OC REGENERATIVE & PAIN CENTER
BY DR MIKE

New Patient Packet

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Patient Information

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Mobile Number _____ Email Address _____

Gender ☐ Male ☐ Female ☐ Other

Street Address _____ Street Address 2 _____

City _____ State _____ Zip Code _____

Emergency Contact / Account Type

Emergency Contact _____ Relationship _____ Phone _____

Account Type ☐ Insurance ☐ Lien (Personal Injury) ☐ Self-Pay (Cash)

Pain Area # 1

Area of Pain _____

Pain Level ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain Type ☐ Constant ☐ Intermittent

Choose each that apply

☐ Aching ☐ Numb ☐ Throbbing ☐ Tingling ☐ Shooting ☐ Sharp ☐ Cramping ☐ Dull ☐ NONE

Choose one - Onset

☐ Injury ☐ Work Related ☐ Gradual ☐ NONE

What makes it worse? _____

What makes it better? _____

Does your injury affect your: ☐ Daily activities ☐ Sleep ☐ Work/employment ☐ Function ☐ NONE

Is your condition ☐ Disaility Related ☐ Personal Injury ☐ NONE

Pain Area # 2

Area of Pain _____

Pain Level ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain Type ☐ Constant ☐ Intermittent

Choose each that apply

☐ Aching ☐ Numb ☐ Throbbing ☐ Tingling ☐ Shooting ☐ Sharp ☐ Cramping ☐ Dull ☐ NONE

Choose one - Onset

☐ Injury ☐ Work Related ☐ Gradual ☐ NONE

What makes it worse? _____

What makes it better? _____

Does your injury affect your: ☐ Daily activities ☐ Sleep ☐ Work/employment ☐ Function ☐ NONE

Is your condition ☐ Disaility Related ☐ Personal Injury ☐ NONE

Pain Area # 3

Area of Pain _____

Pain Level ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain Type ☐ Constant ☐ Intermittent

Choose each that apply

☐ Aching ☐ Numb ☐ Throbbing ☐ Tingling ☐ Shooting ☐ Sharp ☐ Cramping ☐ Dull ☐ NONE

Choose one - Onset

☐ Injury ☐ Work Related ☐ Gradual ☐ NONE

What makes it worse? _____

What makes it better? _____

Does your injury affect your: ☐ Daily activities ☐ Sleep ☐ Work/employment ☐ Function ☐ NONE

Is your condition ☐ Disaility Related ☐ Personal Injury ☐ NONE

Medical History - Choose Each That Apply

- [ ] High blood pressure
- [ ] Abnormal heart rhythm
- [ ] Bleeding disorder
- [ ] Kidney disease
- [ ] Cancer
- [ ] Bowel or urinary incontinence
- [ ] Diabetes
- [ ] Stroke
- [ ] Anemia
- [ ] Liver / ulcer disease
- [ ] Weakness
- [ ] Heart disease / heart attack
- [ ] Asthma / lung disease
- [ ] Arthritis
- [ ] Thyroid disease
- [ ] Constipation
- [ ] NONE

Other:

_____

_____

Additional details

_____

_____

Surgical History

Any prior surgeries? [ ] Yes [ ] NONE

Surgery / Procedure	Surgery / Procedure	Surgery / Procedure
_____	_____	_____
_____	_____	_____
Approximate date	**Approximate date**	**Approximate date**
_____	_____	_____
_____	_____	_____

Current Medications [ ] Yes [ ] NONE

Medication	Medication	Medication
_____	_____	_____
_____	_____	_____
Dose / Frequency	**Dose / Frequency**	**Dose / Frequency**
_____	_____	_____
_____	_____	_____

Allergies [ ] Yes [ ] NONE

Allergies	Allergies	Allergies
_____	_____	_____
_____	_____	_____
Reaction	**Reaction**	**Reaction**
_____	_____	_____
_____	_____	_____

Social / Family History

Tobacco	[ ] Never	[ ] Former	[ ] Current
Alcohol	[ ] Never	[ ] Occasionally	[ ] Regularly
Recreational Drugs	[ ] Never	[ ] Occasionally	[ ] Regularly

Important family medical history _____

General Consent & Patient Certification

I authorize evaluation and treatment by OC Regenerative & Pain Center by Dr. Mike. I certify that the information I provided is true and complete to the best of my knowledge. I authorize use and disclosure of my medical information as permitted for treatment, payment, healthcare operations, and other purposes allowed by law.

Patient / Legal Representative Name	Signature	Date

HIPAA Privacy Practices Acknowledgment

I acknowledge that I have been offered or received the practice's Notice of Privacy Practices, which explains how my protected health information may be used and disclosed and describes my privacy rights.

- ☐ I received the Notice of Privacy Practices I decline a paper copy at this time.
- ☐ I was offered the Notice of Privacy Practices I decline a paper copy at this time.

Patient / Legal Representative Name	Signature	Date

Communication Preferences

Choose each that apply - may we contact you regarding appointments and care by:

☐ Phone ☐ Text ☐ Email

Choose each that apply - may we contact you regarding appointments and care by:

☐ Yes ☐ No

Patient / Legal Representative Name	Signature	Date

Billing & Financial Responsibility

I understand that I am financially responsible for charges incurred for my treatment, including amounts not covered by insurance, an attorney, or another third-party payer. Insurance patients authorize direct payment of medical benefits to the practice and remain responsible for applicable co-pays, deductibles, and non-covered services. Personal injury / lien patients remain ultimately responsible for unpaid charges. Cash / self-pay patients are responsible for payment at the time of service unless prior arrangements are made.

By signing below, I acknowledge that I have read, understand, and agree to the Financial Responsibility Policy

Patient / Legal Representative Name	Signature	Date

Appointment Cancellation / No-Show Policy

Please provide at least 48 hours' notice to cancel or reschedule. Appointments canceled or rescheduled with less than 48 hours' notice, or missed without notice, may be subject to a $50 fee. The fee may be waived for emergencies or unavoidable circumstances at the clinic's discretion. Repeated missed appointments or repeated late arrivals may affect future scheduling privileges. Cancellation and no-show fees are the patient's responsibility and are not billed to insurance or attorney liens. Courtesy reminders may be provided; failure to receive a reminder does not excuse a missed appointment or late cancellation.

By signing below, I acknowledge that I have read, understand, and agree to the Appointment Cancellation / No-Show Policy above

Patient / Legal Representative Name	Signature	Date

Opioid Prescribing Policy & Patient Acknowledgment

OC Regenerative & Pain Center is not an opioid-focused practice. Our treatment approach emphasizes appropriate interventional, regenerative, and non-opioid treatment options.

A consultation or establishment of care does not guarantee that an opioid medication will be prescribed. The decision whether to prescribe, continue, refill, replace, increase, decrease, or assume management of any opioid or other controlled medication is made solely by the treating physician, based on the physician's independent medical judgment and discretion.

Office staff cannot authorize, promise, or guarantee an opioid prescription or determine whether the physician will assume management of medications prescribed by another provider. Any information provided by staff regarding prescriptions or scheduling should not be interpreted as a commitment that an opioid or other controlled medication will be prescribed.

The physician may decline to initiate or assume management of an existing opioid regimen when, in the physician's clinical judgment, doing so is not medically appropriate or is inconsistent with the practice's treatment model. Patients requiring ongoing opioid management that this practice does not provide may be advised to continue care with their existing prescriber or seek an appropriate provider.

By signing below, I acknowledge that I have read and understand this policy and understand that evaluation at this practice does not create an entitlement to, or guarantee of, an opioid prescription.

Patient / Legal Representative Name	Signature	Date

Opioid Treatment Consent & Agreement

If an opioid medication is prescribed, I understand and agree to the following conditions for safe treatment. Opioid prescribing remains at the treating physician's clinical discretion.

- ☐ I will take opioid medication only as prescribed, at the dose and frequency directed.
- ☐ I will not share, sell, misuse, or obtain opioid medication from another provider without notifying and obtaining approval from Dr. Michael Shahbazian.
- ☐ I will keep medications secure. Lost or stolen medications or prescriptions may not be replaced.
- ☐ I will inform the physician/office of medications, supplements, and substances I use and will not request early refills except as clinically appropriate.
- ☐ I understand treatment may be monitored through CURES and may include urine drug screening and medication/pill counts when requested.
- ☐ I understand my care may include non-opioid and multimodal treatments to improve safety and outcomes.
- ☐ I understand that non-compliance, misuse, unsafe medication use, or inconsistent monitoring results may lead to modification or discontinuation of opioid prescribing, based on clinical judgment.
- ☐ I have read, understand, and agree to the Opioid Treatment Consent & Agreement above.

Patient / Legal Representative Name	Signature	Date

Prescription Medication Prior Authorization Policy

OC Regenerative & Pain Center does not guarantee insurance coverage or approval of any prescribed medication, including opioid and non-opioid medications.

Our office generally limits routine medication prior authorizations, formulary exceptions, repeated insurance inquiries, and appeals. Assistance may be provided when required by applicable law, insurance contracts, or the treating physician's clinical judgment.

If a medication is not covered, the physician may consider an appropriate covered alternative when medically indicated. Patients are encouraged to contact their insurance carrier or pharmacy regarding medication coverage and benefits.

- ☐ I have read, understand, and agree to the Opioid Treatment Consent & Agreement above.

Patient / Legal Representative Name	Signature	Date