Norman J Dozier, MD PA

Dr. Norman Dozier Dr. David Lindley

PLEAE COMPLETE ALL INFORMATION Today's Date _____________

Patient Name: ____ Age: ______ Date of Birth: ___________

What name do you prefer to be called? ________________________Social Security No._______________

Address: ____
Street City State Zip

Home Ph:( )___________________Work Ph: ( )__________________Cell: ( )_______________

Marital Status: Married Single Divorced Widowed Sex: Male Female

Preferred Language: (circle) English Spanish Deaf Other: ____

Ethnicity: Hispanic or Latino or Not Hispanic or Latino

Race: (circle) White, American Indian, Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander Email: ____

Employer: _______________________________ Occupation: ____________________________________

Address: ____
Street City State Zip

Spouse's Name: ______________________________ Social Security No________________ DOB _______

Insurance Information

Primary Insurance: ___________________________________Policy #__________________Group_____
Policy Holder's Name: ____ Relationship________________

Secondary Insurance: _________________________________Policy #_________________ Group______
Policy Holder's Name: ____ Relationship ________________

EMERGENCY CONTACT: ____ Relationship______________
Phone Number: ______________________________ Cell Number: _______________________________

AUTHORIZATIONS AND RELEASES

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other governmental sponsored programs, private insurance and other health plans to: Norman J Dozier, MD PA. I understand that I am financially responsible for all charges whether or not paid by said insurance and hereby authorize said assignee to release all information necessary to secure payment.
I hereby grant permission for release of all medical records, documents, and associated information to Norman J Dozier, MD PA or his authorized agent.

____ _______________________________

Patient Signature **Date**

Norman J Dozier, MD PA

Dr. Norman Dozier Dr. David Lindley

Today's Date ______________

Name: ____ Age: ______ HT: ________ WT: _______

Reason for your visit today: ____

Do You have any Drug Allergies? YES or NO If yes, please list:

____

List Current Medications with
Dosages:____

____

____

____

Right-Handed ___ Left-Handed ___ Ambidextrous ___ Women Only: Pregnant? YES or NO

Medical History: please circle all that apply

Anemia	Headache	Osteoporosis
Arthritis	Heart Murmur	Parkinson's Disease
Asthma	Heart Palpitations	Peripheral Vascular Disease
Bleeding Problems	Heart Problems	Polio
Cancer	Hepatitis	Prior Heart Surgery
Depression	High Blood Pressure	Prostate Disease
Diabetes	Incontinence	Rheumatic Fever
Dialysis	Intestinal Disorder	Thyroid Disease
Emphysema	Kidney Problems	Ulcers
Frequent Infections	Meniere's Disease	Other:_________
Gallbladder Disease	Myasthenia Gravis	Other: _________
Gout	Neuropathy	Other: _________

Habits: Please (check all that apply)

Do you smoke? Yes or No

If yes, __packs per day If no, have you every smoked? Yes or No Quit When? ___________

Alcohol: Type & Amount: ________________________ Illicit Drugs: Type: _________________

OFFICE USE ONLY: ____

WEIGHT: _________________ BLOOD PRESSURE: _________________

HEIGHT: __________________ PULSE: ___________________________

PAIN LEVEL: _______________

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Diabetes						
Epilepsy/ Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						

Review of Systems: (Circle ay of the following that you have or have ever had)

Constitutional- night sweats, unexplained weight loss, trouble sleeping

HEENT- chronic runny nose, sinus infections

Visual- recent visual changes

Cardiac- chest pains, palpitations, congestive heart failure

Pulmonary- shortness of breath, chronic cough, bloody sputum

Abdominal- abdominal pain, bloating, diarrhea, constipation

Hepatic- jaundice, gallbladder problems, hepatitis

Renal- Kidney stones, kidney failure, dialysis

Musculoskeletal- back pain, neck pain, shoulder pain, hip pain, knee pain

Neurologic- seizures, numbness, paralysis

Skin- skin lesions, sores, rashes, itching

Psychiatric- depression, mania, bipolar illnesses

When did your problem begin? Month: _______________ Year: _____________________

Previous Surgery : *Please provide dates and details*

____

____

Circumstances of Onset: (Circle One)

Accident at work   Accident at home   Other Accident: _________________________________

Following illness   Following Surgery   Pain "Just Began" (no accident of injury)

____

Please circle the level of your primary pain from 0 (no pain) to 10 (worst pain) for the following:

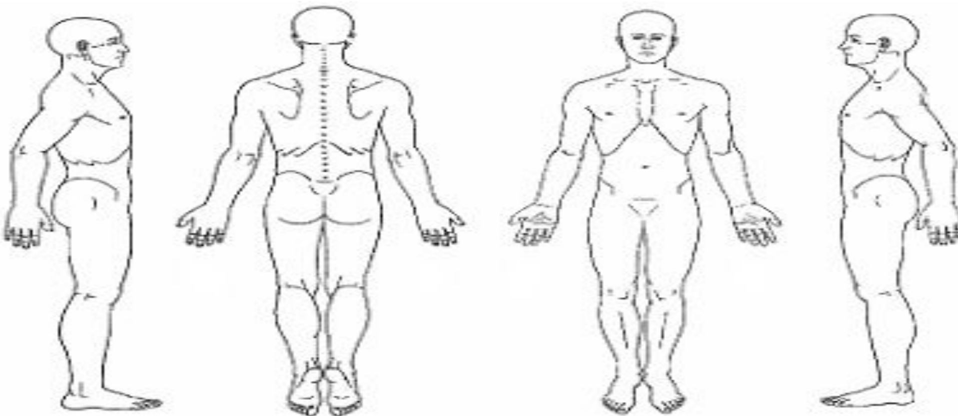
Present pain level: 0 1 2 3 4 5 6 7 8 9 10

Worst pain level: 0 1 2 3 4 5 6 7 8 9 10

Least pain you've had: 0 1 2 3 4 5 6 7 8 9 10

What level of pain is acceptable to you? 0 1 2 3 4 5 6 7 8 9 10

**************************please shade the area of pain below***************************



Please circle your symptoms: Throbbing, Aching, Sharp, Dull, Shooting, Tingling, Burning, Numbness, Hotness, Coldness, Continuous, Intermittent

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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT AS REQUIRED BY THE TEXAS MEDICAL BOARD REFERENCED TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170 3RD Edition: Developed by the Texas Pain Society(www.texaspain.org)

Patient Name: ____ Date: ____________________________

TO THE PATIENT: As a patient you have the right to be informed about you condition and the recommended medical or diagnostic procedure or drug therapy to be used, so you may make the informed decision whether or not to take the drug 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 you may give or withhold your consent/permission to use the drug(s) recommended to you by 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 medications include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand 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. 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 MEDIATION(S) MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIVED AND DOCUMETED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATION FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND HE GOVERNMENT (THIS 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 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.

Patient Initials _____

To the best of my knowledge, I am **NOT** pregnant.
If I am not pregnant, I will use my 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 IMMEDIATLEY.**
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 medications(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 THE MOST COMMON SIDE EFFECTS THAT COULD OCCU IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NO LIMITED TO THE FOLLOWING:

- Emotional and physical dependence, which is rare (occurring in approximately 1 in10,000 patients without a history of substance abuse).
- Constipation, difficulty with urination, nausea, vomiting, itching, slow breathing, reduced sexual function, depression insomnia and tolerance to medication(s)
- Decreased ability to perform activities such as driving and using machinery
- Patient is aware taking benzodiazepines (alprazolam, diazepam, lorazepam) with opioids can lead to an overdose

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 medications on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realized that the treatment for some will require prolonged or continuous use of medications but an appropriate treatment goal may also mean that the eventual withdrawal from the use of all medications. 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 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 result 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 procedures to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedures, and I believe that I have sufficient information to give this informed consent.

SOAPP-R Score ________________
ORT Score ____________________
Date: _________________________

For Chronic Opiate (Narcotic) use

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 "narcotic pain killers", 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 substances. Therefore, medications will only be provided so long as I follow the rules specified in the Agreement.

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

Opiate drugs taken with alcohol or street drugs, or in greater doses than prescribed, can cause increased side effects leading to dangerous situations like coma, organ damage or even death. If you suddenly stop taking an opiate after using it for a long period you may feel withdrawal symptoms such as sweating, nausea, vomiting, uncontrollable yawing, tearing of the eyes, runny nose, muscle spasms, diarrhea, bone and muscle pains, hot and cold flashes, sleeplessness, etc.

- My progress will be periodically reviewed and, if the medications are not improving my quality of life, the medications may be discontinued.
- I will disclose to my physician all medications that I take at any time, prescribed by any physician.
- I will use the medications exactly as directed by my physician.
- All medications 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 will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medications will be refilled on regular basis. I understand that my prescription and my medications are exactly like money. If either are lost or stolen, they will **NOT BE REPLACED.**
- Refills will not be ordered before the scheduled refill date. I will not expect to receive additional medications prior to the time of my next scheduled refill, even if my prescription(s) run out. Please allow 24-hour notice for refill requests.
- I will receive medications **only from ONE physician** unless it is for an emergency or the medication that is being prescribed by another physician is approved by my physician. Information that I have been receiving medications prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medications and treatment. *Obtaining narcotic prescriptions from more than one physician at the same time is considered "diversion" and subject to reporting to the Department of Public Safety and may lead to arrest.*
- Medications that are not prescribed for you should not be used. ***DO NOT*** share, sell, or trade these medications for money, good, or services. This too is considered "diversion" and is subject to reporting to the Department of Public Safety and may lead to arrest. Tell your physician if any over-the-counter medication are being used.
- If it appears to my physician that there are no demonstrative benefits to my daily function or quality of life from the medications then my physician may try alternative medications or may taper me off all medications. I will not hold my physician liable for problems caused by discontinuance of medications.

Patient Initials: _____________

- I agree to submit the urine and/or blood screens to detect the use of non-prescribed and prescribed medications at any time and without prior warning. If I test positive for illegal substances 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 qualified physician such as an addictionologist or a physician whose 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 that I am enrolled in a pain management program, since the use of other medications 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) as instructed by my physician. Any unauthorized increase in the dose of the 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 cause form discontinuation of the treatment.

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

- Physical or verbal threats to health-care providers or the staff may be cause of discontinuation of opiate medication and discharge from this practice.

I certify and agree to the following:

1. I am not currently using illegal drugs or abusing prescription medications 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 judgement.
2. I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain killers) 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 realized that it provides me an opportunity to lead a more productive active life.
4. I have reviewed the side effects of the medication that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medications and I agree to the use of these medications in the treatment of my chronic pain.

___________________________________	___________________________________
Patient Signature	Printed Name
___________________________________	**NORMAN J DOZIER** **DAVID LINDLEY, DO**
Physician Signature (or Authorized Assistant)	

DATE: ______________________________

Authorization to Release Information

Patient Name: ____ DOB: _____________________

The health information you may release subject to this authorization is as follows:

____

Release my protected health information to the following person(s)/ entity:

Name:____

Address:____

He reasons or purposes for this release of information are as follows:

____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information (Norman J Dozier, MD PA Po Box 2587 Abilene, TX 79604 Fax: 325-676-7991) I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer to the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event of condition: ____

I understand that authorizing the disclosure of this health information is voluntary . I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure or the information carries with it the potential to an unauthorized re-disclosure and that information may not be protected by federal confidentiality rules.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

____ ____________________________________

Patient Signature or Representative Name of Patient or Personal Representative

____ ____________________________________

Date Description of Personal Rep