# WELLPOINT PAIN CENTER
## Kenneth C. Moy, D.O.

A department of Missouri Delta Medical Center

Dear New Patient,

Thank you for choosing WellPoint Pain Center!

To save time during your first appointment, feel free to print and fill out the following forms and bring with you to your appointment.

☐ Patient Information ☐Health History Form ☐ Acknowledgement of Privacy Practices

Also, please remember to bring with you to the appointment:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

We look forward to meeting you. If you have any questions, please let us know!

201 Plaza Drive, Suite C
Sikeston MO 63801
(573) 481-2210
*www.missouridelta.com*

**MISSOURI DELTA PHYSICIAN SERVICES**
**SIKESTON, MISSOURI**

**PATIENT INFORMATION**
(to be completed by patient) **Date:** _____

Name: First _____ Middle _____ Last _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____ Race _____ Religion _____

Social Security Number _____ Maiden/Other Name _____ Family Doctor _____

Patient Address _____

City/State/Zip _____ Home Phone _____ Cell Phone _____

Email Address _____

Patient Employer _____

Address: _____

City/State/Zip _____ Phone _____

Preferred Pharmacy _____

## Next of Kin

Spouse/Father/Mother Name _____ D.O.B. _____

**(Spouse or Parent if Patient is under 18 years of age)**

S.S.N.# _____ Cell Phone Number _____

Address if different from above _____

Spouse/Parent Employer _____

Address _____

City/State/Zip _____ Phone _____

## Closest Relative NOT Living With You

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

## Person to Notify (other than Next of Kin)

Name _____

Address _____

City/State/Zip _____ Phone _____

Relationship to Patient _____

Phone: (573) 472-7696

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# PATIENT HISTORY

Patient Name_____ Date_____

Date of Birth_____ Sex_____ Marital Status _____

Telephone Numbers/ Home (  )_____ Work (  ) _____

Home Address _____

Street_____

City_____ State_____ Zip _____

## *General Health Review*

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

_____ _____ _____

_____ _____ _____

Surgical History (**unrelated** to pain; such as appendectomy)

_____ _____ _____

_____ _____ _____

Surgical History (**related** to pain; such as laminectomy)

_____ _____ _____

_____ _____ _____

Allergies (include medication and food allergies)

_____ _____ _____

_____ _____ _____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

_____ _____ _____

_____ _____ _____

Current Medications (include vitamins and birth control pills, if applicable)

_____ _____ _____

_____ _____ _____

Which pharmacy do you use? Name:_____ Phone: _____

Do you have any of the following? (Circle all that apply)

| | | |
|---|---|---|
| Headaches | Stomach Pain | Chest Pain |
| Vision Problems | Nausea | Shortness of Breath |
| Hearing Problems | Vomiting | Urinary Problems |
| Dizziness | Constipation | Rashes |
| Difficulty Swallowing | Diarrhea | Swollen Joints |
| | | Chronic Fatigue |

## *Domestic Situation*

With whom do you live? _____

Are there any substance abuse issues in the household? Yes_____ No_____

If yes, please explain _____

Are you able to take care of yourself? Yes_____ No_____

If not, please enter name of caregiver _____

## *Work History*

Job Years worked Why did you leave?

_____

_____

## *LegalMatters*

Are you presently involved in a lawsuit? Yes_____ No_____ If yes, please explain.

_____

_____

## *Substance Abuse*

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

| | | |
|---|---|---|
| Alcohol_____ | Barbiturates_____ | Cocaine_____ |
| Heroin_____ | Amphetamines | Marijuana _____ |
| Other _____ | Other _____ | Other _____ |
| (specify) | (specify) | (specify) |

Are you presently using any of the drugs or substances below? (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

| | | |
|---|---|---|
| Alcohol _____ | Barbiturates_____ | Cocaine_____ |
| Heroin_____ | Amphetamines _____ | Marijuana _____ |
| Other _____ | Other _____ | Other _____ |
| (specify) | (specify) | (specify) |

Do you presently smoke cigarettes or use tobacco in any form? Yes_____ No_____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes_____ No_____

How many packs do (did) you smoke a day?_____ For how many years? _____

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# PATIENT POLICY

Dr. Kenneth C. K. Moy, or any other physician performing services in the name of Missouri Delta Medical Center, may elect to discontinue providing pain management treatment if any of the following events occur:

1. Patient does not comply with medication usage and dosage, as prescribed.
2. Patient falsely misrepresents needs and requirements for pain medication.
3. Patient is convicted of a felony involving diversion of pain medication.
4. Patient misrepresents prior medication and pain treatment performed by another physician.
5. Patient is disruptive and disrespectful in the presence of the staff or patients of _____, such as using foul language or making threats.
6. Patient is inconsiderate regarding appointments for treatment by missing three appointments without notification of cancellation twenty-four (24) hours prior to the time of the appointment.
7. Patient hereby acknowledges that he/she has read and received a copy of this patient policy.

Patient's Signature_____ Date_____

MISSOURI DELTA MEDICAL CENTER

SIKESTON MISSOURI

ACKNOWLEDGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: _____

Date:_____

□ Patient was unable /unwilling to sign acknowledgment.

Reason: _____

Staff initials: _____

Date: _____

Time: _____

Below is a list of people that may receive full disclosure of my medical information:

_____

_____

_____

Copy of Notice was included in patient's Admission Information Packet