PEMCO

pain evaluation & management center

PLEASE BRING:
Photo ID
Insurance Card
List of Medications
Any records/testing

Dear Patient:

Welcome to the Pain Evaluation & Management Center of Ohio (PEMCO). Our multidisciplinary pain practice has been in existence for over 20 years. We provide pain management that is state of the art, the most aggressive and advanced treatment offered anywhere in Ohio. PEMCO was the first outpatient pain center in southwest Ohio and we are proud to have been innovators of many of the current pain practices that are used by other physicians across the country.

Our medical staff is comprised of three physicians; Dr. Donnini who is the founder of the clinic, Dr. Pauley and Dr. Syllaba. Combined, they have over 40 years of clinical experience in pain management.

We have three licensed nurse practitioners, Lidia Berrone, Yvonne Clark PhD., and Kathi Flanders. They have extensive experience in nursing and are board certified nurse practitioners; who can see and treat patients and write prescriptions.

Your new patient appointment will be scheduled with a physician; however, it might be necessary for you to see one of the other physicians or nurse practitioners at follow up visits. Our providers work together, practice very closely and are able to discuss your treatment and any specific issues on a daily basis. We believe that this provides good continuity of care. If you feel a concern or an issue was not addressed, at any time you can leave a message for any of the physicians or nurse practitioners by calling the nurse line at extension #107. Just dial our office number and listen for the prompts. Your call will be returned as soon as possible and always within 24 to 48 hours. If you have any questions or concerns regarding the management and operations of our practice, you may direct a call to Karen at extension #118.

We look forward to serving you and all of your pain management issues and will provide the utmost quality of care that is possible.

Richard Donnini, D.O.

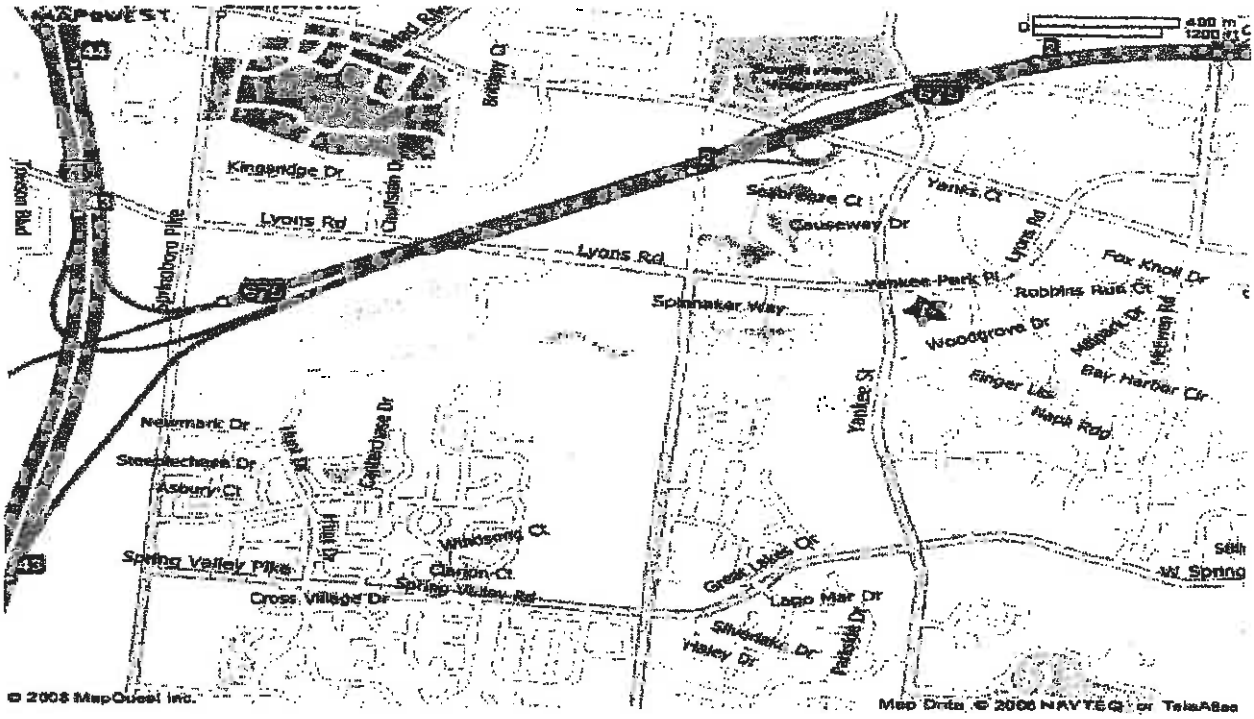
Janice Pauley, M.D.

Andreas Syllaba, D.O.

Your appointment is scheduled with Dr. _____ on _____.

***If we do not have your complete records at the time of your appointment, we may not be able to initiate treatment.**

1550 Yankee Park Pl, Dayton, OH 45458 (937) 439-4949 Fax (937) 439-4948



DIRECTIONS TO PAIN EVALUATION & MANAGEMENT CENTER OF OHIO

Coming from either north or south on I-75, take the I-675 north exit and go to the first exit, which is Exit 2. The off-ramp will come to a stoplight, which is State Route 725. Take a right on State Route 725 and go less than ¼ mile to the very next light, which is Yankee Street, and turn right onto Yankee Street. Continue just a short distance to the next stoplight, which is the intersection of Yankee Street and Lyons Road. Turn left onto Lyons Road and take an immediate first right into the complex driveway and bear to the right to come to our clinic, which is directly on the corner of Yankee and Lyons.

Coming from I-675 north, continue south to Exit 2, which is the last exit on I-675 before it intersects to I-75. You will exit on the right side of the highway and come to a stoplight at Yankee Street. Turn left onto Yankee Street and continue straight through the intersection of Yankee Street and State Route 725 (which is the first stoplight) until you come to the second light, which is the intersection of Yankee Street and Lyons Road. Turn left onto Lyons Road and take an immediate first right into the complex driveway and bear to the right to come to our clinic, which is directly on the corner of Yankee and Lyons.

Coming from either the north or south on State Route 48, continue to the intersection of Spring Valley Pike and State Route 48, which is just south of downtown Centerville. Head west onto Spring Valley Pike and continue until you intersect with Yankee Street. Turn right onto Yankee Street until just before the next stoplight at Lyons Road. You will see a driveway on the right just before the stoplight at Lyons Road, which will enter into our building parking lot, which is directly on the corner of Yankee Street and Lyons Road.

Pain Evaluation & Management Center of Ohio, Inc.

Richard M. Donnini, DO Janice L. Pauley, MD Andreas H. Syllaba, DO Thomas W. Heitkemper, PhD

PATIENT INFORMATION SHEET (Please complete both pages)

FULL NAME: _____ ___MALE ___FEMALE DATE: _____
(Last, First, Middle)

ADDRESS: _____ _____ _____ _____
(Street) (City) (State) (Zip)

HOME PH: _____ CELL: _____ DOB: _____ SSN: _____

MARITAL STATUS: _____Single _____Married _____Divorced _____Widowed

RELATIONSHIP TO INSURED: _____Self _____Spouse _____Dependent _____Other: _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____ REFERRING PHYSICIAN: _____

EMERGENCY CONTACT: _____ _____
(Full Name & Relationship) (Full Name) (Phone Number)

****

IF RESPONSIBLE PARTY IS OTHER THAN PATIENT, PLEASE COMPLETE THIS SECTION

FULL NAME: _____ _____ MALE _____ FEMALE
(Last, First, Middle)

ADDRESS: _____ _____ _____ _____
(Street) (City) (State) (Zip)

HOME PHONE: _____ CELL: _____ DOB: _____ SSN: _____

EMPLOYER: _____ WORK PHONE: _____

****

PLEASE COMPLETE THIS SECTION

PRIMARY INSURANCE	SECONDARY INSURANCE
POLICY HOLDER: _____	POLICY HOLDER: _____
INSURANCE CO: _____	INSURANCE CO: _____
ADDRESS: _____	ADDRESS: _____
PHONE: _____	PHONE: _____
POLICY NO: _____	POLICY NO: _____
GROUP NO: _____	GROUP NO: _____

****

IF WORKERS' COMPENSATION OR LEGAL CASE, PLEASE COMPLETE THIS SECTION

ORIGINAL DATE OF INJURY: _____ CLAIM NO: _____

MCO: _____ REPRESENTATIVE: _____

DOCTOR OF RECORD: _____ _____
(Full Name) (Phone Number)

EMPLOYER AT TIME OF INJURY: _____

EMPLOYER'S ADDRESS: _____

ATTORNEY: _____ _____
(Full Name) (Phone Number)

ATTORNEY'S ADDRESS: _____

INSURANCE AGENT: _____ _____
(Full Name) (Phone Number)

ORIGINAL DATE OF ACCIDENT: _____ CLAIM NO: _____

CONSENT FOR TREATMENT

I understand I am responsible for payment in full in a timely manner; I authorize the release of any medical information necessary to process this claim; and, I authorize direct payment of medical benefits to the providing physician for services rendered. In the event of out-of-network charges, I understand that I am responsible for payment of these charges in full.

_____ _____

Signature of Patient/Responsible Party Date

Patients with Medicare, please read and complete the following:

I certify the information given by me, applying for payment under Title XVIII of the Social Security Act, is correct. I authorize any holder of my medical information to release any information needed for this, or a related Medicare claim, to the Health Care Financing Administration or its intermediaries or carriers. I request that payment of authorized services be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ _____

Signature of Patient/Responsible Party Date

PEMCO
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name _____ **First** _____ **MI** _____

Sex ☐ Male ☐ Female **Date of Birth:** _____ **Height** _____ **Weight** _____

Name of Primary Care Physician: _____

Pharmacy Preference (include location): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ____ **Yes** ____ **No.** If yes, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____Yes ____No
If yes, please list type of problems: _____

_____

_____

List any surgeries you have had (including dates):

_____

_____

_____

Have you ever been hospitalized for non-surgical reasons? ___Yes ___ No
If yes, list reasons for hospitalizations _____

_____

CURRENT OR MOST RECENT OCCUPATION: _____

Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# _____

Do not write above this line

Date: _____ Time: _____

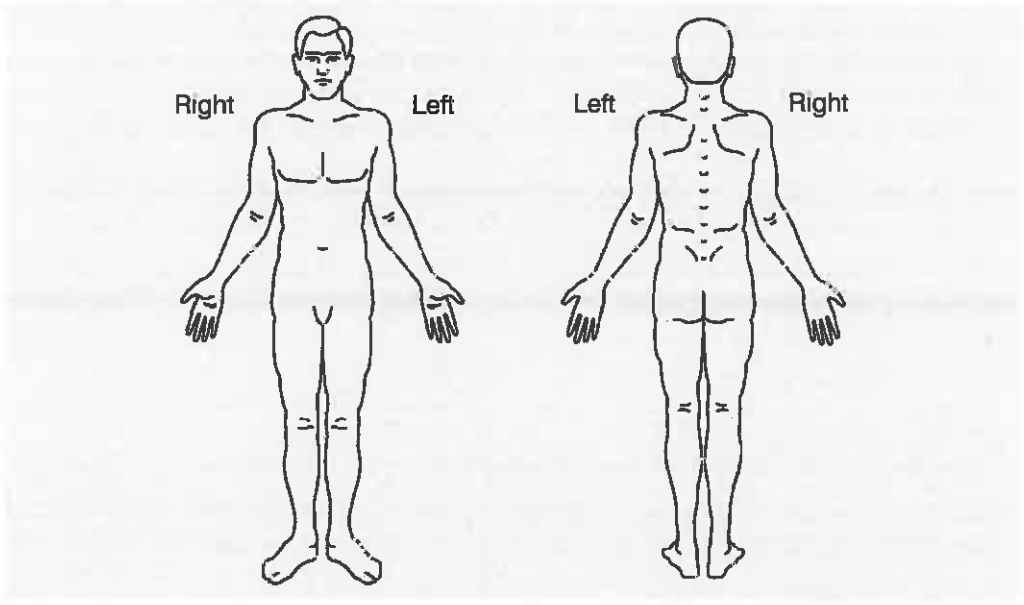
Name: _____

Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Complete the following two pages only if you are taking controlled substances or plan to ask for controlled substances as part of your treatment plan.

ADDICTION(S)

Do you have a history of smoking cigarettes? Yes _____ No _____

If yes, when? _____

Do you have a history of alcohol/substance abuse? Yes _____ No _____

If yes, when? _____

History of substance abuse in your mother/father? Yes _____ No _____

Whom? _____

Do you consume alcohol? Yes _____ No _____

If yes, how much? Daily _____ Weekly _____ Socially _____ Rarely _____

Have you ever felt you should cut down on your drinking? Yes _____ No _____

Have people annoyed you by criticizing your drinking? Yes _____ No _____

Have you ever felt bad or guilty about your drinking? Yes _____ No _____

Have you ever had a drink first thing in the morning or to get rid of a hangover (eye-opener)? Yes _____ No _____

Do you consume caffeine? Coffee _____ Tea _____ Cola _____

Patient Name: DOB:

Drug Use Questionnaire

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months. Carefully read each statement and decide if your answer is *"Yes"* or *"No"*. Then circle the appropriate response beside the question.

In the following statements "drug abuse" refers to:

1. the use of prescribed or over-the-counter drugs in excess of the directions, and
2. any non-medical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These Questions Refer to the Past 12 Months			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No