Edward T. Shin, M.D., D.A.B.P.M.
Comprehensive Pain Management
American Society of Anesthesiology/ American Board of Pain Medicine
Office) 972-781-0300 Fax) 214-200-9135

PATIENT INFORMATION

Personal Information

Patient Name_____ SSN_____-_____-_____ DOB_____

Address_____ City_____ St._____ Zip_____

Home #_____ Cell #_____ Email_____

Married? Y_____ N_____ If yes, please provide spouse's Name_____ DOB_____

Employment

Employer_____Occupation_____ Work Phone #_____

Address_____ City_____ St._____ Zip_____

Emergency Contacts

Name_____ Relationship_____ Contact #_____

Name_____ Relationship_____ Contact #_____

►Primary Care Physician_____ Office #_____

►Referring Physician_____ Office #_____

►List any other physicians: _____ Office # _____

►List any other physicians: _____ Office # _____

Insurance Information

►Primary Insurance_____ PPO HMO EPO MEDICARE

Policy #_____ Group#_____ Guarantor_____

►Secondary Insurance_____ PPO HMO EPO MEDICARE

Policy #_____ Group#_____ Guarantor_____

►Tertiary Insurance_____ PPO HMO EPO MEDICARE

Policy #_____ Group#_____ Guarantor_____

PHARMACY INFO: _____ Contact # _____

Address _____

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DATE OF EXAM_____

NAME _____

AGE _____

REFERRING DOCTOR: _____

1. Where is your pain?_____
2. When did it start? _____
3. Briefly describe the history of your pain_____

_____

_____

4. Where is the location of your pain? _____
5. When is the pain the worst? Morning Afternoon Night
6. Circle the best descriptions of your pain: Burning Aching Sharp Stabbing Shooting Throbbing
7. What activity makes the pain worse? Standing Sitting Walking Bending Lying down
8. What activity makes your pain better?_____
9. Grade your pain from 0 to 10 *(zero=no pain/10=worst pain ever)*: Usual pain_____ Pain w/ activity_____
10. Have you had any of these treatments: Physical therapy / Epidural steroid injections / Facet blocks / Trigger point injections
    Narcotic pump implant / Spinal cord stimulator implant / Botox injections / Chiropractic treatments
11. Is your case under Worker's Compensation? Y/ N If yes, date of injury is_____
12. Are you involved in any lawsuits concerning your case? Y / N
13. Please list all other physicians who are involved in your care_____

_____

Pain Clinic Page 2

Past Medical History: (Please circle)

Heart attack Stroke Diabetes Hypertension COPD Mitral valve prolapse Atrial fibrillation Seizures

Heart failure Emphysema Asthma Breast cancer Lung cancer Hepatitis Cirrhosis Pancreatitis Insomnia

Acid Reflux Gastric ulcers Crohn's disease Anxiety Depression Panic attacks Bipolar disorder Suicide attempt

Kidney disease Irritable bowel syndrome Liver disease Low thyroid High thyroid Osteoarthritis HIV Addiction

Rheumatoid arthritis Fibromyalgia Sleep Apnea Using Aspirin Using Coumadin Using Plavix Multiple sclerosis

Head injury Blood clots Lupus Ulcerative colitis Endometriosis Chronic fatigue syndrome TMJ Blood transfusions

Chronic back pain Chronic neck pain Scoliosis TB Peripheral neuropathy Restless leg syndrome Bleeding problems

Other:_____

Do you have allergies to steroids? Y/ N

Do you have allergies to anesthesia? Y/ N

Do you have any allergies to any medications? Y/ N **:** If yes, what are your allergies?

_____

_____

Please list all Major surgeries: **Date:**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

Name of Medications and their Doses: **Frequency:**

1._____ _____

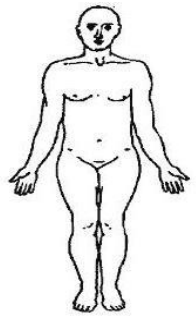
2._____ _____

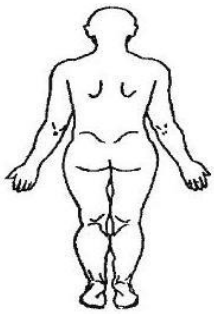
3._____ _____

4._____ _____

5._____ _____

6._____ _____





Pain Clinic Page 3

Have you had an MRI? Y/ N If yes, Date of last MRI_____

Have you had an EMG/NCV? Y/ N If yes, Date of last EMG?_____
(Muscle testing and nerve testing)

Have you had an EKG? (Cardiac tracing) Y/ N If yes, Date of last EKG_____

Previous Medications used: (Please circle)

Demerol Dilaudid Morphine Codeine MS Contin Kadian Avinza Methadone Percocet Percodan Talwin
Hydrocodone Tylenol#3 Tylox Ultram Ultracet Lortab Lorcet Vicodin Oxycontin Oxycodone Opana
Duragesic Patch Actiq Elavil Neurontin Lyrica Xanax Ativan Valium Flexeril Soma Zoloft Trazadone

Have you had any problems with over use or abuse with any of the prescription drugs as listed above? Y / N

Social History: (Please circle)

Married / Single/ Widowed?

Current or past Occupation_____

Do you collect social security disability or work related disability?_____

Do you Smoke? Y/ N If yes, how much do you smoke?_____

Do you drink alcohol? Y/ N Have you been through alcohol rehab? Y / N Have you been through Drug rehab? Y / N

Do Have you ever been convicted on DUI? Y / N

Do you have any history of current or past drug abuse? Y/ N

If yes, please list: _____

Family History: (Please circle)

Mother's medical history:

Living or Deceased

If deceased, cause of death_____

*Father's medical history***:**

Living or Deceased

If deceased, cause of death_____

Are there any family members with a history of alcoholism? Y/ N If yes, who_____

Are there any family members with a history of drug abuse? Y/ N If yes, who_____

Pain Clinic Page 4

Do you currently suffer from any of these problems? (Please circle)

1. General: frequent fever chronic insomnia chronic fatigue

2. Eyes and ears: double vision or blurred vision as a result of medication side effects?

3. Skin: easy bleeding get infections easily

4. Psychiatric: uncontrolled anxiety uncontrolled depression thoughts of suicide

5. Neurologic: new onset headache new onset dizziness confusion

6. Cardiovascular: new onset chest pain shortness of breath dizziness

7. Respiratory: new onset cough problems breathing

8. Gastrointestinal: new onset abdominal pain chronic constipation chronic diarrhea

9. Genitourinary: new bladder control problems new bowel control problems

10. Musculoskeletal: new onset muscle pain new onset joint pain

11. Endocrine: unexpected weight loss unexpected weight gain

Important patient information:

Please do not drive while taking any prescription medications

Please do not drink alcohol while taking your medications.

Please bring your bottle of pain medications with you if you need refills. We will perform random pill counts.

We perform random urine screens. If you are positive for illegal drugs, including marijuana, we may not be able to provide any prescriptions. As per pain management protocol, random urine screens will be done according to risk stratification.

If you have been treated at a previous pain clinic and are already taking pain medications, we may not be able to refill your medications.

For patients receiving injection treatments:
The risk of injury while undergoing any type of injection therapy is very low. Many safeguards are used to maximize our chance of success. Possible side effects of steroid injections are swelling, weight gain, feeling feverish, irritability, anger, anxiety, depression, insomnia, hyperglycemia, increased appetite, allergic reactions, and pituitary dysfunction. Patients with diabetes must monitor for possible large rises in serum glucose. Patients with psychiatric conditions must monitor for worsening anxiety or depression. Possible complications of injection treatments include bleeding, infection, nerve injury, paralysis, pneumothorax, meningitis, weakness, numbness, worsening of the pain and possible death

Patient's Signature_____

I give my permission to text messages with the office staff and the physician:

Patient's Signature_____

EDWARD T. SHIN, MD
PAIN MANAGEMENT CLINIC

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PHYSICIAN DISCLOSURE

The purpose of this Disclosure is to notify you, the patient, that your attending physician may receive remuneration in connection with referring you to various facilities. Some of these facilities may be:

List of Facilities:
Ambulatory Surgical Institute of Dallas
Baylor Scott & White Surgicare of Plano
West Plano Anesthesia

I acknowledge that my attending physician has disclosed to me that he may receive, directly or indirectly, remuneration for the referral. I understand that I, the patient, have the right to choose the providers of my health care services and/or products.

You are free to choose these facilities or any other facility for treatment or testing services required, without penalty, subject to any limitations of your health insurance plan. Please let us know if you would like to be referred to any other facility.

Signature: _____

Patient Name: _____

Date: _____

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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

4th Edition: Developed by the Texas Pain Society, August 2017 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug (s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:
_____To the best of my knowledge **I am NOT pregnant.**
_____If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.
_____**If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heaving equipment or a moto vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

_____I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my physician each time a prescription is written.

_____My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the **medication(s) may be discontinued**.

_____I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.

_____I will use the medication(s) **exactly as directed by my physician**.

_____I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.

_____I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.

_____All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.

_____My pain management physician will manage the chronic pain symptoms. All other health related issues must be managed by my primary care physician.

_____I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**

_____Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.

_____I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

_____If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).

_____I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

_____I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.

_____I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

_____I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my pain physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

_____I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

_____I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

_____I understand many prescription medication for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.

I certify and agree to the following:

_____1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

_____2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

_____3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

_____4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____5) If I become a patient in this clinic and receive controlled substances to control my pain, this pain management agreement supersedes any other agreement that I may have signed in the past.

_____

Name and contact information for pharmacy

_____ _____

Patient Signature

Physician Signature
(or Appropriately Authorized Assistant)

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Consent for the Use and Disclosures of Protected Health Information ("PHI")

I, the undersigned patient, give my consent to the provider entity, Edward Shin, M.D., P.A., and its agents to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care personnel including, but not limited to, physicians, certified registered nurses anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physicians assistants, child life specialists, physical therapists, respiratory therapists, X-ray personnel, audiologists, students in each of the above disciplines, and other such entities or persons as deemed related to treatment, payment, and health care operations, as determined in sole discretion of the provider, his/her/practice group, and their respective agents.

Permission to Release Medical Records or Providers

If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical records maintained by the provider to those other providers.

Permission to Call and Leave Voice Messages

I agree that the provider, Edward Shin M.D., P.A, or its agents or representatives may call and leave a voice mail message at my home or other numbers I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.

Permission to Discuss Protected Health Information with Third Persons

I agree that the provider, Edward Shin M.D., P.A., may discuss my PHI with any person that accompanies me to a visit or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the provider may discuss my PHI with any persons that identifies him or herself as active in my mental, physical, emotional, spiritual care, including but not limited family, friends, clergy, and patient advocates. I also agree that the provider, his/her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

Permission to Discuss Protected Health Information Regarding Minors

I agree that the provider, Edward Shin M.D., P.A, his/her practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and step parents. I acknowledge that state may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

Person(s) or Organization(s) NOT authorized to receive this information:

_____

_____

Notice to the Patient

By signing this form, you grant us consent to use and disclose your protected healthcare information for the purpose of treatment, various activities associated with payment and healthcare operations. If there is not a copy of the Notice with this form, please ask for one. By signing this form, you understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations. We reserve the right to change our privacy practices. Since revisions may apply to your healthcare information, you have a right to receive a copy and can do so by contacting our office. You have the right to revoke your consent by giving a written notice to our office. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent we may decline to treat you. Upon request, you are entitled to a copy of this consent form after you have signed it

_____ _____

Patient's Signature Date

_____ _____

Patient's Name or Patient's Representative Relationship to Patient