



SPINE CARE & PAIN MANAGEMENT

Because life doesn't have to hurt.

*D. Janene Holladay, M.D. - Reginald Strother, M.D. - Richard Campbell, M.D.
Woodley Mardy-Davis, M.D. - Kiley J. Reynolds, D.O. - Peter Fong, M.D. - Curtis Thornhill, M.D.*

Self Referral Form

Which of our offices would you like to visit?

Athens Rome Winder Cumming Hiram Lavonia Greensboro Alpharetta

1. Patient Name (*Please Print*): _____

2. Date of Birth (*Month / Day / Year*): _____ / _____ / _____

3. Patient's Phone Number: _____ - _____ - _____

4. Address: _____ City: _____ State: _____ Zip: _____

5. Social Security # _____ - _____ - _____

6. Insurance: _____ Member # _____ Group # _____

7. Please list the type of pain you are having: _____

8. What medications do you take for this problem? _____

9. Are you on any type of pain medication? _____ Yes _____ No

10. Have you had an X-ray or MRI for this problem: _____ Yes _____ No

11. If yes, where have you had this done? _____

12. Who has treated you for this problem in the past? _____

13. Have you ever been treated by a pain management physician? _____ Yes _____ No

14. If yes, please list the name and the telephone number of the Pain Clinic to obtain medical records.

Pain Clinic: _____ **Telephone #:** _____ - _____ - _____

15. Have you ever been to a Methadone Clinic? _____ Yes _____ No

16. How did you hear about our office? _____

Athens – Tel: 706.549.8114 Fax: 706.549.7558
Winder – Tel: 770.868.5644 Fax: 770.868.5650
Greensboro – Tel: 706.433.0723 Fax: 706.549.7558
Cumming – Tel: 678-455-8693 Fax: 770-868-5650

Rome – Tel: 706.378.1202 Fax: 706.378.1204
Lavonia – Tel: 706.356.4015 Fax: 706.549.7558
Hiram – Tel: 770.439.1172 Fax: 706.378.1204
Alpharetta – Tel: 678-393-9830 Fax: 770-868-5650



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Our physicians are specialists in pain management. Our goal is to improve your quality of life while decreasing dependence on narcotic medication, if you are currently using such, through other treatments. We understand that you may have been prescribed certain medications in the past. We may NOT write narcotic medications on your first visit, unless our physician feels that is appropriate.

Please understand that our doctors will write prescriptions for medications they feel are safe for you. Your first visit with our office will be a consult with one of our doctors to determine the appropriate plan of treatment, which may include procedures, physical therapy, massage therapy, psychological evaluation and/or a referral to another specialist. In order for you to receive treatment in our clinic we strongly recommend that you follow the plan of treatment recommended by our doctor. Please be advised your payment is for the care and treatment plan received from the doctor, not to receive prescriptions.

Please note that by signing below you are acknowledging that you understand and will comply with the information above.

Patient Name (Please print)

Patient Signature

Date

List of Past Medical Providers

So that we may better evaluate your medical condition, we would like to have a complete record of your past medical history. Please list all of the medical providers you have seen for your pain so that we may request your records. We ask that this list be as complete as possible so that we may provide a proper treatment plan.

Medical Provider's Name:	Provider's Telephone #:
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Spine Care & Pain Management

MEDICAL INFORMATION RELEASE FORM

1. I AUTHORIZE:

Name of sending person/organization

Street Address

City State Zip Code

2. TO RELEASE TO:

Spine Care and Pain Management

Name of receiving person/organization

Street:

City: State: Zip:

Ph. Fax:

3. INFORMATION TO BE RELEASED:

- Last three Office Notes**
- Current Medication list**
- X-ray & MRI Reports in paper format only, actual films not to be included.**

4. RECORDS FROM THE TIME PERIOD: ____/____/____ through ____/____/____

5. PURPOSE OF DISCLOSURE: (Check applicable purpose) **Continued Medical Care**

Payment of Insurance Personal Workers' Compensation Claim Other: _____

6. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requestor may be provided with a copy of this authorization.

Patient's Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Please Note

Fill out below and sign ONLY if it applies to you.

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below:

By signing below, I am authorizing the office to release any and all information regarding:

Alcohol Drugs Mental Health Sexually Transmitted Diseases HIV AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

For office use only: _____
MR# Date Initials of Staff Member Sending