

HAL S. BLATMAN, M.D.
10653 TECHWOODS CIRCLE, SUITE 101
CINCINNATI, OHIO 45242
513-956-3200

Directions to our office:

75 Southbound:

75 South to 275 East
Exit onto Reed Hartman Highway (3 exits) turn right
At the 5th or 6th light turn left onto Creek Road.
Make a right at the first driveway on the right, which is
Techwoods Circle
Turn into the 4th driveway on the right
Take an immediate left and park in designated area.

75 Northbound:

75 North to 275 East
Exit onto Reed Hartman Highway (3 exits) turn right
At the 5th or 6th light turn left onto Creek Road.
Make a right at the first driveway on the right, which is
Techwoods Circle
Turn into the 4th driveway on the right
Take an immediate left and park in designated area.

71 Southbound:

Exit Pfeiffer Road
Take a right at the light onto Pfeiffer Road
Turn right onto Kenwood Road
At light make a left onto Creek Road
Take a left onto Techwoods Circle
Turn Left into 3rd driveway, which is after Candlewood Hotel
Take and immediate left and park in designated area

71 Northbound:

Exit Pfeiffer Road
Take a left at the light onto Pfeiffer Road
Turn right onto Kenwood Road
At light make a left onto Creek Road
Take a left onto Techwoods Circle
Turn Left into 3rd driveway, which is after Candlewood Hotel
Take and immediate left and park in designated area

CHECK LIST OF ITEMS TO **MAIL** BACK **PRIOR** TO YOUR VISIT

- FINANCIAL POLICY SIGN AND DATE ON BACK
- PATIENT INFORMATION RECORD COMPLETELY FILLED OUT
(BOTH SIDES)
- CURRENT MEDICAL HISTORY COMPLETELY FILLED OUT
- INITIAL PAIN ASSESSMENT TOOL COMPLETELY FILLED OUT
- ZUNG SELF-RATING DEPRESSION SCALE COMPLETELY FILLED OUT
- TIPS ON TALKING ABOUT PAIN WITH
YOUR HEALTHCARE PROVIDER COMPLETELY FILLED OUT
- WHO MAY WE SPEAK TO REGARDING COMPLETELY FILLED OUT

PATIENT INFORMATION RECORD
PLEASE PRINT LEGIBLY

DATE OF INJURY OR DATE SYMPTOMS STARTED: _____

DATE TODAY: _____

PATIENT FIRST NAME MIDDLE INITIAL	LAST NAME	SINGLE	WIDOWED
		MARRIED	DIVORCED
STREET ADDRESS		CITY, STATE, ZIP CODE	
BIRTHDATE AGE		PATIENT'S SOCIAL SECURITY NUMBER	
LIST ANY OTHER NAME YOU HAVE USED		OCCUPATION	
EMPLOYER		ADDRESS, CITY, STATE, ZIP CODE	
SIGNIFICANT OTHER		BIRTHDATE	
EMPLOYER		ADDRESS, CITY, STATE, ZIP CODE	

IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME BIRTHDATE	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ()
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ()
MOTHER'S NAME BIRTHDATE	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ()
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ()

INSURANCE INFORMATION
MUST BE FILLED OUT COMPLETELY

PRIMARY INSURANCE _____ PHONE NUMBER _() _____

SUBSCRIBER NAME _____ EFFECTIVE DATE: _____

MEMBER NUMBER _____ GROUP NUMBER _____

WORKERS COMPENSATION CL# _____ MCO NAME _____

CLAIMS REPRESENTATIVE _____ MCO PHONE NUMBER _____

EMPLOYER AT DATE OF INJURY _____ DATE OF INJURY _____

PLEASE INITIAL TO VERIFY ALL THE INFORMATION ABOVE IS CORRECT _____

OVER PLEASE

ADDITIONAL INFORMATION

FAMILY PHYSICIAN _____ REFERRING PHYSICIAN _____
STREET ADDRESS _____ STREET ADDRESS _____
CITY, STATE, ZIP _____ CITY, STATE, ZIP _____
TELEPHONE _(_____) _____ TELEPHONE _(_____) _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP TO YOU: _____
STREET ADDRESS: _____ TELEPHONE: _(_____) _____
CITY, STATE, ZIP CODE: _____

WHO IS RESPONSIBLE FOR PATIENT'S MEDICAL EXPENSES

PARENT SIGNIFICANT OTHER SELF

NAME OF PARENT OR SIGNIFICANT OTHER (GUARANTOR) _____
DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____
GUARANTOR SIGNATURE: _____ DATE: _____

THE OFFICE OF HAL S. BLATMAN, M.D., INC WILL PROCESS YOUR PRIMARY INSURANCE CLAIM AS A COURTESY TO YOU, HOWEVER, THE GUARANTOR IS FULLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE ALL PAYMENTS MADE BY THE INSURANCE COMPANY TO BE PAID DIRECTLY TO HAL S. BLATMAN, M.D., INC.

PATIENT SIGNATURE: _____ DATE: _____
PARENT SIGNATURE: (IF MINOR) _____ DATE: _____

BLATMAN PAIN CLINIC
10653 Techwoods Circle, Suite 101
Cincinnati, OH 45242
513-956-3200 fax 513-956-3206
www.blatmanpainclinic.com

Office Hours are 8:00AM to 5:00PM, Monday through Thursday
Our office is closed Friday, Saturday and Sunday

FINANCIAL POLICY

We welcome you to our office, and we are pleased to have this opportunity to help you as a patient. We are providing this information to help you understand how our business office operates, and to acquaint you with the policies of our practice.

We are committed to providing you with the best possible care, and we are always willing to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions about our fees, financial policies, or your financial responsibility, please call our billing specialist.

PAYMENT METHODS

We accept cash, money orders, Visa, Mastercard, Discover and American Express.

INSURANCE

We are not a participant in any insurance plans. Most insurance company networks do not cover our treatment completely. It is your responsibility to contact your insurance company prior to your office visit. Payment for services in full is due at the time services are rendered. If you would like, we will file a claim with your insurance company. You must realize however, that your insurance company is a contract between you, your employer and the insurance company. We are not a party to that contract. Again, we urge you to check with your company before your first visit.

We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

OVER PLEASE

APPOINTMENTS

We schedule 2 hours for a new patient visit. If you cancel your new patient office visit, you must let us know at least 72 hours in advance of your appointment, or you will be charged \$100.00. As an established patient, if you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. This courtesy allows us to be of service to other patients. You will be charged a \$65.00 no show fee if you cancel less than 24 hours prior to your scheduled time and this charge must be paid prior to your next office visit.

Furthermore, if your account does fall behind and we are forced to send it to a collection agency, you will be further charged a \$50.00 fee as well as any other fees associated with the collecting of the money owed. These rates are all subject to change without notice.

CURRENT BALANCES ON PATIENT ACCOUNTS

In an effort to help you manage your account balance, any balance that reaches 30-60 days past due will be expected in full prior to rescheduling.

MEDICARE/MEDICAID

We have had to “opt” out of Medicare/Medicaid. We **CANNOT** bill Medicare, and patients **CANNOT** bill Medicare for reimbursement of our services. Please contact our billing specialist to review your situation.

ATTORNEY/ACCIDENT CASES/INSURANCE REPORTS/DISABILTIY FORMS

Request for information to be sent to your attorney or insurance carrier must come as a written request for information with your signed authorization to release this information. Disability forms require a \$55.00 payment for the first form, \$35.00 for additional forms. FMLA forms require \$75.00 prior payment. There will be fees for all narrative reports and letters, including BWC, the cost will depend on what is needed. In general, these will be completed within 7 to 10 business days of receipt of payment.

CONFIDENTIALITY

Your medical records are strictly private and confidential. No information from your chart will be given to family members, your employer, your attorney or other doctors without your written permission. Worker’s Compensation patients have already signed a release for medical records in order to be seen by the Ohio BWC.

I have read the financial policy of the Blatman Pain Clinic and agree.

Patient

Date

Zung Self-Rating Depression Scale (SDS)



Reply to questions using one of the four replies below (A – D)

A – Little or none of the time

B – Some of the time

C – A large part of the time

D – Most or all of the time

	A	B	C	D
	Little or none of the time	some of the time	A large part of the time	Most of the time
1. I feel downhearted and blue	1	2	3	4
2. Morning is when I feel the best	4	3	2	1
3. I have crying spells or feel like it	1	2	3	4
4. I have trouble sleeping at night	1	2	3	4
5. I eat as much as I used to	4	3	2	1
6. I still enjoy sex	4	3	2	1
7. I notice that I am losing weight	1	2	3	4
8. I have trouble with constipation	1	2	3	4
9. My heart beats faster than usual	1	2	3	4
10. I get tired for no reason	1	2	3	4
11. My mind is as clear as it used to be	4	3	2	1
12. I find it easy to do the things I used to do	4	3	2	1
13. I am restless and can't keep still	1	2	3	4
14. I feel hopeful about the future	4	3	2	1
15. I am more irritable than usual	1	2	3	4
16. I find it easy to make decisions	4	3	2	1
17. I feel that I am useful and needed	4	3	2	1
18. My life is pretty full	4	3	2	1
19. I feel others would be better off if I was dead	1	2	3	4
20. I still enjoy the things that I used to	4	3	2	1

Some questions ask the information positively and others negatively but in all cases the **symptom severity is Scored from 1 to 4. The total score is often converted to a 100 point scale (SDS index)**

SDS Index = (score / 80 total points) x 100 or SDS Index = score x 1.25

Initial Pain Assessment Tool

Patient's name: _____ Date: _____

Age: _____ Diagnosis: _____

1. Intensity: Rate your pain. Use the scale on the back of this form. _____
Present: _____
Worst pain gets: _____
Best pain gets: _____
Acceptable level of pain: _____
2. Onset of pain, duration, variations: _____

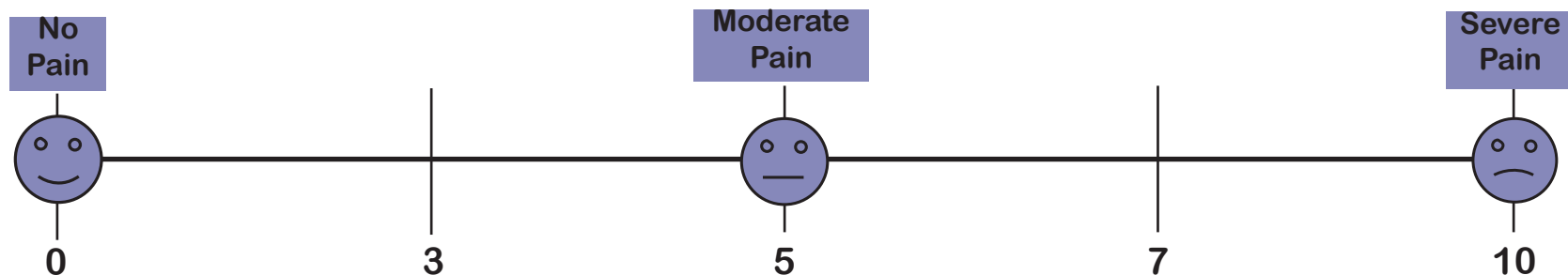
3. Manner of expressing pain: _____
4. What relieves the pain? _____
5. What causes or increases the pain? _____
6. Effects of pain: (ex: decreased function, decreased quality of life) _____

7. Accompanying symptoms (ex: nausea) _____
Sleep _____
Appetite _____
Physical activity _____
Relationship with others (ex: irritability) _____
Emotions (ex: anger, suicidal, crying) _____
Concentration _____
Other _____
8. Other comments: _____

PAIN SCALE



- 0** = No Pain
- 1** = You are slightly uncomfortable. Occasional minor twinges. No medicine needed.
- 2** = Pain is a minor bother. No medicine needed.
- 3** = Pain is annoying enough to be distracting. Mild painkillers like Aspirin or Tylenol help.
- 4** = Pain can be ignored if you are really involved; it is still distracting. Mild painkillers help for 3-4 hours.
- 5** = Pain can't be ignored for more than 30 minutes. Mild painkillers help for 3-4 hours.
- 6** = Pain can't be ignored, but you can still work. Stronger narcotic painkillers help for 3-4 hours.
- 7** = It is hard to concentrate. Pain bothers sleep. You can still function. Painkillers only help some.
- 8** = Your activity is limited a lot. You can read and talk with effort. Nausea and dizziness are part of the pain.
- 9** = You are unable to speak. You are crying out or moaning.
- 10** = You are unconscious. Pain makes you pass out.



Tips on Talking About Pain With Your Healthcare Provider

Pain assessment is critical to effective pain management. The following approach to assessing your pain-focusing on words to describe intensity, location, duration and aggravating and alleviating factors-will better help your healthcare provider develop effective treatment strategies.

Words to Describe Pain (please circle all that apply)

Aching	Throbbing	Shooting
Stabbing	Gnawing	Sharp
Tender	Burning	Exhausting
Tiring	Penetrating	Nagging
Numb	Miserable	Unbearable
Dull	Radiating	Squeezing
Cramping	Deep	Pressure

Intensity (0 to 10)

If 0 is no pain and 10 is the worst possible pain, what is your pain now? In the last 24 hours? _____

Location

Where is your pain? _____

Duration

Is the pain always there? Or does the pain come and go (breakthrough pain)? Do you have both types of pain?

Does pain affect: (please circle all that apply)

Sleep	Energy	Relationships
Appetite	Activity	Mood

Are you experiencing any other symptoms? (please circle all that apply)

Nausea/vomiting	Itching	Urinary retention
Constipation	Sleepiness/confusion	Weakness

CURRENT MEDICAL HISTORY

Patient name _____

Date of birth _____ Age _____ Today's Date _____

Who referred you? _____

Family Physician _____ Doctor's Phone _____

Address of family physician _____

What are your Major Concern(s) _____

What are your Other Concerns and when did they start _____

When did your major concern(s) begin (be specific) _____

Pain and Problem History:

What seemed to really start it? If it was an injury, how did it happen? _____

What do you do that makes it better or improves your symptoms? _____

What do you do that makes it feel worse? _____

List the weather conditions you feel best in: _____

List the weather conditions you feel worst in: _____

DIAGNOSTIC TESTING—Please bring a paper copy of test reports, and the actual films of plain x-rays if possible.

Don't copy the test report into this table.

TEST NAME	DATE TEST was DONE	FACILITY where test was DONE	WHAT RESULTS WERE YOU TOLD?

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What SURGERIES have you had?

SURGERY	DATE	REASON for SURGERY	SUCCESSFUL?

Continue on separate sheet of paper if needed.

REVIEW OF SYSTEMS

Please check any symptoms that are bothersome to you NOW.

General

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Bleed/bruise easily	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Fevers
<input type="checkbox"/> Poor sleeping	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Chills
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Strong thirst	<input type="checkbox"/> Localized weakness	<input type="checkbox"/> Tremors	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Cravings for:	<input type="checkbox"/> Sweets	<input type="checkbox"/> Fats	<input type="checkbox"/> Salty food	<input type="checkbox"/> Other _____

Skin & Hair

<input type="checkbox"/> Rashes	<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Pimples	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Recent moles	<input type="checkbox"/> Excema	<input type="checkbox"/> Hives
<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Itching	<input type="checkbox"/> Change in hair	<input type="checkbox"/> Change in skin	<input type="checkbox"/> Herpes	<input type="checkbox"/> Finger nails chip/crack/peel	<input type="checkbox"/> Other

Cardiovascular

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Chest pains	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Swelling feet	<input type="checkbox"/> Swelling hands	<input type="checkbox"/> Blood clots
<input type="checkbox"/> Difficulty breathing	Other _____		

Head, Eyes Ears Nose & Throat

<input type="checkbox"/> Concussions	<input type="checkbox"/> Jaw clicks (TMJ) L or R	<input type="checkbox"/> Tooth problems	<input type="checkbox"/> # of teeth pulled
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___ # of silver fillings	___ # Root canals	___ Eye pain	___ Poor vision
___ Migraine	___ Other headache	Type of headache _____	___ Sores on lips/tongue
___ Sinus problems	___ Nose bleeds	___ Spots in front of eyes	___ Trouble with night vision
___ Grinding teeth	___ Facial pain	___ Trouble with taste or smell	___ Glasses
___ Ear aches	___ Cataracts	Other _____	

Rheumatoid disease? ___Y ___N	Tested for Lyme disease? ___Y ___N	Diabetes? ___Y ___N	Thyroid problems? ___Y ___N
Cancer? ___Y ___N What Kind _____	Hepatitis? ___Y ___N What Kind _____	AIDS? ___Y ___N	Breast implants? ___Y ___N What Kind _____
Other communicable disease? _____			

Immunology

Respiratory

___ Cough	___ Shortness of breath with minimal exercise	___ Difficulty breathing when lying down	___ Pain with deep breath
___ Coughing blood	___ Pneumonia	___ Asthma	___ Shortness of breath
___ Bronchitis	Other _____		

Gastrointestinal

___ Nausea	___ Abdominal pain/cramps	___ Indigestion	___ Hemorrhoids	___ Constipation
___ Vomiting	___ Diarrhea	___ Black stools	___ Belching	___ Gas
___ Rectal pain	___ Blood in stools	___ Bad breath	___ Heartburn	___ Pancreatitis
How many bowel movements a day _____	How many bowel movements a week _____	Other _____		

Genitourinary

___ Pain with urination	___ Frequent urination	___ Blood in urine	___ Urgency to urinate
___ Unable to hold urine	___ Kidney stone #: ___	___ Decrease in flow	___ Wake up to urinate
___ Problem with sexual function	___ Impotency	___ Loss of libido (desire)	___ Pain with intercourse
___ Sexually transmitted disease or exposure	___ Sores on genitals	Other:	

Pregnancy & Gynecology

Pregnant? ___Y ___N	Planning a pregnancy? ___Y ___N	Post menopausal? ___Y ___N	Menopause symptoms? ___Y ___N
First date of last menses: _____	Unusual character (heavy/light)	Hot flashes? ___Y ___N	Fibrocystic breast ___Y ___N
___ Clots	___ Painful periods	___ Irregular periods	___ Vaginal discharge
___ Vaginal sores	___ Breast lumps	Birth control ___Y ___N	Type of birth control :
# of children: _____	# of C-section delivery(s) _____	# of vaginal delivery(s) _____	# of abortion(s) _____

Ages of children _____	_____	_____	_____
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Musculoskeletal

<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Jaw pain	<input type="checkbox"/> Face pain	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Elbow pain	<input type="checkbox"/> Arm pain	<input type="checkbox"/> Wrist pain	<input type="checkbox"/> Hand pain
<input type="checkbox"/> Finger pain	<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Thigh pain
<input type="checkbox"/> Knee pain	<input type="checkbox"/> Leg pain	<input type="checkbox"/> Ankle pain	<input type="checkbox"/> Foot pain	<input type="checkbox"/> Toe pain
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Other: _____	_____

Neuropsychological

<input type="checkbox"/> Seizures	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Lack of coordination
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Concussion	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Bad temper	<input type="checkbox"/> Easily susceptible to stress	<input type="checkbox"/> Treated for emotional problems	<input type="checkbox"/> Aneurysm
Ever considered suicide? <input type="checkbox"/> Y <input type="checkbox"/> N	Ever attempted suicide? <input type="checkbox"/> Y <input type="checkbox"/> N	Areas of numbness? <input type="checkbox"/> Y <input type="checkbox"/> N	Where?
Other _____			

Other information you think is important that did not come up during review of systems:

Family History

	Father	Mother	Father's pare	Mother's parent	Siblings	Children
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			nts	s		
Heart disease						
High Blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/seizures						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental illness						
Osteoporosis						
Fibromyalgia						
Other						

Additional History

Childhood illnesses: _____

Childhood accidents and any lasting effects: _____

Environmental allergies—list agent and reaction:

History of allergy testing and treatment:

Have you ever smoked Tobacco? Y N How many packs per day? _____ Now ? _____

How many years a smoker? _____ How many times did you quit? _____ When? _____

Do you have a history of alcohol or drug abuse? Treatment for abuse? Please explain: _____

Diet:

red meat — number of meals per week _____

milk — number of glasses per week _____ or per day _____

cheese — number of times per week _____ or per day _____

coffee or tea — number of cups per week _____ or per day _____.

soda — number of cans per week _____ or per day _____,

what kind usually? _____

other sugar — what sweets do you usually eat and how much? _____

bread — what kind and how much? _____

which do you use margarine or butter? _____

what cooking oils do you use? _____

what are your favorite foods? _____

Vitamins: what do you take, and why (only list why for unusual supplements or herbs)?

Sleep: how well do you sleep? _____

If not well, why not? _____

What position do you sleep in? _____

Do you use a pillow? what kind? where placed? _____

Do you have stomach sensitivity to aspirin? ____Y ____N

Do you have irritable bowel? _____ for how long? _____

How is this treated? _____

Who is the treating doctor? _____

Do you have a history of ulcer or indigestion? ____Y ____N please explain: _____

How is this treated and who is the doctor? _____

When was your last complete physical examination? _____

For what reason? _____

What is your occupation? _____ What was your occupation? _____

If you are disabled, when did you last work? _____

What is your disability caused by? _____

Anything else you would like us to know? _____

What are your goals for this treatment? What do you expect to be able to change?
with regard to your pain and your life? If you are not working, do you plan to return to work, and how soon?
How hard are you willing to work to reach your goals?

To the best of my knowledge, this is complete and accurate.

Signed: _____ **Date:** _____