

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



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!

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)**

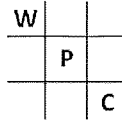
Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Phone: (573) 472-7696



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



Fax: (573) 472-7324

**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?
_____	_____	_____
_____	_____	_____

**Legal Matters**

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").

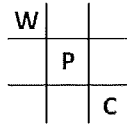
- |               |                    |                 |
|---------------|--------------------|-----------------|
| Alcohol _____ | Barbiturates _____ | Cocaine _____   |
| Heroin _____  | Amphetamines _____ | Marijuana _____ |
| Other _____   | Other _____        | Other _____     |
| (specify)     | (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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# WELLPOINT PAIN CENTER

## Kenneth C. Moy, D.O.



Fax: (573) 472-7324

### 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