



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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Primary Care Physician _____	Phone (____) _____	
Address _____	City _____	State _____ Zip _____
Full-time Student: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer _____		
Address _____	City _____	State _____ Zip _____

Guarantor <i>(if different from above)</i>		
Relationship to Patient _____		
Last Name _____	First _____	Middle _____
Address _____	City _____	State _____ Zip _____
Home Phone (____) _____	Cell (____) _____	Work (____) _____
Date of Birth ____ / ____ / ____	Social Security# _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Employer _____		
Address _____	City _____	State _____ Zip _____

Emergency Contact	
Name _____	Relationship _____
Daytime Phone (____) _____	

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 NoIs this injury related to a motor vehicle accident: Yes No

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

Case Worker Name _____ Phone (____) _____

Advance DirectivesDo 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

I 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.

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 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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Initial Consent for Treatment

Name _____

DOB _____ Date _____

I desire to be treated at Pain Relief of Dayton by Dr. Ricardo Buenaventura. I understand that I may discontinue treatment at any time.

I understand that in order to receive appropriate treatment, I will undergo a clinical evaluation consisting of, but not limited to, a medical history and evaluation, and may include an x-ray, MRI, physical examination, and psychological assessment. The purposes of such evaluations are to assist in identifying the cause of my problem and applying the most appropriate medical treatments possible.

I understand and consent to the administration of an evaluation. After the evaluation, my doctor will offer treatment options which may include, but are not limited to, non-narcotic medications, physical therapy, injection therapy, chiropractic treatments, and psychological therapy as considered necessary and advised by the physician.

I understand that treatments provided by Pain Relief of Dayton are voluntary, and in no way guaranteed to relieve my pain fully and completely.

I also understand that Pain Relief of Dayton does not utilize the regular use of narcotic medications.

Patient Signature: _____