Interventional Pain Medicine
for Spine & Chronic Pain Care
Board Certified • Fellowship Trained

www.painreliefofdayton.com

Rick Buenaventura, M.D.
7244 Far Hills Avenue
Centerville, Ohio 45459
p (937) 395-1300
f (937) 395-1311

Patient Information

Date ______________________

If you have scheduled an appointment with us, go to the Treatment page on our website www.painreliefofdayton.com for the downloadable pain questionnaire and medical history form that you can fill out prior to your appointment — to save you time.

Last Name ______________ First ______________ Middle ______________
Address ______________ City ______________ State ______ Zip ______
Home Phone (____) ______________ Cell (____) ______________ Work (____) ______________
Date of Birth ____/____/____ Social Security# ______________ Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Primary Care Physician ______________ Phone (____) ______________
Address ______________ City ______________ State ______ Zip ______
Full-time Student: ☐ Yes ☐ No
Employer ______________
Address ______________ City ______________ State ______ Zip ______

Guarantor *(if different from above)*

Relationship to Patient ______________
Last Name ______________ First ______________ Middle ______________
Address ______________ City ______________ State ______ Zip ______
Home Phone (____) ______________ Cell (____) ______________ Work (____) ______________
Date of Birth ____/____/____ Social Security# ______________ Sex: ☐ Male ☐ Female
Employer ______________
Address ______________ City ______________ State ______ Zip ______

Emergency Contact

Name ______________ Relationship ______________
Daytime Phone (____) ______________

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Insurance Information *(Please present insurance cards to office)*

Primary Insurance ______________________________

Policy Holder ____________________ Policy Holder SS# ____________________

Secondary Insurance ______________________________

Policy Holder ____________________ Policy Holder SS# ____________________

Is this a work related injury: ☐ Yes ☐ No

Is this injury related to a motor vehicle accident: ☐ Yes ☐ No

If yes to above: Claim # ____________ Date of Injury ____________

Case Worker Name ____________ Phone (___) ____________

Advance Directives

Do you have any advance directive? Living Will? ☐ Yes ☐ No

If yes, at which hospital is it filed? ______________________________

How did you hear about our office?

☐ Friend/Family ☐ Physician ☐ Advertisement

☐ Other: ______________________________

Whom may we thank for your referral to our office? ______________________________

Missed Appointment Policy

We at Pain Relief of Dayton are concerned about your health care. Not keeping scheduled appointments hinders our ability to provide quality care. Pain Relief of Dayton requires a 24 hour notice for all cancellations. This allows us to offer another patient your time slot in the event you can not keep it. If you do not provide a 24 hour cancellation notice you may be charged for the visit. This charge is not payable by your insurance carrier and will be your responsibility.

Co-payments

All co-payments and deductibles are due at the time of service. Additional charges will apply if you must be billed.

Authorizations

1 authorize examination, diagnosis and general treatment (including but not limited to, the use of x-ray and other Non-invasive procedures such as diagnostic tests) to be performed by the physicians and staff of Pain Relief of Dayton. I realize that if a medical procedure is required, I will be given additional information.

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I understand that as part of my healthcare, this practice originates and maintains health records and radiology films describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records and radiology films will be retained by Pain Relief of Dayton even if my healthcare provider(s) leave the practice.

I authorize the release of any medical information necessary to process insurance claims and request payments of benefits either to myself or the party who accepts assignment/participates.

Financial Agreement

I understand the bill is my responsibility. I assign and authorize payments be made directly to Pain Relief of Dayton of all Insurance benefits and agree to pay any balance due. I understand that I will be responsible for any additional fees incurred from the following: Returned Checks, Missed Appointments, Non-payment of co-pays or deductibles at time of service and Copies of Medical Records.

Date: ______________________

Signature of Patient or Patient Representative: ______________________________________

Printed Name of Patient or Patient Representative: ____________________________________

Representatives relationship to patient. ____

A copy of legal authority to act for the patient must be presented.

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A Letter to Our Patients Regarding Our Role in Your Care

Name ______________________

Date ______________________

Dear Patient,

We are happy to see you in our practice. We utilize a wide array of therapies and non-addicting medications to minimize and control your pain. Our goal is to do this without the use of narcotics or controlled pain medicines. In most cases, we prefer not to prescribe or escalate any controlled pain medicines you are currently taking.

Several new procedures and non-controlled pain medicines have been developed in the last few years. Our approach is to implement these therapies and medicines into your treatment regimen. We will evaluate your case and offer the most reasonable, safe and beneficial treatment for you. We may also use physical therapy. A psychologist specializing in the treatment of painful and chronic conditions, located on the premises, can be consulted as well to help in the treatment of your condition.

We will make suggestions to your referring physician about what medicines, including controlled medicines, we think are right for you and your condition. We may start you on some non-controlled pain medicines and then turn these over to your primary care doctor for the continuance of these. Other times we may suggest all the medicines to him so that he may decide which are safe and best in your case.

Hopefully, through the use of these pain relieving procedures and non-narcotic pain medications we can minimize or delay your future need for controlled substances. This will delay the development of tolerance or dependence on these medicines later. Please keep in contact with your primary care doctor and make sure you have enough medicine to get back to their clinic.

From all of us at Pain Relief of Dayton, we look forward to seeing you and making your evaluation a pleasant one.

Rick M. Buenaventura

— RICK BUENAVENTURA, M.D.
PAIN RELIEF OF DAYTON

Patient Signature: ______________________

We will include this letter in your medical records.

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Confidential Communication

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have the right to request that communications concerning your personal health information be made through confidential channels.

______________________________ (print name) requests the use of the following confidential channels for the communication of information related to my personal health, treatment, diagnostic results, or appointment reminders.

Phone:

I want you to contact me by telephone at this primary number: ______________________

☐ **Do** ☐ **Do Not** Leave detailed messages on my answering machine.
☐ **Do** ☐ **Do Not** Leave detailed messages with any other person.

I want you to contact me by telephone at this secondary number: ______________________

☐ **Do** ☐ **Do Not** Leave detailed messages on my answering machine.
☐ **Do** ☐ **Do Not** Leave detailed messages with any other person.

Fax:

You may contact me by fax at the following number: ______________________

If there any people with whom we may discuss your health information, please list them below:

____

____

____

Signature: ______________________ Date: ______________

Printed Name: ______________________________

Date Granted: ______________ Date Terminated: ______________

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