Patient Name: ______________________________

Appointment Date & Time: ______________________________

MIND MOOD PAIN

Jeffrey Miller, MD

INTERVENTIONAL PAIN & PSYCHIATRY

New Patient Packet

Mind Mood Pain, Interventional Pain and Psychiatry, is a dual disciplinary practice aimed at helping patients improve functionality and ease emotional and psychiatric distress associated with pain and depression. MMP recognizes that there is a direct correlation between living with chronic pain and developing depression and anxiety secondary to the effect this has on functionality and living one's normal daily life. Our treatments involve proven therapies along with new evolving treatments targeting chronic and abnormal pain signals. Through neuromodulation and minimally invasive spine procedures, we can help with chronic central or peripheral nerve pain. Our medication management aims at targeting receptors along the pathways of chronic pain, which we feel are in close relation to nerve path signals for mood stability. Our therapy attempts to focus on each patient individually, and our goal is to incorporate a treatment plan that involves mind and body rehabilitation.

Locations

SOUTH OFFICE
1109 S.W. 30th CT, Suite A
Moore, OK 73160

NORTH OFFICE
15132 Traditions Blvd
Edmond, OK 73013

Appointments

Patients are seen by appointment only. If you are unable to keep your appointment, please contact our office at (405) 703-0937 as soon as possible. We do require at least a 24-hour notice to cancel/reschedule your appointment. If we do not receive a 24-hour notice, there will be a $25 charge. The policy is not intended to be punitive; rather, it allows us to continue to provide a high level of care to all of our patients. We customarily provide a reminder call prior to your appointment; however, a lack of receiving a reminder call does not exempt the patient for a missed appointment fee. Excessive no-shows or missed appointments may lead to discharge from our clinic. In order to keep our office on schedule and as a courtesy to our other patients, if you arrive more than 15 minutes late it will be considered a missed appointment, and we will have to reschedule your appointment.

Before Your First Visit

Prior to your appointment, it is important to us that you have completed and signed the new patient paperwork. Also, please obtain copies of your medical records and/or imaging reports as well as a list of all prescription and over-the-counter medications.

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At Your First Appointment

Please arrive 15-20 minutes early. Please bring your current drivers license and health insurance card. Payment of services is due at the time of service. Please be prepared to spend at least an hour with us at your initial visit. A thorough examination and understanding of your medical history is vital to providing you with appropriate treatment, and we strive for nothing less.

After Hours

Our answering machine is available for non-emergent messages. If an urgent matter arises after hours, please contact your nearest emergency room or call 911.

Office Closings

From time to time, Oklahoma weather creates inclement conditions which may impede our ability to see our scheduled patients. In the event that we close our office, we will call our scheduled patients as far in advance as possible to inform them of the office closing. In addition we will leave a recorded message on our answering machine for any patients who call our office hours on those days we are closed. If you live out of town and your local schools are closed due to weather conditions, our policy is that you are not required to give us the usual 24 business hour notice. However, we do ask that you kindly give us a call to inform us that you will not be at your appointment due to weather conditions and that your local schools are in fact closed. We can reschedule your appointment at that time as well.

Confidentiality

We commit to keeping your medical records confidential. The information in them will never be released to any person or organization without your written permission, unless required by law. Also, available to you is a copy of our Privacy Notice per your request. Please sign and complete the "Acknowledgement Form". This form includes the option for you to designate the names of other people that you may want to be able to access your information (i.e., family, etc.).

Contact Us

Please visit our website at www.mindmoodpain.com and explore the Patient Education link to learn more about the many procedures Dr. Miller specializes in. Again, we welcome you and look forward to providing you with excellent care! If you have any questions or need to change your appointment, please call us at (405) 703-0937.

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Office Use Only

☐ Patient Photo
☐ Insurance/License
☐ Packet Scanned
☐ Transcribed by MA
☐ Note Completed by Dr

Patient Information

Please print and complete ALL sections below!

DEMOGRAPHICS:

Full Name: ____ DOB: _______________

Home Address: ______________________________ City, State & Zip: _______________

Employer: ___________________________ Occupation: ___________________________

Employer Address: ____

Cell Phone: ______________________ Home Phone: _______________________________

SSN: _____________________ Email: ____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

SPOUSE INFORMATION OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR):

Full Name: ____ DOB: _______________

Employer: ______________________________________ Occupation: ___________________

Cell Phone: __________________ Work phone: ________________ SSN: ________________

PRIMARY INSURANCE CARRIER NAME: ______________________________________

Name of Insured: _____________________________ DOB: ________ SSN: _____________

Insurance Policy #: ____________________________ Insurance Group #: _____________

Insurance Carrier Address: ____

SECONDARY INSURANCE CARRIER NAME: ____________________________________

Name of Insured: _____________________________ DOB: __________ SSN: ____________

Insurance Policy #: __________________________ Insurance Group #: _______________

Insurance Carrier Address: ____

EMERGENCY CONTACT:

Name: ______________________________________ Relationship: ______________________________

Address: ____

Home Phone: ________________________________ Cell phone: ________________________________

PREFERRED PHARMACY:

Name: ____

Address & Phone Number: ____

REFERRAL:

Referred by: ____

Name of other Physicians that care for you: ____

*****ASSIGNMENT OF BENEFITS- FINANCIAL AGREEMENT*****

I hereby give lifetime authorization for payment of insurance made directly to Jeffrey A. Miller, MD and any assisting physicians, for services rendered. I understand I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Signature: ____ **Date:** ______________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Jeffrey Miller, M.D. reserves the right to modify the privacy practices outlined in the notice. I have been offered a copy of the Notice of Privacy Practices for Jeffrey Miller, M.D.

____
Name of Patient (print)

____
Signature of Patient

____
Date

Secure Phone Option
Is there a phone number on which personal health information could be left on your message recording in the event you are not available when we call? ☐ Y ☐ N

If 'Yes', what is the number? ____________________________

Expanded Authorization Option:
Please list any persons you would like to authorize to have access to your billing, appointment or health information* such as your spouse, caretaker, or other family member:

Name	Relationship

*With the exclusion of information that is protected under State and Federal Law.

If Patient is a minor:

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient
Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.

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FINANCIAL POLICY

Dear Patient:

Jeffrey A. Miller MD is honored that you have chosen him for your medical care. The following is his Financial Policy. His main concern is that you receive the proper and optimal treatment needed. Therefore, if you have any questions or concerns about the payment policies, please do not hesitate to ask the billing department. All patients are asked to read and sign the Financial Policy as well as complete the Patient Registration Form prior to seeing Dr. Miller.

Payment for services is due at the time services are rendered. Dr. Miller accepts cash, check, Mastercard, Visa, Discover and American Express. The office staff will be happy to file your insurance claim for you. However, please be aware that, although Dr. Miller has contracts with several insurance companies, he is not on all PPO/network plans. Please be sure to inquire with your insurance company as this may affect the amount you are responsible for paying.

All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services along with unpaid deductibles and co-payments are due at the time of treatment.

Questions regarding your insurance coverage should be directed to your insurance company. Please note that all laboratory services are provided by a separate entity. If you receive a bill from a laboratory company, please contact the lab company directly.

Please be aware that insurance contracts and policies can change on a yearly basis.

____

Signature Date

Name: ___________________________

D.O.B: ___________________________

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Office Use Only

Weight: ____________________ lbs

Height:____________________inches

BP: ____________________ mmHg

HR: ____________________bpm

O2 Sat: ____________________ %

MEDICAL QUESTIONNAIRE * REQUIRED INFORMATION*

This form is to help us understand your health history. It will allow us to ensure your records are complete so we can provide the best care possible at the time of your visit. We understand that your answers are very personal, and we will maintain them in the strictest confidence.

MEDICAL HISTORY: Have you personally ever been treated for or diagnosed with any of the following

☐ Y ☐ N	Emphysema/COPD	☐ Y ☐ N	Blood Disease
☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N	Abnormal Bleeding Tendencies
☐ Y ☐ N	Abnormal Chest X-Ray	☐ Y ☐ N	Blood Vessel Disease (Phlebitis)
☐ Y ☐ N	Congestive Heart Failure	☐ Y ☐ N	Positive HIV/AIDS Blood Test
☐ Y ☐ N	Atrial Fibrillation	☐ Y ☐ N	Jaundice
☐ Y ☐ N	Heart Attack	☐ Y ☐ N	Mononucleosis
☐ Y ☐ N	Coronary Artery Disease	☐ Y ☐ N	Glaucoma
☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Stroke
☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Epilepsy
☐ Y ☐ N	High Cholesterol	☐ Y ☐ N	Seizures
☐ Y ☐ N	Anticoagulant Therapy	☐ Y ☐ N	Thyroid Disease
☐ Y ☐ N	Bladder Infection	☐ Y ☐ N	Enlarged Prostate
☐ Y ☐ N	Kidney Disease/Dialysis	☐ Y ☐ N	Stomach Ulcers
☐ Y ☐ N	Irritable Bowel Syndrome	☐ Y ☐ N	Heartburn/GERD
☐ Y ☐ N	Hepatitis | Type: ___________	☐ Y ☐ N	Diabetes | Type: __________
☐ Y ☐ N	Cancer | Where: ___________	☐ Y ☐ N	Current or History of Pulmonary Embolism
☐ Y ☐ N	Arthritis | Type: _________	☐ Y ☐ N	Current or History of Deep Vein Thrombosis

☐ Y ☐ N Mental Disorders | List: ____

Other Medical Illness | List:

____

FAMILY PHYSICIAN: ______________________________ PHONE: ____________________

CARDIOLOGIST: ______________________________ PHONE: ____________________

REFERRING PHYSICIAN: ______________________________ PHONE: ____________________

OTHER PHYSICIAN(S): ______________________________ PHONE: ____________________

CURRENT MEDICATIONS: ** PLEASE MARK N/A IF NO MEDICATIONS ARE TAKEN** ☐ N/A

*Please include prescription drugs and/or non-prescription medications, including over the counter and vitamins/supplements; if needing more space, please use a separate sheet of paper. *

MEDICATION NAME: (i.e.Tylenol#3)	DOSAGE: (i.e. 30MG)	FREQUENCY: (i.e. Take 1 tablet every 4 hours as needed)

ALLERGIES: ** PLEASE MARK N/A IF NO CURRENT ALLERGIES** ☐ N/A

(Please list medication allergies, food allergies, latex allergies and the reaction to each).

ALLERGY: (i.e. Tylenol #3, Peanuts, Latex)	REACTION: (i.e. Itching, Swelling, Rash)
1.	
2.	
3.	
4.	

SURGERY HISTORY: ** PLEASE MARK N/A IF NO PAST SURGERIES** ☐ N/A

(Please list all past surgeries/reason and date)

SURGERY/REASON:	DATE:

** Have you ever had problems with Anesthesia? ☐ Y ☐ N

If yes, please explain: ____

PREVIOUS TREATMENTS/TESTS: If yes, please list date below of last treatment/test

- ☐ Y ☐ N Physical/Occupational Therapy ____________
- ☐ Y ☐ N Chiropractor/Manipulation ____________
- ☐ Y ☐ N Acupuncture ____________
- ☐ Y ☐ N Hypnosis ____________
- ☐ Y ☐ N TENS Unit ____________
- ☐ Y ☐ N Psycho/Psychiatric Therapy ____________
- ☐ Y ☐ N Lumbar MRI ____________
- ☐ Y ☐ N Thoracic MRI ____________
- ☐ Y ☐ N Cervical MRI ____________
- ☐ Y ☐ N CT Scan ____________
- ☐ Y ☐ N Myelogram ____________
- ☐ Y ☐ N Nerve Conduction ____________
- ☐ Y ☐ N Bone Scan ____________
- ☐ Y ☐ N Discogram ____________

FAMILY HISTORY: ** PLEASE MARK N/A IF UNKNOWN ** ☐ N/A

Mother: ☐ Alive ☐ Deceased *Father:* ☐ Alive ☐ Deceased *Siblings:* ☐ Alive ☐ Deceased

Please check yes or no to the following questions if they apply please specify family member (i.e. Maternal Grandmother breast cancer):

☐ Y ☐ N Heart Disease	☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Cancer | Type: ________	☐ Y ☐ N Stroke
☐ Y ☐ N Diabetes | Type: _______	☐ Y ☐ N Blood Clots
☐ Y ☐ N Dementia	☐ Y ☐ N Lung Disease
☐ Y ☐ N Kidney Disease	Other: ____________________

SOCIAL HISTORY:

☐ Married ☐ Divorced ☐ Single ☐ Widowed

Do you live alone? ☐ Y ☐ N If not, with whom: ____________________

Residence Type (House, apartment, assisted living): ____________________

☐ Working ☐ Disabled ☐ Retired ☐ Student

Occupation: ____________________

Are you currently pregnant or nursing? ☐ Y ☐ N

# of months: ____________

☐ Never Smoked or Chewed Tobacco

☐ Current Tobacco User: Type ____________How Often __________ per day

☐ Quit Date: (Smoking or Chewing) ____________________

Are you regularly exposed to tobacco smoke? ☐ Y ☐ N

If yes, how? ☐ At home ☐ At Work

Have you been diagnosed with a tobacco related illness? ☐ Y ☐ N

If yes, What illness? ________________________________

Do you drink alcohol? ☐ Y ☐ N

How Much? __________________

How Often? __________________

Do you currently use or have a history of illicit substance use? ☐ Y ☐ N

Have you ever been diagnosed with Depression and/or Anxiety? ☐ Y ☐ N

If yes, how well has it been controlled in the past 3 months? (circle)

Excellently Well Could be better Poorly

Are you currently under the care of a psychiatrist or psychologist? ☐ Y ☐ N

If yes, how long?____

Have you ever been hospitalized for a psychiatric illness? ☐ Y ☐ N

If yes, when and for how long?____

The following are some questions given to all patients at MMP who are 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 treatment.

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 close friends had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
5. How often have you attended an AA or NA meeting? 0 1 2 3 4
6. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
7. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
8. How often have your medications be lost or stolen? 0 1 2 3 4
9. How often have other expressed concern over your use of medication? 0 1 2 3 4
10. How often have you felt a craving for medication? 0 1 2 3 4
11. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4
12. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4
13. How often have you used illegal drugs (example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
14. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4

REVIEW OF SYSTEMS: (other than the reason you are here today)

MUSCULOSKELETAL:

☐ Y ☐ N Joint Pain/Stiffness

☐ Y ☐ N Joint Swelling

☐ Y ☐ N Back Pain

☐ Y ☐ N Difficulty Walking

RESPIRATORY:

☐ Y ☐ N Oxygen at Home

☐ Y ☐ N Cough

☐ Y ☐ N Wheezing

☐ Y ☐ N Snoring

☐ Y ☐ N Shortness of Breath

HEME/LYMPH:

☐ Y ☐ N Easily Bruised

☐ Y ☐ N Bleeds Easily

☐ Y ☐ N Swollen Lymph Nodes

GASTROINTESTIONAL:

☐ Y ☐ N Nausea/Vomiting

☐ Y ☐ N Constipation

☐ Y ☐ N Diarrhea

EARS, NOSE, THROAT, MOUTH:

☐ Y ☐ N Difficulty Hearing

☐ Y ☐ N Difficulty Swallowing

☐ Y ☐ N Dentures

PSYCHIATRIC:

☐ Y ☐ N Feeling of Depression

☐ Y ☐ N Anxiety

NEUROLOGICAL:

☐ Y ☐ N Headaches

☐ Y ☐ N Numbness/Tingling

CARDIOVASCULAR:

☐ Y ☐ N Chest Pain/Tightness

☐ Y ☐ N Irregular Heartbeat

☐ Y ☐ N Swelling of Feet or Legs

ENDOCRINE:

☐ Y ☐ N Excessive Thirst

☐ Y ☐ N Excessive Urination

☐ Y ☐ N Heat/Cold Tolerance

CONSTITUTIONAL:

☐ Y ☐ N Fever/Chills

☐ Y ☐ N Fatigue/Weakness

☐ Y ☐ N Weight Loss/Gain

GENITOURINARY:

☐ Y ☐ N Incontinence

☐ Y ☐ N Frequent Urination

☐ Y ☐ N Painful Urination

SKIN:

☐ Y ☐ N Rashes

☐ Y ☐ N Dryness

☐ Y ☐ N Open Sores

THE REASON YOU ARE HERE TODAY:

Where is most of your pain?______________________________ Is this new or old?__________________

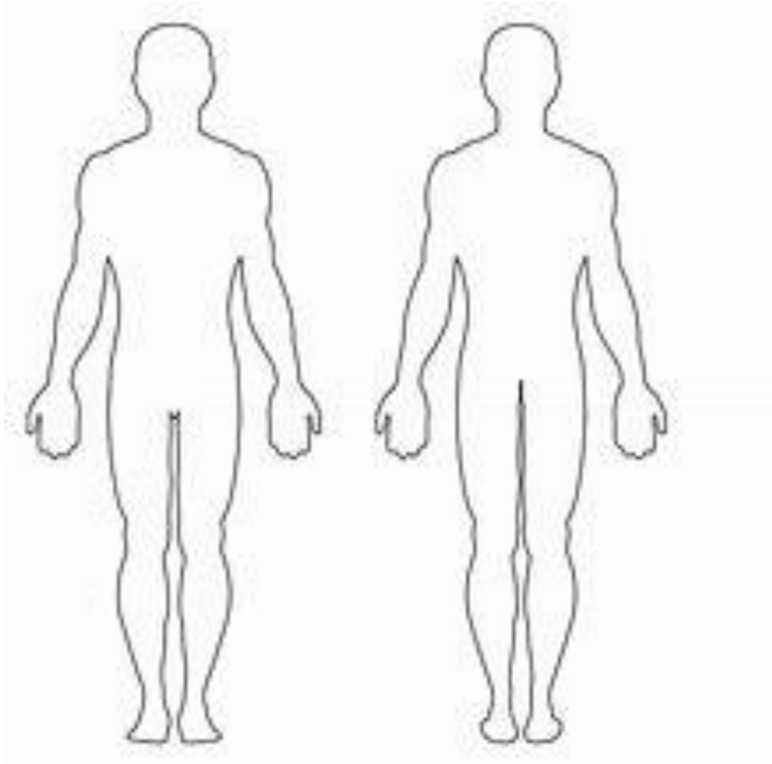
What activity were you doing or what caused the injury? ____

Where were you at the time of injury? ____

ON THE DIAGRAM, SHADE IN THE AREAS WHERE YOUR PAIN IS LOCATED:

(R) FRONT

(L) BACK



Mark your level of pain on this scale: (circle)

None Severe

0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse? ____

What makes the pain better? ____

Circle a FEW words that best describe your pain

Flickering	Pricking	Pinching	Tugging	Hot	Dull	Tender	Annoying	Tight
Quivering	Boring	Pressing	Pulling	Burn	Sore	Tiring	Troublesome	Numb
Pulsing	Drilling	Gnawing	Wrenching	Scald	Hurting	Exhausting	Freezing	Miserable
Pounding	Stabbing	Cramping	Crushing	Sting	Aching	Nagging	Unbearable	Intense

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:________________________________ **DATE:**________________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ________
	Somewhat difficult ________
	Very difficult ________
	Extremely difficult ________

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