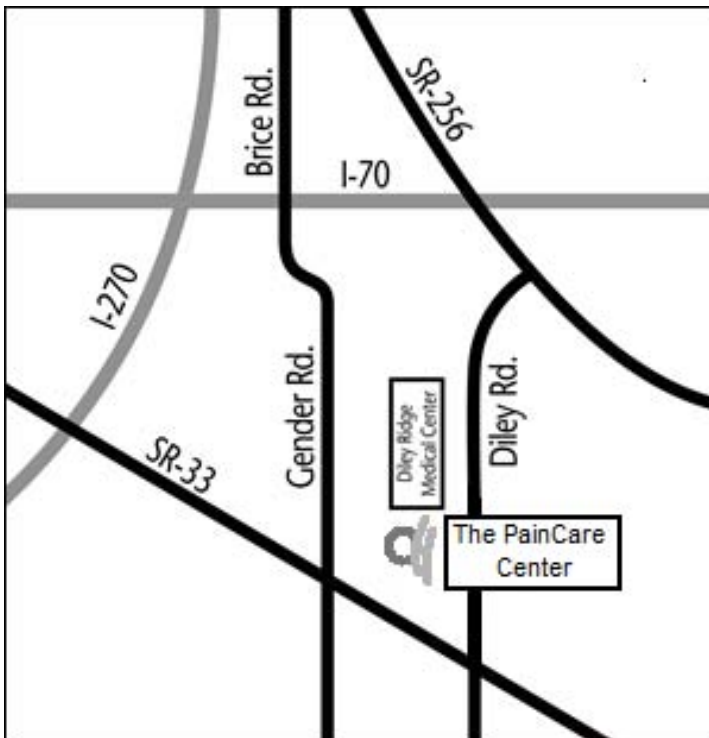


Martin J. Andrews, M.D.
Board certified in Pain Management and Anesthesiology

Initial Visit Package

- PLEASE FILL OUT ATTACHED PAPERWORK AND BRING TO APPOINTMENT
- HAVE A CURRENT INSURANCE CARD AND COPAY
- IF INJECTIONS ARE INDICATED, YOU WILL NEED A DRIVER



Your Appointment is in:

The Diley Ridge Medical Office Building

7901 Diley Road, Suite 130

Canal Winchester, OH 43110

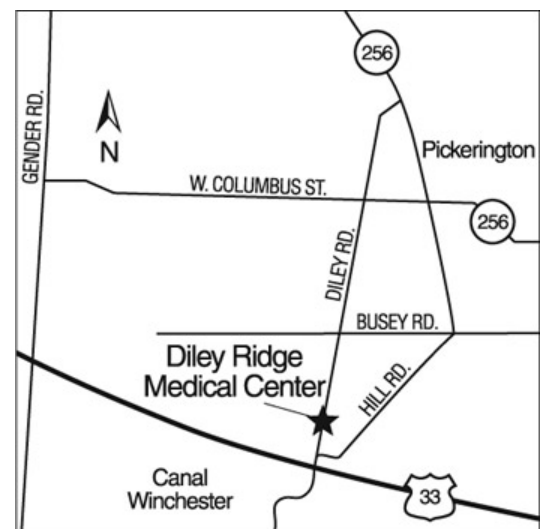
With Dr. Martin J. Andrews, M.D.

Date: _____

Time: _____

Phone: 614.FOR.PAIN

740.653.HURT



- Should you need to reschedule, a 24 hour notice is appreciated.
You should expect a reminder call one day before your appointment
- Please fill out all patient information sheets prior to your appointment. If you are unable to do this, please show up 15 minutes before your appointment to complete them.

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Signature and Authorization

1. Consent to Medical Procedures:

The undersigned consents to the treatment that may be performed during the initial office visit or on a follow up visit to this office. Care may include emergency treatment or services that may include, but are not limited to laboratory procedures, medical or surgical treatment or procedures, local anesthesia. Surgical procedures rendered to the patient, other than emergency, will have a separate consent.

2. Authorization, Consent, and Waiver for Releases of Information:

The PainCare Center physicians are hereby authorized to release any information necessary, including copies of my medical records, to collect benefits. Such records may include those with information of psychological or psychiatric nature, pertaining to my medical condition or treatment for such a condition, my condition or treatment relating to the use of alcohol, my condition or treatment relating to the use of drugs, and emergency treatment and services. I hereby release The PainCare Center physicians from and waive all liability that may rise from the release of such information.

3. Assignment of Benefits:

In consideration of services received or to be received, I, the undersigned, hereby assign The PainCare Center physicians participating in service the amount due me or that which becomes due to me up to an amount not exceeding the physician charges for the period of treatment and I hereby authorize and direct that payments be made directly to the said physician. I further recognize that if payment is made directly to me by said insurance company or HMO, the amount received up to the amount of the physician bill is the property of The PainCare Center physicians and should be paid over to said physicians immediately.

4. Financial Agreement:

I hereby promise to pay The PainCare Center physicians participating in my treatment and care, for any and all services rendered to the named patient. I hereby acknowledge financial responsibility of any and all services rendered which my insurance plan or HMO may exclude from payment, either because the plan deems such services not medically necessary, or for any other reason, including pre-certification requirements, second opinions, or pre-existing conditions. I shall hereby be responsible for payment in the event my insurance plan or HMO does not pay within the payment terms.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Signature: _____

Patient Name: _____

Date: _____

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Patient History Form

Please fill out both sides of form

*Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date: _____ / _____ / _____ / Date of Last Physical Exam: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Patient Name: _____

Today's Date: _____ / _____ / _____ / Height: _____ Weight: _____ Age _____

Chief Complaint

What is the main reason for your visit today? Describe your problem in detail

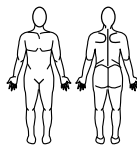
History of Present Illness Please answer the following questions

Location of the Problem:

Abdomen Back Leg

Other _____

Front Back



How Long Does The Problem Last?

30 Minutes 1 Hour It is always there

Other _____

Is Anything Occurring At The Same Time?

Yes No (If Yes, Please Explain) _____

Nausea Rash Headaches

Other: _____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem:

1 2 3 4 5 6 7 8 9 10

When Did You First Notice the Problem?

2 Days Ago 2 Weeks Ago 1 Month Ago

Other _____

Is The Problem Constant or Variable?

Dull Then Sharp Very Sharp Then Leaves

It Is Always There Other _____

Does Anything Help or Make the Problem Worse?

Moving Around Standing Up Lying On My Side

Other _____

Does The Problem Interfere With Your Normal Activity?

Yes No If Yes, Please Explain _____

Past Medical & Social History

Please List All Serious Illness In Your Past. (Example: Diabetes, Tuberculosis, Cancer, Heart Disease, Hepatitis, ect.,)

List Any Past Surgeries and Year Occured:

Do You Smoke? Yes No How Much? _____

Do You Drink? Yes No How Much? _____

Do You Have Allergies? Yes No Please List _____

Review of Systems

Do you now have, or have you had in the past any problems related to the following systems?

Please explain any yes answers in the space provided

Eyes:

Blurred Vision Yes No _____

Double Vision Yes No _____

Pain Yes No _____

Other _____

Neurological:

Tremors Yes No _____

Dizzy Spells Yes No _____

Numbness/tingling Yes No _____

Other _____

Cardiovascular:

Chest Pain Yes No _____

High Blood Pressure Yes No _____

Other _____

Physical Therapy:

Yes No Current Past How Long? _____ When? _____ Where? _____
Results _____

Tens Unit: Current Past How Long? _____ When? _____ Where? _____
Results _____

Traction: Current Past How Long? _____ When? _____ Where? _____
Results _____

Do you wear a brace, use anything to assist you in movement? Yes No Type _____

Have you ever been seen in a pain management program before? Yes No Type _____
When _____ Name of Doctor _____ Results _____

Have you had any type of injections for the pain you are being seen for? Yes No Type _____
When? _____ Where? _____ Results _____

Medications

List all current medication, dosages and doctor writing

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____