PATIENT REGISTRATION INFORMATION

PHYSICIAN (Please circle): **Dr. Mohamed Tolba, MD**

REFERRING PHYSICIAN: _____

PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex**: ☐ Male ☐ Female

Name: _____

Address: _____ City, State, Zip: _____

Social Security # _____-_____-_____ Date of Birth :_____/_____/_____

Cell Phone: (____) _____ Home Phone: (____) _____

Email Address: _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

PHARMACY INFORMATION

Name: _____ City: _____

Name: _____ City: _____

EMERGENCY CONTACT

Name: _____ Phone: (____)_____

Relationship: _____

MARKETING

How did you hear about us? _____

EMPLOYER:

Name: _____ Number: _____

Assignment of Benefits/Financial Agreement

I hereby give **lifetime authorization** for payment of insurance benefits to be made directly to **Noydeen Medical Group** and any physician for services rendered. I understand that I am financially responsible for all charges, whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I further acknowledge, if I provide incorrect or missing insurance information, or if payment is denied due to missing Coordination of Benefits (COB), I acknowledge that I am fully responsible for all charges.

Signature: _____ Date: _____

HIPAA/PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that Noydeen Medical Group is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as applicable Arkansas state laws, to protect the privacy and security of my Protected Health Information (PHI). I understand that my PHI may be used and disclosed for treatment, payment, and healthcare operations as permitted by law, and that Arkansas law may provide additional protections for certain sensitive health information. I further understand that I have rights regarding my medical records, including the right to access, request amendments, request restrictions, request confidential communications, and file a complaint if I believe my privacy rights have been violated. I acknowledge that I have been offered or have received a copy of Noydeen Medical Group's Notice of Privacy Practices.

I also consent to Noydeen Medical Group's use of a virtual medical scribe for the purpose of documenting my medical visits. I understand that the virtual scribe is bound by HIPAA and confidentiality requirements, that my information will be safeguarded in accordance with HIPAA and Arkansas law, and that the virtual scribe's role is limited solely to medical documentation purposes.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OTHERS

I authorize Noydeen Medical Group to discuss and/or release my medical information to the following individual(s):

Please **PRINT** the name clearly:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

This authorization remains in effect unless revoked by me in writing.

Patient **Printed** Name: _____ Date: _____

Patient Signature: _____ Date of Birth: _____

Patient Representative: _____ Relationship: _____

This form complies with HIPAA and applicable Arkansas privacy laws.
For questions regarding privacy practices, please contact Noydeen Medical Group directly.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize Noydeen Medical Group to RELEASE /SEND my health information TO the following:

Name: _____

Address: _____

Phone: _____ Fax: _____

I authorize Noydeen Medical Group to OBTAIN/RECEIVE my health information FROM the following:

Name: _____

Address: _____

Phone: _____ Fax: _____

Description/Dates of information that may be USED/DISCLOSED:

Entire Record? Yes or No

Specified Dates: _____

Information will be used/disclosed for the following purpose: _____

_____

- I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations. The information described above may be re-disclosed and no longer protected by these regulations.
- I understand that Noydeen Medical Group will be paid for the costs of copying the information to be released.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information USED/DISCLOSED under this authorization.
- I understand that I may revoke this authorization in writing at any time by delivering a copy of the revocation to Noydeen Medical Group.

This authorization expires ninety (90) days from the date below:

Patient Name: _____ Date: _____

Date of Birth: _____ Phone: _____

Patient Representative: _____ Relationship: _____

CANCELLATION/NO-SHOW POLICY

CANCELLATIONS:

We value all our patients and strive to provide the best patient care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your medical needs, reserving a room and preparing your records. We kindly ask that if you must change an appointment, please give us a 24-hour notice. This courtesy makes it possible to give your reserved time to another patient who is needing to be seen. If you cannot give us a 24-hour notice, please call us as soon as possible to let us know that you cannot make it to the appointment. We know that your time is valuable and appreciate your cooperation with our policy.

NO-SHOW APPOINTMENTS:

A "NO-SHOW" is defined as missing an appointment without calling us to cancel. We understand that the occasional missed appointments can occur for a variety of reasons. When you do not come to your appointment, not only are you not being seen, but you are preventing another patient from being seen.

Our policy is as follows:

1st No-Show: We will send a letter and reach out to you by phone to get your appointment rescheduled.

2nd No-Show: We will send a letter, reach out to by phone and you will incur a $25 fee added to your chart. No discounts or refunds will be issued for these charges. Your payment will be due in addition to any copay's that you may have at your next visit.

3rd No-Show: After the 3rd no-show, we will send you a letter of dismissal from the practice. We will offer 30 days of emergent care only and will send your medical records to your new physician.

I have read and understand the above policies. Any questions that I have regarding this policy has been answered and copy provided to me.

_____ _____

Patient Signature Date Signed

_____ _____

PRINTED name of patient Date of Birth

PAIN MANAGEMENT QUESTIONAIRRE

Name: _____ Date: _____

Age: _____ Gender: _____ Height: _____ Weight: _____ lb

HAND DOMINANCE

☐ Right hand-dominant ☐ Left hand-dominant ☐ Ambidextrous (able to use both hands equally)

PLEASE INDICATE YOUR PAIN LOCATION:

☐ Low Back	☐ Headache	☐ Right Knee	☐ Chest Wall
☐ Neck	☐ Left Upper Extremity	☐ Left Shoulder	☐ Breast
☐ Mid Back	☐ Right Upper Extremity	☐ Right Shoulder	☐ Abdominal
☐ Buttock	☐ Left Lower Extremity	☐ Left Hip	☐ Pelvic
☐ Tailbone	☐ Right Lower Extremity	☐ Right Hip	☐ Vaginal ☐ Scrotal
☐ Groin	☐ Left Knee	☐ Facial	☐ Anal/Rectal

☐ Other pain location: _____

PAST MEDICAL HISTORY:

☐ High Blood pressure	☐ Anxiety /Depression	☐ Reflux
☐ Diabetes	☐ Thyroid	☐ COPD
☐ Stroke/Seizure	☐ Hepatitis	☐ Aneurysm
☐ Pacemaker/Defibrillator	☐ HIV or AIDS	☐ Kidney Disease
☐ Fibromyalgia	☐ Cancer	☐ Liver Disease
☐ Bleeding Disorder	☐ Ulcer	☐ Sleep Apnea
☐ Heart Attack	☐ Asthma	☐ Other _____

PAST SURGICAL HISTORY:

_____

_____

ONSET AND FREQUENCY OF PAIN:

How did the current pain episode begin? ☐ Gradually ☐ Abruptly

When did your pain first begin? Exact Date: _____ or approximately: _____ ☐ Months ☐ Years

What caused your pain? ☐ Surgery ☐ Fall ☐ Accident at work ☐ Car Accident ☐ Sports injury

☐ Normal Aging ☐ Unknown ☐ Other: _____

Since the pain started, how has it changed? ☐ Decreased ☐ Increased ☐ Unchanged

The frequency of my pain currently is:

☐ Constant and never changing ☐ Fluctuating but always present

☐ Fluctuating but usually present ☐ Fluctuating but rarely present

PAIN SEVERITY, LOCATION, DESCRIPTION & OTHER FACTORS THAT AFFECT YOUR PAIN:

How severe is your pain right now? _____ (0–10)

How severe is your worst pain when aggravated? _____ (0–10)

What is an acceptable pain score goal for you to perform your daily activities? _____ (0–10)

Which activities are you no longer able to do because of your pain but would like to be able to do again?

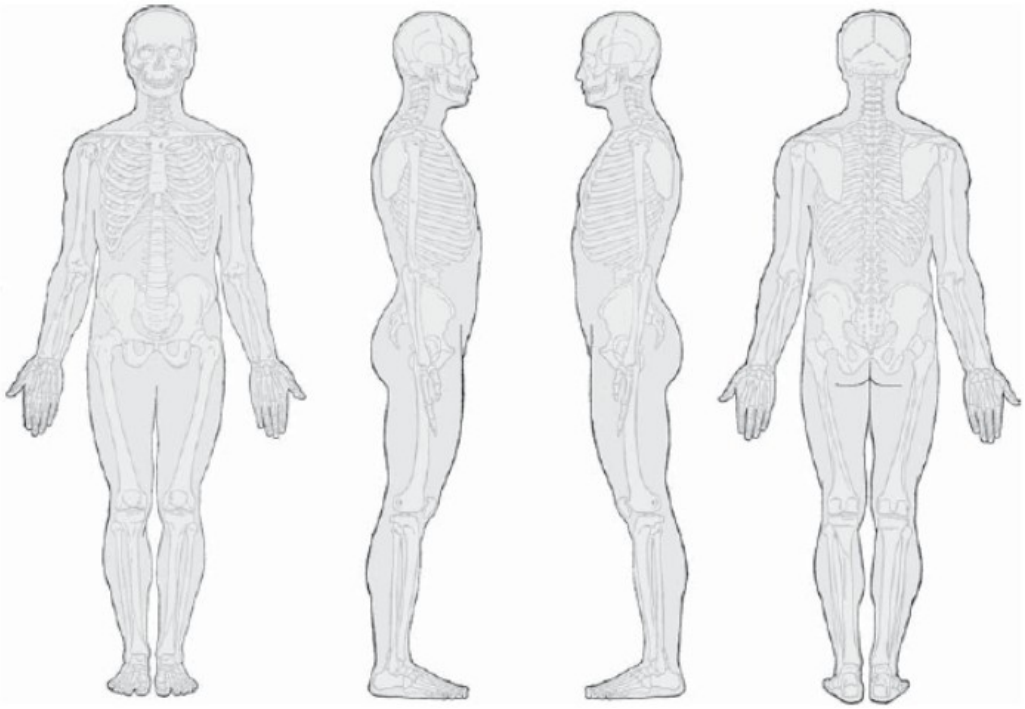
_____

_____

Please mark the areas on your body where you feel your pain. Draw arrows where the pain radiates.

Describe your pain using the following letters:

Aching = A
Burning = B
Cramping = C
Dull = D
Electrical = E
Gnawing = G
Muscle Spasm = M
Numbness = N
Pins/Needles = P
Pressure = R
Sharp = H
Stabbing = S
Throbbing = T



Please indicate if the following INCREASE or DECREASE your pain:

Factor	Increase	Decrease
Heat	☐	☐
Cold	☐	☐
Weather Changes	☐	☐
Standing	☐	☐
Walking	☐	☐
Exercise	☐	☐
Bending forward	☐	☐
Leaning back	☐	☐
Twisting at waist	☐	☐
Looking up	☐	☐
Looking down	☐	☐
Turning head	☐	☐
Lying flat on back	☐	☐
Lying on side (R/L)	☐	☐
Massage	☐	☐
Physical therapy	☐	☐
Bowel movement	☐	☐
Sneezing/Coughing	☐	☐
Stress	☐	☐
Medications	☐	☐

Do you have any other symptoms associated with your pain?

☐ Sweating
☐ Skin color changes
☐ Swelling
☐ Hair/nail growth changes
☐ Skin temperature changes
☐ Bowel or bladder changes
☐ Dizziness
☐ Headaches
☐ Blurred vision
☐ Other: _____

In the past 3 months have you developed any new symptoms?

☐ Balance problems
☐ Difficulty walking
☐ Bladder incontinence
☐ Bowel Incontinence
☐ Weakness; Where? _____
☐ Numbness; Where? _____
☐ Fine motor control problems (buttoning shirt, using a pencil, etc.)
☐ Falls/Near Falls; Date: _____
☐ Use of assistive devices: ☐ Cane ☐ Walker ☐ Other
☐ Other symptoms (please explain): _____

Have you had any other concerning symptoms unrelated to your pain?

☐ Yes ☐ No

If yes, please explain:

How much does your pain affect your functional abilities? (0 = Does not affect, 10 = Significant affect)

- Activities of daily living, such as hygiene & household chores: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
- Ability to function and interact well with family and friends: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
- Work in my usual occupation: *(☐ if not working):* ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
- Ability to sleep well: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

PREVIOUS PAIN MANAGEMENT PROVIDERS

Have you previously been under the care of a PAIN MANAGEMENT SPECIALIST? ☐ Yes ☐ No

If "Yes," please list up to the two most recent physicians you have seen:

Name	Address/City/State/Zip Code	Why are you no longer under the care of this physician?

CURRENT PAIN MEDICATIONS

Please list ALL CURRENT PAIN MEDICATIONS. Include all prescription and over-the-counter medications.

Medication Name	Dose (mg)	Frequency	Prescribing Provider	No Relief	Mild Relief	Moderate Relief	Excellent Relief
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

If you are currently taking pain medications, will the prescribing provider continue to prescribe these medications?

☐ Yes ☐ No ☐ I am currently not taking any pain medications.

CURRENT PAIN MEDICATION EFFECTIVENESS

Overall, do your pain medications provide PAIN RELIEF? ☐ Yes ☐ No ☐ N/A

If "Yes," how much? ☐ less than 50% ☐ More than 50%

Overall, do your pain medications IMPROVE YOUR FUNCTION? ☐ Yes ☐ No ☐ N/A

If "Yes," how much? ☐ less than 50% ☐ More than 50%

Overall, do your pain medications IMPROVE YOUR QUALITY OF LIFE? ☐ Yes ☐ No ☐ N/A

If "Yes," how much? ☐ less than 50% ☐ More than 50%

ARE YOUR PAIN MEDICATIONS CAUSE ANY SIDE EFFECTS? ☐ Yes ☐ No ☐ N/A

If yes, please note which side effects you are experiencing…

_____

_____

_____

PAIN AND RELATED MEDICATION HISTORY

Please list all the medications you used for pain in the past:

_____

_____

Please list all the medications you are currentlaly using for pain including Opioids ,NSAIDS,Muscle relaxers,Benzodiazepine and Sleeping Aids:

_____

_____

Have you had Physical therapy or Chiropractic therapy in the last year ? ☐ Yes ☐ No When _____

Do you have back Brace/TENS unit? ☐ Yes ☐ No

Have you had any recent MRI/CT scan done for your spine or joints? ☐ Yes ☐ No When _____

ANESTHESIA AND PAIN PROCEDURE HISTORY

Have you ever had any problems or adverse reaction to anesthesia? ☐ Yes ☐ No ☐ NA

If "Yes," which type of anesthesia? _____

What was the reaction? _____

Have you ever had an adverse reaction to the iodine contrast used during a pain procedure? ☐ Yes ☐ No

If "Yes," what was the reaction? _____

ALLERGIES

Do you have any drug allergies? ☐ Yes ☐ No

If "Yes," please list all drugs and the allergic reactions: _____

Drug/Medication	Allergic Reaction

SOCIAL HISTORY

Alcohol Use: ☐ Never ☐ Occasional ☐ Daily ☐ History of Alcoholism

Tobacco Use: ☐ Never ☐ Occasional ☐ Daily How many packs per week? _____

Illegal Drug Use: ☐ Never ☐ Occasional ☐ Daily ☐ History of Drug Use. What Drug? _____

Any problems with prescription medication misuse, abuse, addiction? ☐ Yes, currently ☐ Yes, in past ☐ No

If "Yes," which prescription medications? _____

What is your current work status? ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled (% disabled: _____)

Occupation (if employed): _____

If you are unemployed, employed part-time, or have work restrictions, is this due to your current pain condition? ☐ Yes ☐ No

Are you currently involved in litigation related to this pain? ☐ Yes ☐ No

If "Yes," attorney's name/phone number: _____

PAIN MANAGEMENT AGREEMENT

Patient Name: _____ DOB: _____

The purpose of this agreement is to prevent misunderstanding about certain medicines you will be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

I wish to enter a treatment agreement to prevent possible chemical dependency. I understand that if I break this agreement, my doctor will **stop** prescribing these pain control medicines. The doctor may terminate the patient physician relationship if I have made a misrepresentation or false statements concerning my pain or my compliance with this agreement or any other disagreement that my doctor may have with me.

Please initial by each statement…

_____ All new patients will submit to a urine substance screen.
_____ You may be subjected to random witnessed urine test.
_____ There will be random urine substance screens. I will submit if called upon for a random urine test within 24 hours of phone call.
_____ I will not share, sell, or trade my medication(s) with anyone.
_____ I will not attempt to obtain any controlled medicines, including opioid pain medicines, or controlled stimulants from any other doctor.
_____ I will take my medications as prescribed by my physician. There will be NO EARLY REFILLS.
_____ I will be responsible for making sure that I do not run out of my medications on weekends and Holidays. There will be NO after-hour coverage for medication refills.
_____ I agree NOT to mix opioid medication with the use of alcohol and understand the risks involved.
_____ I will keep my scheduled appointments unless I give a notice of cancellation 24 hours in advance.
_____ I will safeguard my pain medicine(s) from loss or theft. Lost or stolen medicines cannot and will not be replaced.
_____ Original containers of medication should be brought into each office visit.
_____ I fully understand the risks and benefits of the controlled medicines and will also discuss any interaction of my medications with the pharmacist.
_____ I will notify Noydeen Medical Group should I visit the ER for treatment of pain.
_____ I will be discharged from Noydeen Medical Group should I test positive for illicit drugs or prescription drugs not prescribed to me.

I agree to use _____pharmacy, located at:_____

and their phone number is:_____

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's board pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine(s). I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to authorizations.

Patient's Signature: _____ **Date:** _____