AFTER YOUR CONSULATION IS COMPLETED. All medication decisions, diagnostic methods, and treatment decisions will be based on the opinions of Dr. Boyajian and Dr. Rogers, and not of your previous prescribing physician.**

Dr. Boyajian and Dr. Rogers have very advanced training and each physician has over twenty-five years of experience diagnosing and treating very challenging and complex patients with chronic pain. They strive to use their expertise and pain management science to help all of their patients.

By signing below, you are acknowledging your acceptance of our policies and terms.

_____ _____

Patient/Representative Signature **Date**