Mark A. Ellis, M.D.
Board Certified Pain Management Specialist
Medical/Lab Director

Terrance L. Hughes, M.D.
Board Certified Pain Management Specialist
Board Certified Physical Medicine & Rehabilitation

Dear Patient,

We would like to welcome you to our practice, Ellis Pain Center. **PLEASE BE ADVISED THERE IS NO GUARANTEE ANY MEDICATIONS WILL BE PRESCRIBED AT YOUR 1ST VISIT.** That decision will be made after your physical exam, review of records, and diagnostic studies/testing that have been completed. We promise to provide you with quality service and innovative and effective treatment for your pain.

Our staff has scheduled you an appointment with _____ on _____ at _____. We have enclosed the personal information and an evaluation form for you to complete.

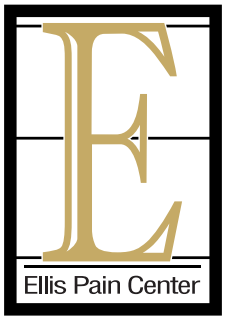
For your initial evaluation, you **MUST** bring all current **insurance cards** and a **VALID GEORGIA Drivers License**. You will also be responsible for any co-payments and/or decuctibles associated with your insurance carrier. These amounts will be DUE at the time of service.

Also, please bring with you all of your medications in the original bottles that you are currently taking.

If you have any questions or are unable to keep this appointment, please call our office at least 24 hours in advance at (706) 208-0451. Our office hours are Monday through Friday, 8:00am – 5:00pm.

We look forward to serving you.

Physicians and Staff



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Patient Information Sheet

Patient Name: _____ DOB: _____

Phone Number: _____ SSN: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
(if different) Street City State Zip

Email Address: _____
*Mandatory to access Patient Portal

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Please circle all that apply:

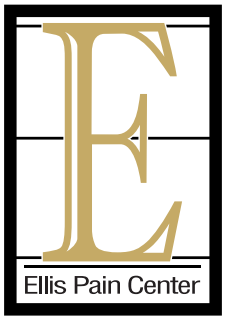
Race: Caucasian (white) Black or African American American Indian or Alaskan Native
Native Hawaiian Asian Refused to Report/Unreported

Language: English Spanish Other: _____

Marital Status: Single Married Divorced Widowed

Family History: Has any of your family members (parents, grandparents, siblings) had the following diseases/conditions?

	Family Member?	Age of Diagnosis?
Cancer	_____	_____
Diabetes	_____	_____
Stroke	_____	_____
Heart Disease	_____	_____
Hypertension	_____	_____
Other (*specify*)	_____	



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Pain Assessment

NAME: _____ AGE:_____ TODAY'S DATE:_____

1. Where is your pain located? _____
2. Describe your pain (example: dull, sharp, burning, etc.): _____
3. Was your pain caused by an injury? YES _____ NO _____
   If yes, how did you hurt yourself? _____
4. Were you at work when the injury occurred? YES _____ NO _____
5. Are you currently unable to work due to the pain? YES _____ NO _____
6. What is the legal status of your claim? (Please check one)
   Retained attorney _____ Currently in litigation _____
   Claim Settled _____ N/A _____
7. What treatments have you had for your pain? (Check all that apply)
   Medications _____ Please list _____
   Physical Therapy _____ When? _____
   Nerve Block _____ When? _____ Performed Where: _____
   Surgery _____ When? _____ Name of Surgeon: _____
   Other _____
8. Do you have any of the following conditions?
   Any Contagious Diseases YES ____ NO ____ Kidney Disease YES ____ NO ____
   Bleeding Problems YES ____ NO ____ Liver Diseases YES ____ NO ____
   Diabetes YES ____ NO ____ Thyroid Problems YES ____ NO ____
   High Blood Pressure YES ____ NO ____
   Other (please specify) _____
9. List all previous surgeries: _____
   _____
10. List any allergies to medications: _____
    _____
11. List all CURRENT medications:

Medication	How Often
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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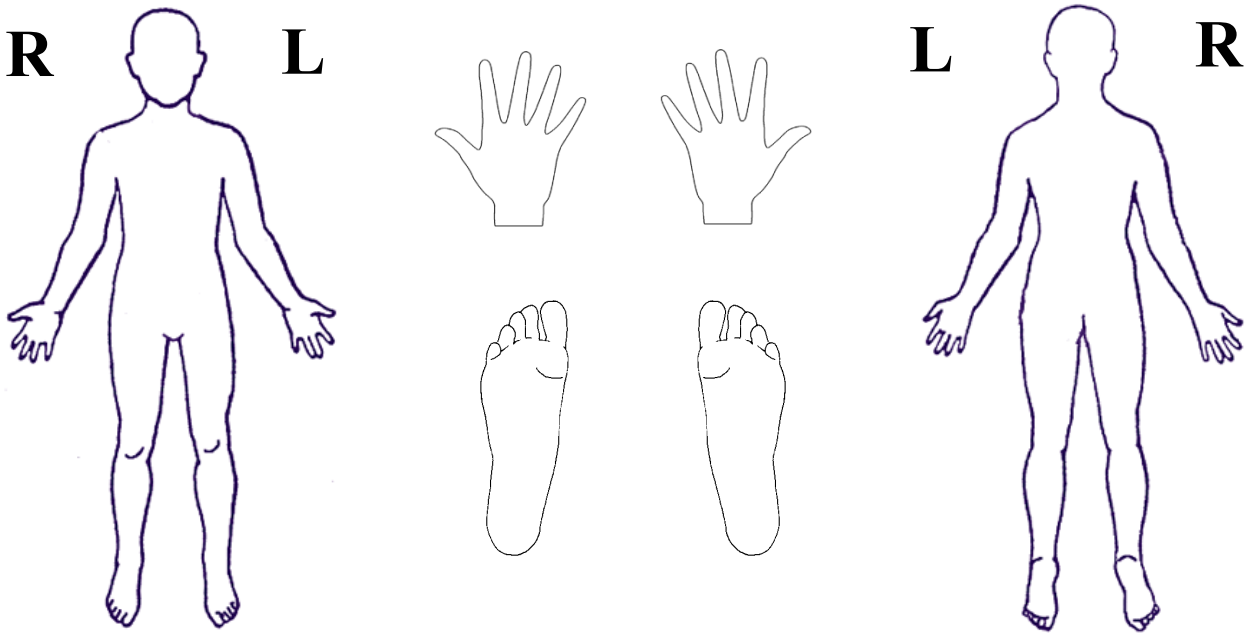
Pain Assessment

Patient Name: _____ Date: _____

Please shade the areas where you are having pain on the diagram below:



On a scale from 1 to 10, please answer the questions below appropriately:

12. What is your level of pain?

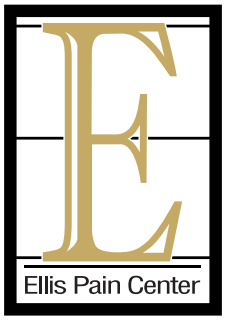
1 2 3 4 5 6 7 8 9 10
No Pain **Worst Pain**

13. How does the pain affect your level of activity?

1 2 3 4 5 6 7 8 9 10
No Pain **Worst Pain**

14. How does pain affect your sleep?

1 2 3 4 5 6 7 8 9 10
No Pain **Worst Pain**



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Privacy Practices Acknowledgement

I have had the opportunity to read and review the content of this authorization form and I agree with all statements made in this authorization. By signing this form, I understand that I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations in this form.

_____ _____
Patient Signature Date

I hereby give authorization for the person(s) below to obtain any medical records and/or health information pertaining to myself:

_____
Name of Person(s)

_____
Relationship to Patient

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.
Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____
Patient Name Date of Birth

_____
Patient Signature

_____
Date