**Noor Gajraj, M.D., F.R.C.A., D.A.B.P.M.**
*Office 972 612 3800  Fax 972 612 3811*

**Patient Information**

Patient Name__________ SSN____-____-____ DOB__________

Address__________ City________ St.____ Zip________

Home #__________ Cell #__________ Pharmacy #__________

Email__________ Married? Yes (  )  No  (  )

**Patient Employment**

Employer__________ Occupation__________ Phone #__________

Address__________ City________ St.____ Zip________

**Emergency Contacts**

Name__________ Relationship__________ Contact #__________

▶ Referring Physician__________ Office #__________

▶ Primary Care Physician__________ Office #__________

**Insurance Information**

▶ Primary Insurance__________ PPO HMO EPO Other: __________

Policy #__________ Group#__________ Guarantor__________

Guarantor's Date of Birth:__________

▶ Secondary Insurance__________ PPO HMO EPO Other: __________

Policy #__________ Group#__________ Guarantor__________

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize all insurances, healthcare & other benefits, proceeds, and other monies payable to the Patient of for the Patient's benefit for services and/or supplies provided, including but not limited to liability settlements, group medical, indemnity, self-insured, ERISA, COBRA, personal injury protection, uninsured motorist, underinsured motorist, liability, automobile, and/or homeowner insurance benefits and coverage and I direct all such entities to make checks jointly payable to the beneficiary or covered person and to mail payment to the covered person in care of Noor Gajraj, M.D. and I authorize Noor Gajraj, M.D. to open such correspondence. I agree, as part of this consent for payment operations, that the provider, its group, and their billing personnel, billing agents, or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number

I understand that I am fully financially responsible for any and all charges incurred for the above named Patient by Noor Gajraj, M.D. I understand that I am responsible for all charges whether or not paid by insurance. I further acknowledge that I am responsible for any financial charges even if there is no recovery from person(s) responsible for the condition. This assignment authorizes but does not obligate Noor Gajraj, M.D. to file or prosecute suits or insurance claims or appeals.

**I have read the above and understand it. In exchange for and in consideration of treatment provided to the Patient, I agree to the above terms and conditions.**

Patient or Responsible Party Signature__________ Date__________

**Date:**___________________ **Name:**___________________________ **Age:** __________

1. What part of your body hurts? ___________________________________________________________________

2. For how long have you had pain?___________________________________________________________

3. Did the pain start with an injury? Yes ( ): No ( ) If yes, explain ________________________________________

4. Have you had any surgery for your pain condition? Yes ( ): No ( ) If yes, explain__________________________

_________________________________________________________________________________________

5. When is the pain the worst? Morning Afternoon Night

6. Is your pain constant ? Yes ( ) No ( )

7. Circle the best descriptions of your pain: Burning Aching Sharp Stabbing Shooting Throbbing

8. What activity makes the pain worse? Standing Sitting Walking Bending Lying down

9. What activity makes your pain better ? _______________________________________________________

10. Grade your pain from 0 to 10 *(zero= no pain / 10 = worst pain imaginable)*: _________________

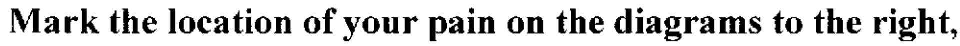
11. Have you had any of these treatments (circle): Physical therapy / Epidural steroid injections / Facet blocks / Trigger point injections, chiropractic treatments, other___________________________________

12. Are you involved in any lawsuits concerning your case? Y ( ) N ( )

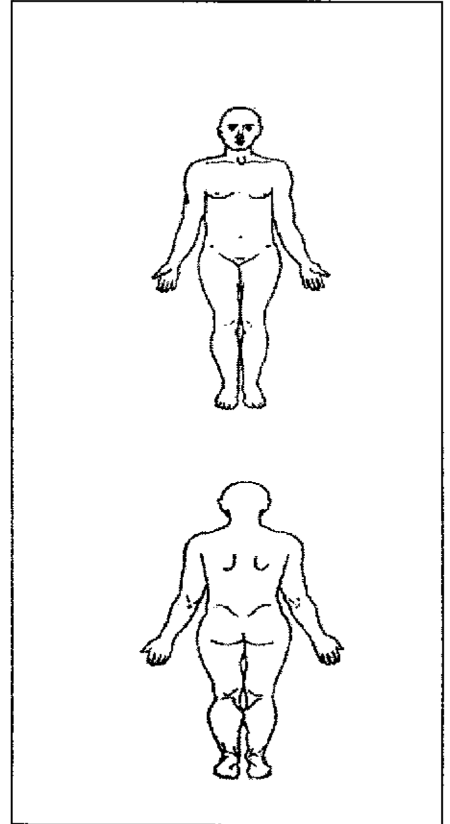
13. Have you ever had psychological/psychiatric counseling? Y ( ) N ( )

14. Please list all other physicians who are involved in your care_________________________________________

_________________________________________________________________________________________



**Mark the location of your pain on the diagrams to the right,**



**Please list all your medical conditions-CUURENT & PAST**

________________________________

________________________________

________________________________

________________________________

________________________________

**Do you have any allergies to any medications?** Yes ( ) No ( )

If yes, what are your allergies?________________________________

| **Please list all Major surgeries:** | **Date:** |
| --- | --- |
| 1.________________ | ________________ |
| 2.________________ | ________________ |
| 3.________________ | ________________ |
| 4.________________ | ________________ |
| 5.________________ | ________________ |

| **CURRENT Medications and their Doses:** | **Frequency:** |
| --- | --- |
| 1.________________ | ________________ |
| 2.________________ | ________________ |
| 3.________________ | ________________ |
| 4.________________ | ________________ |
| 5.________________ | ________________ |
| 6.________________ | ________________ |
| 7.________________ | ________________ |
| 8.________________ | ________________ |
| 9.________________ | ________________ |
| 10________________ | ________________ |

**Previous Medications used:** (Please circle)

Oxycontin, Morphine, Methadone, Fentanyl patch (Duragesic), Opana, Nucynta, Exalgo
Dilaudid, Percocet, Percodan, Hydrocodone, Tylenol # 3, Ultram, Ultracet, L, Vicodin Norco
Oxycodone, Suboxone, Butrans patch, Belbuca

Have you had any problems with over use or abuse with any prescription drugs as listed above? Y ( ) No ( )

**Social History:**

Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( )

Number of children________________

Are you currently employed? Yes ( ) No ( ) Occupation______________________________________

Do you collect social security disability or work related disability? Yes ( ) No ( )________________________

Do you Smoke? Yes ( ) N ( ) If yes, how much do you smoke?____________________________________

Do you drink alcohol? Yes ( ) N ( ) If yes how many drinks per ______day _____week or _______month

Have you been through drug or alcohol rehab? Yes ( ) No ( )

Have you experienced any childhood abuse Yes ( ) No ( )

Have you ever overused pain medications? Yes ( ) No ( )

Do you have ever taken any of the following? Yes ( ) No ( ) If yes then circle: Marijuana, Cocaine
Heroin, Methamphetamine, Amphetamines, PCP, Ectascy Crack

**Family History:**

*Mother's medical history:*

Living or Deceased

Age________________ If deceased, cause of death______________________________________________

List mother's medical
problems:_________________________________________________________________________

*Father's medical history:*

Living or Deceased

Age________________ If deceased, cause of death,

List father's medical
problems:_______________________________________________________________________

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

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

1. **General:** Weight loss Fever Chills Weakness Fatigue
2. **Eyes, Ears and throat:** Double vision Blurred vision Hearing loss
   Sneezing Runny nose Sore throat.
3. **Skin:** Rash Itching
4. **Psychiatric:** Anxiety Depression Thoughts of suicide Insomnia
   Restlessness/Agitation Hostility Attention Deficit
5. **Neurologic:** Headache Dizziness Tremors Vertigo Numbness
   Restless legs Amnesia, Change in bowel or bladder control
6. **Cardiovascular:** Chest pain Chest pressure Palpitations Swelling of legs
7. **Respiratory :** Cough Shortness of breath Wheeze
8. **Gastrointestinal:** Abdominal pain Constipation Diarrhea Nausea Vomiting
9. **Genitourinary:** Burning on urination
10. **Musculoskeletal:** Muscle pain Joint pain
11. **Hematological:** Anemia Bleeding Bruising
12. **Lymphatics:** Enlarged glands or nodes Spleen removed
13. **Endocrine:** Sweating Feeling too hot Feeling too cold Excessive urination
    Excessive thirst
14. **Allergies:** Allergies Asthma Hives Eczema

**Height**: ______________________ **Current Weight:** ______________________

# INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT: READ CAREFULLY

**TO THE PATIENT:** As a patient, you have the right to be informed about your condition and the recommended tests, procedures and prescribed medications. After understanding all relevant risks and benefits, you may make a careful and informed decision as to whether or not proceed with recommended treatments. 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 Dr. Gajraj and his assistants to treat my chronic pain condition. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for medications.

**I understand that narcotics are controlled and dangerous substances, which can be lethal, especially when mixed with alcohol or drugs that cause sedation. I am aware of increasing concern by regulating authorities regarding the use of narcotics for chronic pain, especially at high doses.**

I further understand that these medication(s) may lead to psychological or physical dependence, or addiction, and may cause side-effects which can be serious, **including death.** Alternative methods of treatment as well as possible risks and complications, have been explained to me. I understand that this list is not complete, and that it only describes the most common and relevant side effects.

**The specific medications that my physician plans to prescribe, will be documented separately from this document. Medications may be used in ways other than written in in the product label ("off-label"). This is a common and legal practice when medically necessary.**

I HAVE BEEN INFORMED AND UNDERSTAND that I will undergo medical tests and examinations before and during my treatment. Psychological evaluations may be deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment.

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 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 WITH USE OF NARCOTICS, 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, addiction, and even death.** I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The goal of treatment is to reduce pain and improve quality of life. I realize that my pain is unlikely to be eliminated. I realize that use of medication may be prolonged, but an appropriate treatment goal may be to use medication only short-term while other treatments, such as physical therapy, take effect. 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 discontinuations. I further understand that I will be provided medical supervision, if needed, when discontinuing medication use.

**I understand that use of narcotics is not the primary treatment in this clinic, and will only be prescribed when appropriate. Providers will not be pressured into prescribing narcotics or increasing doses.**

**I am aware of non-medication treatments** that have been shown to be helpful: **Injections,** Spinal Cord Stimulation, **Physical therapy**, **Weight loss**/healthy diet, supplements, Yoga, Pilates, Tai Chi, Heat, Ice, Chiropractic therapy, Acupuncture, TENS/Magnets, Pain Support Group/coping skills, Meditation, Prayer, Self-hypnosis, Relaxation exercises, Music-528 HZ, Laughter/intimacy, Aromatherapy, Massage, Reiki, Biofeedback, Pet therapy-Equine therapy, Adequate sleep, **Stopping smoking.**

**I understand that certain medications such and Xanax and Soma will not be prescribed.**

I understand that altering a prescription in any way, including the date, or prescription forgery is a second degree **felony**.

I understand that any display of hostility or disorderly conduct in the clinic will not be tolerated and will result in discharge.

I understand that any discussion of medications with other patients in the waiting room may lead to discharge from the clinic.

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. 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.

**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:**

- My progress will be periodically reviewed and, if the medication(s) are not improving my 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 medications exactly as directed by my physician-No Increases EVER** ! **Any unauthorized increase** in the dose of medication may result in medication discontinuation.
- I will keep my medications safe and secure, and out of the reach of children.
- 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 of my medication and will not give or sell them** to anyone else. I will not take anyone else's medication.
- 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 provide my pharmacist with a copy of this agreement if requested. I authorize my physician to release my medical records to my pharmacist as needed, and/or discuss my use of medication.
- **Lost or stolen medications or prescriptions may NOT BE REPLACED AND NECESSITATES FILING OF A POLICE REPORT AND PURCHASE OF A LOCKABLE BOX.**
- Refill(s) **will not be authorized 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. 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, as requested at any time and without prior warning,** to detect the use of non-prescribed medication and illegal drugs and to established that the prescribed medications are actually being taken and not for example being sold. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. I may be referred to other specialists such as a psychiatrist, psychologist or addiction specialist. I may be reffered for drug detoxifcation and rehabilitation
- I 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 to take responsibility in improving my general health, for example by not smoking, exercising and maintaining a healthy diet.
- 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 must take the medication(s) exactly 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 am aware of the fee for No-shows, Same day cancellation/re-scheduling or missing my appointment by being 30 minutes late.
- I will dispose of medications as recommended. Drugs should be taken out of their containers, mixed with undesirable substances, (e.g., cat litter, used coffee grounds) and put into a disposable container with a lid or into a sealed bag before putting in the trash. Remove any personal information by covering the information with black marker, or duct tape, or by scratching it off.

**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 treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment.

4) IMPORTANT WARNING: **I understand that if I must get medical attention right away if I experience symptoms of an irregular heart beat such as palpitations, dizziness, lightheadedness, or fainting or if I experience symptoms suggestive of taking too much pain medication, such as slow or shallow breathing; extreme tiredness or sleepiness; blurred vision; inability to think, talk or walk normally; and feeling faint, dizzy or confused.**

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.**

______________________________________________________________

**Patient Name (PRINTED)** **Signature**

**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 Noor Gajraj, MD, and his 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 and Email Appointment Reminders**

I agree that the provider, Noor Gajraj,MD or his 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. In addition, I agree to an email, appointment reminder being sent.

**Permission to Discuss Protected Health Information with Third Persons**

I agree that the provider, Noor Gajraj, MD 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, Noor Gajraj, MD and 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:

# SOAPP® Version 1.0-14Q

Name: ______________________________ Date: ______________

***The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.***

Please answer the questions below using the following scale:

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
6. How often have you attended an AA or NA meeting? 0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
9. How often have your medications been lost or stolen? 0 1 2 3 4
10. How often have others expressed concern over your use of medication? 0 1 2 3 4

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PainEDU

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

11. How often have you felt a craving for medication? 0 1 2 3 4

12. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4

13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4

14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

*Please include any additional information you wish about the above answers. Thank you.*

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Pain

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**3108 Midway Road, # 206, Plano, Texas 75093**
**Office: 972 612 3800 Fax: 972 612 3811**

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Name:** ______________________________________ **Date of Birth:** ___________
**First** **Middle** **Last**

**SS #:** ________________

**Authorization:** I voluntarily authorize and direct my health care provider

______________________________________ to disclose my health

information during the term of this authorization to Dr. Gajraj.

# Please Fax (Mail): Recent Records and MRI Reports In a Timely Manner

**Information to be disclosed:**

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

**Term:** This Authorization will remain in effect for 90 days from the date of this Authorization.

**Redisclosure:** I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

**Refusal to sign/right to revoke:** I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

**Revocation:** I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

______________________ ______________
Signature Date