

LISE WILTSE

ASMG

PHONE: 888 722 6246 | FAX: 858.244.0152

PATIENT REGISTRATION

We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name		Today's Date	
Date of Birth	Age	Sex	
Parent's Name (if patient is a minor)			
Patient's Social Security Number		Marital Status	
Home Address	City	State	Zip
Mailing Address (if different than home address)	City	State	Zip
Home Phone Number	Work Phone Number	Cell Phone Number	
Occupation	Employer's Name		
Employer's Address	City	State	Zip
Spouse's Name	Spouse's Employer		
Primary Physician's Name			

NOTIFY IN CASE OF EMERGENCY

Name		Relationship	
Address	City	State	Zip
Home Phone Number	Work Phone Number	Cell Phone Number	
Nearest Relative (not living with you)			
Home Phone Number	Work Phone Number	Cell Phone Number	

Patient Name _____

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FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Name	Telephone		
Address	City	State	Zip
Insurance Company	Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN	
Insurance ID Number			
Secondary Insurance Company	Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN	
Were You Injured on the Job? YES NO	Have you Informed Your Employer? YES NO N/A	Date of Original Injury	
Worker's Compensation Carrier Name	Address		

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to ANESTHESIA SERVICE MEDICAL GROUP. I understand that I am financially responsible for any balance. I authorize the release of any information required to process my claims.

Patient Signature	Date
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Patient Name _____

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Referring Physician
Reason for Referral
Diagnosis
When did your pain start? What was the date of your injury?
If you were injured, please describe the injury
Name of Employer (if injury is work related)
Are you involved in litigation? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, attorney's name & address
If your pain is due to an accident at work A. Are you still working? <input type="checkbox"/> YES <input type="checkbox"/> NO B. If you are still working, are your activities or hours restricted because of pain? <input type="checkbox"/> YES <input type="checkbox"/> NO C. Are you receiving disability benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever had nerve blocks or injections to relieve the pain? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, did they relieve the pain? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, how long did the pain last?
What type of injection did you have?
Have you used any of the following to relieve the pain? <input type="checkbox"/> Acupuncture <input type="checkbox"/> Bedrest <input type="checkbox"/> Trigger point injections <input type="checkbox"/> Psychotherapy <input type="checkbox"/> Chiropractor <input type="checkbox"/> Steroid injections <input type="checkbox"/> TENS Unit <input type="checkbox"/> DET, other disc procedures <input type="checkbox"/> Biofeedback/relaxation training <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Message <input type="checkbox"/> Other (describe): _____
Studies

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Please circle all diagnostic tests for your pain.

Tests	Of what body part?	Results (+/-)	Date	Location	Requesting Physician
MRI Scan					
CT Scan					
X-ray					
Bone Scan					
Thermography					
EMG/NCS					

Patient Name _____

Indicate which drugs you have used in the past for relief of your pain.

Anti-epileptics :

- Depakote
- Neurontin
- Topamax
- Tegretol
- Dilantin
- Lyrica

Muscle Relaxants:

- Flexeril
- Robaxin
- Valium
- Soma
- Baclofen

Stimulants:

- Dexedrine
- Ritalin
- Provigil

Stimulants:

- Dexedrine
- Ritalin
- Provigil

Anti-anxiety:

- Ativan (Lorazepam)
- Xanax

Opioids:

- Morphine
- MS Contin
- Roxanol
- Duragesic (Fentanyl)
- Actiq
- Levo-Dromoran
- Methadone
- Percodan
- Percocet
- Codeine
- Vicodin (Hydrocodone)
- Norco
- Dilaudid
- Oxycodone (OxyFast)
- Demerol
- Darvocet/Darvocet-N
- Darvon
- Lort

Anti-migraine:

- Inderal
- Fiofinal
- Carefgot/Ergotamines
- Imitrex

Other:

- _____
- _____

Non-Steroidal Anti-inflammatories:

- Aspirin
- Lodine
- Motrin (Ibuprofen)
- Feldene
- Vioxx
- Toradol
- Orudis
- Bextra
- Naprosyn
- Celebrex
- Relafen
- Indocin

Anti-hypertensive:

- Clonidine (Catapres)

Non-opioids:

- Tylenol

Antidepressants:

- Nortriptyline Trazadone
- Elavil (Amitriptyline)
- Cymbalta
- Zoloft Effexor
- Paxil Remeron

List all **pain** medications you are currently taking:

Medicine	Dose (amount)	Times each day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name _____

List all **other** medications you are currently taking:

Medicine	Dose (amount)	Times each day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all **medication** allergies:

Describe the pain:

Is there a **constant** (continuous, non-stop, all of the time) component to your pain? If yes, indicate any words that best describe your pain.

- | | | | |
|---------------------------------------|------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Pulsing | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Hot |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tender | <input type="checkbox"/> Tiring | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Pounding | <input type="checkbox"/> Taut | <input type="checkbox"/> Cold | <input type="checkbox"/> Scalding |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tight | <input type="checkbox"/> Sharp | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Sore | <input type="checkbox"/> Numb | <input type="checkbox"/> Pinching | <input type="checkbox"/> Itchy |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Gnawing | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Tearing | <input type="checkbox"/> Cramping | <input type="checkbox"/> Intense |
| <input type="checkbox"/> Penetrating | <input type="checkbox"/> Pricking | <input type="checkbox"/> Pulling | <input type="checkbox"/> Unbearable |
| <input type="checkbox"/> Other: _____ | | | |

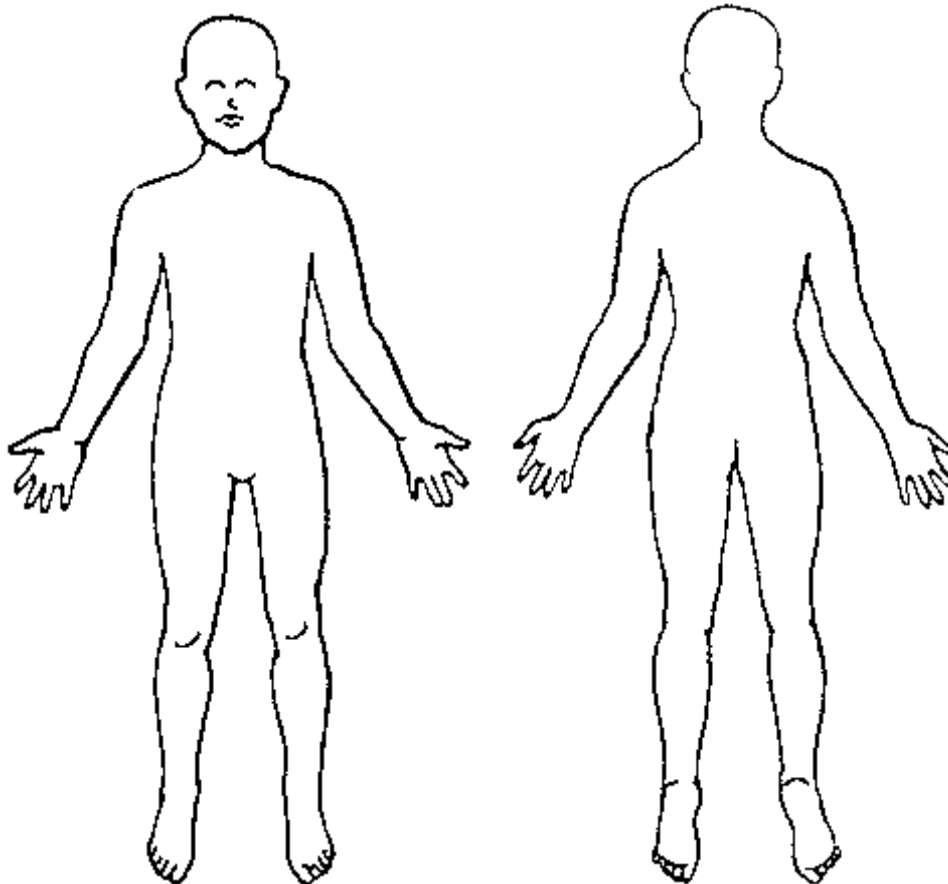
Patient Name _____

Is there an **intermittent** (occasional, periodic, at intervals) component to your pain? If yes, indicate any words that best describe your pain.

- | | | | |
|---------------------------------------|------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Pulsing | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Hot |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Tender | <input type="checkbox"/> Tiring | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Pounding | <input type="checkbox"/> Taut | <input type="checkbox"/> Cold | <input type="checkbox"/> Scalding |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tight | <input type="checkbox"/> Sharp | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Sore | <input type="checkbox"/> Numb | <input type="checkbox"/> Pinching | <input type="checkbox"/> Itchy |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Gnawing | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Tearing | <input type="checkbox"/> Cramping | <input type="checkbox"/> Intense |
| <input type="checkbox"/> Penetrating | <input type="checkbox"/> Pricking | <input type="checkbox"/> Pulling | <input type="checkbox"/> Unbearable |
| <input type="checkbox"/> Other: _____ | | | |

Location:

Please mark on the drawings below with a "C" the areas where you feel constant pain and with a "T" the areas you feel intermittent pain.



Patient Name _____

This section has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer *every* section and mark in each section only the one box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please mark the box which closely describes your problem.

1. Pain Intensity

- I can tolerate the pain I have without having to use pain killers.
- The pain is bad but I manage without having to take pain killers.
- Pain killers give complete relief from pain.
- Pain killers give moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on the pain and I do not use them.

2. Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

3. Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights of the floor, but I can manage if they are conveniently positioned, eg on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

4. Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile. I can only walk using a cane or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Patient Name _____

5. Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.

6. Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 30 min.
- Pain prevents me from standing for more than 10 min.
- Pain prevents me from standing at all.

7. Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using tablets.
- Even when I take tablets I have less than 6 hrs sleep.
- Even when I take tablets I have less than 4 hrs sleep.
- Even when I take tablets I have less than 2 hrs sleep.
- Pain prevents me from sleeping at all.

8. Sex Life

- My sex life is normal but it causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

9. Social Life

- My social life is normal and gives me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, eg dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- I have no social life because of pain.

10. Traveling

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I manage journeys over two hours.
- Pain restricts me to journeys under thirty minutes.
- Pain prevents me from traveling except to the doctor or hospital.

What makes the pain better? _____

What makes the pain worse? _____

Numbness or tingling?

Yes No If yes, describe: _____

Weakness?

Yes No If yes, describe: _____

Bowel or bladder problems?

Yes No If yes, describe: _____

How severe is your pain?



Has the pain affected your:

Mood Yes No If yes, describe: _____

Sleep Yes No If yes, describe: _____

Appetite Yes No If yes, describe: _____

Social Life Yes No If yes, describe: _____

Work Yes No If yes, describe: _____

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Habits (circle all that apply)

	Currently Use	Previously Used	How much?	How long?	When Stopped?
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Recreational/ Street Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Enter medical condition and ages for all family members

	Current Age (or age at death)	Current Medical Condition (or cause of death)
Father		
Mother		
Brother		
Sister		
Children		
Spouse/Partner		

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Have you been in a chemical dependency program?

Yes No

Have you ever been to a pain doctor or pain clinic?

Yes No If yes, please list: _____

Location: City _____ State _____

Have you ever been dismissed from a physician's office due to a disagreement over medications?

Yes No

Please list your exercise program by activity and frequency (EX: run, 20 minutes, 4 times/week)

Please list any hobbies. (EX: sewing, painting, gardening, carpentry, auto repair)

Current Physical Activity Level:

Little Moderate Very Active

Height: _____

Weight: _____

Patient Name _____

Past Medical History:

Have you ever had...

Yes	No	Condition	When?	Please Explain
		Heart Disease		
		Heart Murmur		
		Heart Attack		
		High Blood Pressure		
		Stroke		
		Palpitations		
		Chest Pain		
		Shortness of Breath		
		Asthma or Wheezing		
		Emphysema		
		Bronchitis		
		Tuberculosis		
		Hepatitis (Jaundice)		
		Kidney Disease		
		Sickle Cell Disease		
		Thyroid Disease		
		Diabetes Mellitus		
		Easy bruising/bleeding		
		Blood disorder		
		Glaucoma		
		Frequent headaches		
		Nerve Paralysis		
		Fainting Spells		
		Epilepsy (seizures)		
		Back Problems		
		Other Nervous System issues		
		Phlebitis		
		Drug Addiction		
		Complicated pregnancy		
		Smoking History		
		Gastrointestinal		
		Genitourinary		
		Other		

Patient Name _____

REVIEW OF SYSTEMS/ MEDICAL AND FAMILY HISTORY UPDATE

Required questions for insurance compliance

Do you have an advance directive?.....no yes Had a flu shot this year?.....no yes

Are you a victim of violence or abuse?.....no yes Had a pneumonia shot?.....no yes

Name of primary caregiver (for correspondence): _____

Have you or members of your family recently been hospitalized for any reason?.....no yes

Please indicate below. Are you currently experiencing any of these symptoms?

General, constitutional

Good general health lately.....no yes

Recent weight change.....no yes

Fever.....no yes

Fatigue.....no yes

Eyes and vision

Eye disease or injury.....no yes

Wear glasses or contact lenses.....no yes

Blurred or double vision.....no yes

Glaucoma.....no yes

Ears, nose, throat

Hearing Loss.....no yes

Ringing in the ears.....no yes

Earaches or drainage.....no yes

Sinus problems.....no yes

Nose bleeds.....no yes

Mouth Sores.....no yes

Bleeding gums.....no yes

Bad breath or bad taste.....no yes

Sore throat or voice change.....no yes

Swollen glands in neck.....no yes

Heart and cardiovascular

Heart trouble.....no yes

Chest pains.....no yes

Sudden heartbeat changes.....no yes

Swelling of feet, ankles, hands.....no yes

Respiratory

Frequent coughing.....no yes

Spitting up blood.....no yes

Shortness of breath.....no yes

Asthma or wheezing.....no yes

Gastrointestinal

Loss of appetite.....no yes

Change in bowel movements.....no yes

Nausea or vomiting.....no yes

Frequent diarrhea.....no yes

Painful bowel movements or constipation.....no yes

Blood in stool.....no yes

Stomach pain.....no yes

Genitourinary

Frequent urination.....no yes

Burning or painful urination.....no yes

Blood in urine.....no yes

Change in force or strain with urination.....no yes

Incontinence or dribbling.....no yes

Kidney stones.....no yes

Sexual difficulty.....no yes

Painful periods.....no yes

Irregular periods.....no yes

Vaginal discharge.....no yes

Musculoskeletal

Joint pain.....no yes

Joint stiffness or swelling.....no yes

Weakness of muscles/joints.....no yes

Muscle pain or cramps.....no yes

Back pain.....no yes

Cold extremities.....no yes

Difficulty in walking.....no yes

Skin and breasts

Rash or itching.....no yes

Change in skin color.....no yes

Change in hair or nails.....no yes

Varicose veins.....no yes

Breast pain.....no yes

Breast lump.....no yes

Breast discharge.....no yes

Neurological

Frequent or recurrent headaches.....no yes

Light headed or dizzy.....no yes

Convulsions or seizures.....no yes

Numbness or tingling sensations.....no yes

Tremors.....no yes

Paralysis.....no yes

Stroke.....no yes

Head injury.....no yes

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Psychiatric

Memory loss or confusion..... no yes
Nervousness..... no yes
Depression..... no yes
Sleep problems..... no yes

Endocrine

Glandular or hormone problem..... no yes
Thyroid disease..... no yes
Diabetes..... no yes
Excessive thirst or urination..... no yes
Heat or cold intolerance..... no yes
Dry skin..... no yes
Change in hat or glove size..... no yes

Hematologic/Lymphatic

Slow to heal after cuts..... no yes
Easily bruise or bleed..... no yes
Anemia..... no yes
Phlebitis..... no yes
Transfusion..... no yes
Swollen glands..... no yes

If you have not had a hysterectomy, please give the date of your last menstrual period _____

Patient signature _____

Physician signature _____

Patient Name _____

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Please list all surgeries and dates:

Have you had surgery specifically for your present pain?

Yes No

If yes, please list the operation, hospital, surgeon's name, date, and results:

Have you had any unusual reactions to anesthesia? If so, please describe:

Please list all hospitalizations and dates:

For your convenience, the area below can be used to write down any questions you might have for your doctor.

Patient Name _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name	Date of Birth
Previous Name	Social Security Number

I request and authorize _____
to release healthcare information of the patient named above to:

Name				
Address	City	State	Zip	

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates:

All healthcare information

Other:

Yes No *I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.*

Patient Signature	Date
-------------------	------

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Patient Name _____

NOTICE OF PRIVACY PRACTICES

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and laboratory results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis of planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third-party payers can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as accessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to view and or request a Notice of Privacy Practices that provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and; prior to implementation will post and make available, the revised notice at physical practice site(s). I also understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my healthcare operations; and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing; except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

I have read and understand the Notice of Privacy Practices.

Signature of Patient or Legal Representative	
Signature of Witness	
Date	Notice of Effective Date

Patient Name _____

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FORM COMPLETION FEES

Please refer to the following schedule of fees associated with completing forms on behalf of the patient. These fees cover the cost of processing and are payable in advance. Thank you.

Medical, Disability, and Insurance Forms: \$50 for the first 3 pages; \$5/page for each additional page

DMV Forms: \$20 per form

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CANCELATION POLICY

Please review our policy on cancellation of appointments and procedures.

Appointments require a 2 business day cancellation notice, or will incur a \$45 fee.

Procedures scheduled for 1-hour or less require a 2 business day cancellation notice, or will incur a \$100 fee.

Procedures scheduled for more than 1-hour (discograms, stimulators, narcotic pump placements) require a 3 business day cancellation notice, or will incur a \$200 fee.

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DISCLOSURE OF BENEFICIAL INTEREST

“California Business and Professions Code Section 654.2 requires your physician to notify you when your physician, or someone in his or her immediate family has a ‘significant beneficial interest,’ as that term is defined under section 654.2, in any organization to which your physician refers you for services.” We are providing this notice to inform you that Dr. Lise Wiltse has a significant beneficial interest in the Carlsbad Surgery Center. Please be advised that you may choose any organization for the purpose of obtaining the services ordered or requested by your physician, and a list of such organizations can be obtained by the San Diego County Medical Society.

Patient Name _____