



! ATTENTION !

It is important that you return this packet **COMPLETED** before your appointment in order for us to expedite your check-in experience.



_____ is scheduled in our office with Dr. Kelly, Dr. Lynch or
Dr. Overbey on _____, 2019 at ____:_____.

Enclosed is the paperwork you will need to have filled out before your appointment. Even if you feel the information does not pertain to your specific situation, please fill it out anyway. Mail the paperwork back in the self-addressed-stamped envelope provided. We have also included driving directions.

PLEASE BRING THE FOLOWING ITEMS WITH YOU TO YOUR APPOINTMENT:

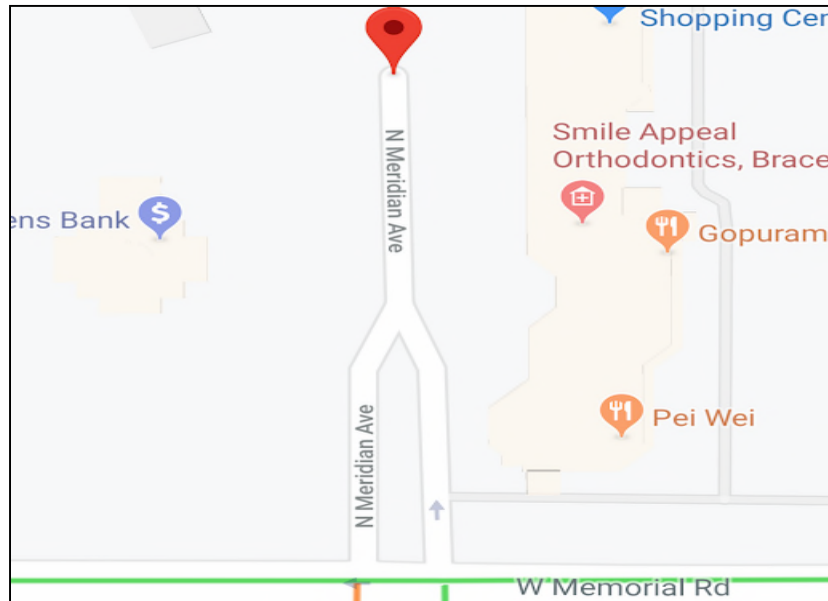
1. A list of the medications you are currently taking.
2. Driver's License or Current Valid ID
3. Insurance cards
4. Payment (Co-Pay amount)

If you would need to reschedule or cancel your appointment, please call AT LEAST 3 BUSINESS DAYS IN ADVANCE! Our office phone number is 405-752-9600.

*****We need ALL your most recent records to be able to give you the *best possible* care. Therefore, please, keep in mind, if we can't get them, we may have to reschedule your appointment. *****



Driving Directions to Oklahoma Pain Center



From Yukon/Western Oklahoma:

Travel east on I-40 to Kilpatrick Turnpike north exit. Continue on Kilpatrick Turnpike approximately 10-15 minutes. Exit right to MacArthur. You will be on Memorial Road going east. (Do not turn onto MacArthur.) Continue east 1 mile on Memorial Road to the Memorial Rd/Meridian intersection. Turn north (left) at Meridian/Memorial intersection. Continue north on Meridian to dead end into our parking lot.

From (I-40) downtown, Del City, Midwest City, Shawnee, etc:

Travel on I-40 west. Exit north on I-44 (I-44 east). Continue north on Hwy 74 (also called Lake Hefner Parkway). Exit right to Memorial Rd. Turn west on Memorial Rd for 1 mile to Meridian. Turn North (Right) on Meridian which will dead end into our parking lot.

From Edmond/Broadway Extension:

Travel Hwy 77 (Broadway Extension) south to Kilpatrick Turnpike West Exit. Continue on Kilpatrick Turnpike to Meridian exit. Turn north (right) at the Memorial/Meridian intersection. Meridian will dead end into our parking lot.

From Kansas, Guthrie, or towns north of Edmond:

Travel I-35 south to Kilpatrick Turnpike West Exit. Continue on Kilpatrick Turnpike to Meridian exit. Turn north (right) at the Memorial/Meridian intersection. Meridian will dead end into our parking lot.

S. Blake Kelly, MD ● James Lynch, MD ● Nathan Overbey, MD.

Karie Stewart, APRN ● Stacy Torres, APRN ● Angela Quick, APRN ● Jennifer McReynolds, PA-C ● Matthew Munda, APRN ● Meredith Pruitt, PA-C ● Cody McBride, APRN
13921 N Meridian ● Oklahoma City, OK 73134 ● Office (405) 752-9600 ● Fax (405) 752-9650

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Patient's Personal Information: Marital Status: single married divorced widowed Sex: male female

Full Name (with middle initial): _____

Social Security # _____ - _____ - _____ Date of Birth: ____/____/____

Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

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

Place of Employment: _____ Address: _____ Phone: _____

Primary Care Doctor: _____ Phone: (____) _____

Patient's Insurance Information: Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of policy holder: _____ Social Security # _____ - _____ - _____ Date of Birth: _____

Relationship to policy holder: Self Spouse Child Other _____

Policy/ID #: _____ Group #: _____ Co-pay \$ _____

SECONDARY Insurance Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of policy holder: _____ Social Security # _____ - _____ - _____ Date of Birth: _____

Relationship to policy holder: Self Spouse Child Other _____

Policy/ID #: _____ Group #: _____ Co-pay \$ _____

Referring Doctor's Information:

Name: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy Information:

Name: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Information (Must be a different number than your own):

Name: _____ Phone: (____) _____ Relationship: _____



List all pain medication taken in the last 2 weeks: _____

If you have Depression or anxiety, how well has it been controlled in the past 3 months?

Excellently Well Could be better Poorly

History of allergy or adverse reactions: (circle all that apply)

Antibiotic Allergy:

Penicillin
Sulfa
Mycins
Tetracycline/Doxycycline
Cephalosporins
Tape/Iodine
Other: _____

Pain Medication:

Morphine (Kadian, Embeda, Avinza)
Codeine (Tylenol #3)
Hydrocodone (Norco, Lortab)
Oxycodone (Percocet, Oxycotin)
Fentanyl (Duragesic)
Dilaudid (Hydromorphone)
Other: _____

Demerol
Tramadol
Toradol
Talwin
NSAIDs
Tylenol
Other: _____

Social History: (Circle all that apply)

___ Drink Alcohol: Occasionally Frequently Daily
___ Use Tobacco ___ packs per day, how long? _____
___ Use street drugs or have a history of substance abuse/addiction
___ Admitted to the hospital for psychiatric treatment, date: _____
___ Admitted to the hospital for drug or alcohol treatment, date: _____

Are you pregnant or trying to become pregnant? Yes No

Marital Status: Married Single Widowed Number of children: _____

Level of Education: _____ Occupation: _____ Employer: _____

Currently Working? Yes No Disabled? Yes No Permanent/temp? Date: _____

Are you or have you even been a victim of domestic violence or sexual abuse? Yes No



Please list all current doctors involved in your care at this time:

Physician	Specialty	Date of last appointment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Treatments:	If yes, date of last treatment		
Physical/Occupational Therapy	Y	N	_____
Chiropractor/Manipulation	Y	N	_____
Acupuncture	Y	N	_____
Hypnosis	Y	N	_____
TENS unit	Y	N	_____
Psycho/Psychiatric Therapy	Y	N	_____

Tests:	Y	N	_____
Lumbar MRI	Y	N	_____
Thoracic MRI	Y	N	_____
Cervical MRI	Y	N	_____
CT Scan	Y	N	_____
Myelogram	Y	N	_____
Nerve Conduction	Y	N	_____
Bone Scan	Y	N	_____
Discogram	Y	N	_____

Describe below any further pertinent health history.



Medical History: (Please mark appropriate response)

Anemia, currently	yes no	Gastrointest. Disease	yes no	Neck pain	yes no
Arthritis (osteo or rheum)	yes no	Gout	yes no	Low back pain	yes no
Auto-immune disorder	yes no	Headaches (daily, migraine, tension)	yes no	Chronic pain, Area _____	yes no
Anxiety	yes no	Heart disease	yes no	Knee pain, right left	yes no
Blood disease/Anemia	yes no	Hepatitis A _ B _ C _	yes no	Hip pain, right left	yes no
Bipolar disorder	yes no	High blood pressure	yes no	Foot/ankle, right left	yes no
Bone disease/Osteoporosis	yes no	High Cholesterol	yes no	Shoulder, right left	yes no
Blood Transfusion	yes no	HIV/AIDS	yes no	Wrist/hand, right left	yes no
Cancer - Type _____	yes no	Irritable bowel	yes no	Pelvic pain	yes no
Coronary Artery Disease	yes no	Kidney disease	yes no	Spinal Stimulator	yes no
Congestive Heart Failure	yes no	Kidney stone, number__	yes no	Neck, lumbar	
COPD/Emphysema	yes no	Liver disease	yes no		
Crohn's disease	yes no	Loss of consciousness	yes no		
Dementia	yes no	Pacemaker	yes no		
Diabetes	yes no	Psoriasis	yes no		
DVT/Blood clot	yes no	Schizophrenia	yes no		
Dysrhythmia	yes no	Seizure disorder	yes no		
Depression	yes no	Stroke/mini-stroke	yes no		
Frequent falls	yes no	Thyroid disease	yes no		
		Vascular disease	yes no		

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Surgical History: (Please mark the appropriate response)

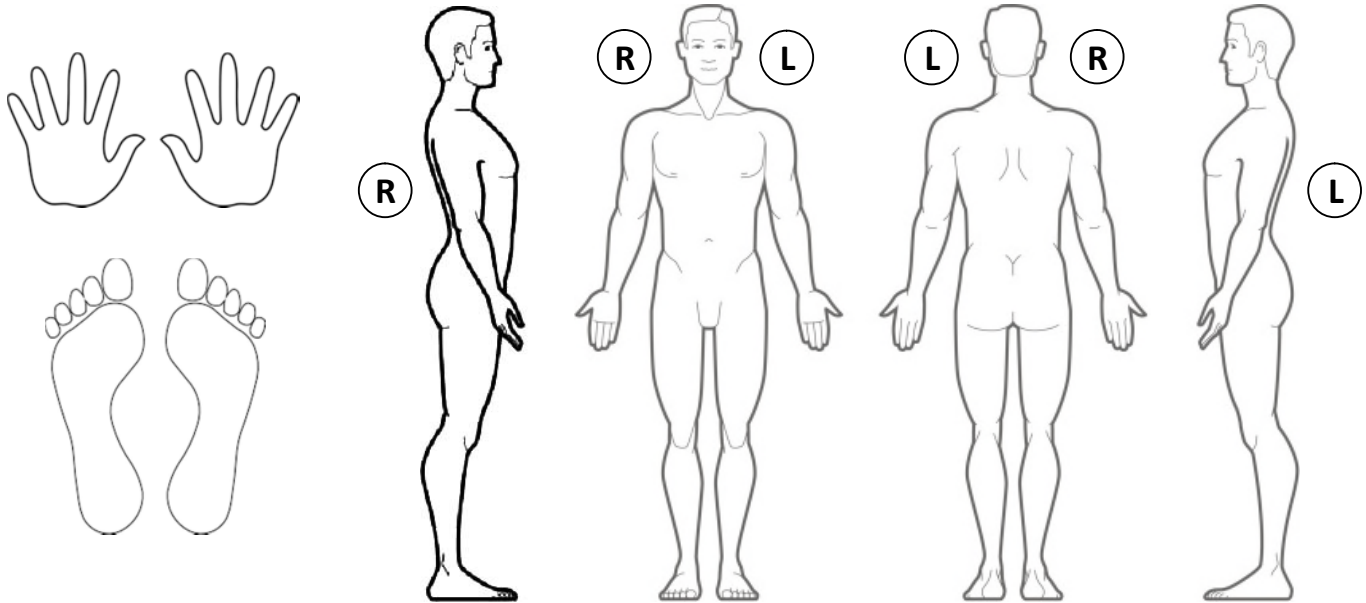
Previous Surgery	yes no	Other surgical history: _____ _____ _____ _____ _____ _____	Spinal Fusion, Date _____	yes no
Appendectomy	yes no		Neck Thoracic Lumbar	
Coronary Artery Bypass	yes no		Spinal Laminectomy, Date _____	yes no
Cardiac Procedure	yes no		Neck Thoracic Lumbar	
Gall bladder removal	yes no		Epidural Steroid Injection	yes no
Hernia	yes no		Neck, date _____	
Hysterectomy	yes no		Lumbar, date _____	
Joint replacement , Area _____	yes no		Thoracic, date _____	
Neck/Lumbar	yes no		Rhizotomy (nerve ablation)	yes no
Neck/Lumbar	yes no		Neck Thoracic Lumbar	
Tonsillectomy	yes no		Vertebral Disc replacement	yes no
Vascular procedure	yes no		Date: _____	
		Neck Lumbar		

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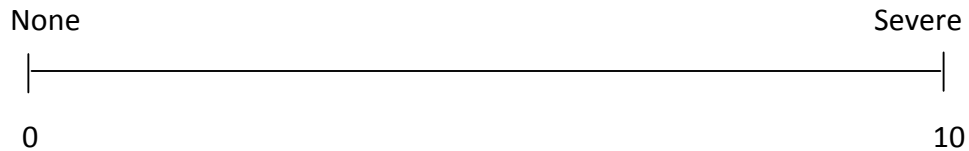
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On the diagram, shade in the areas where your pain is located.



Mark your level of pain on this scale

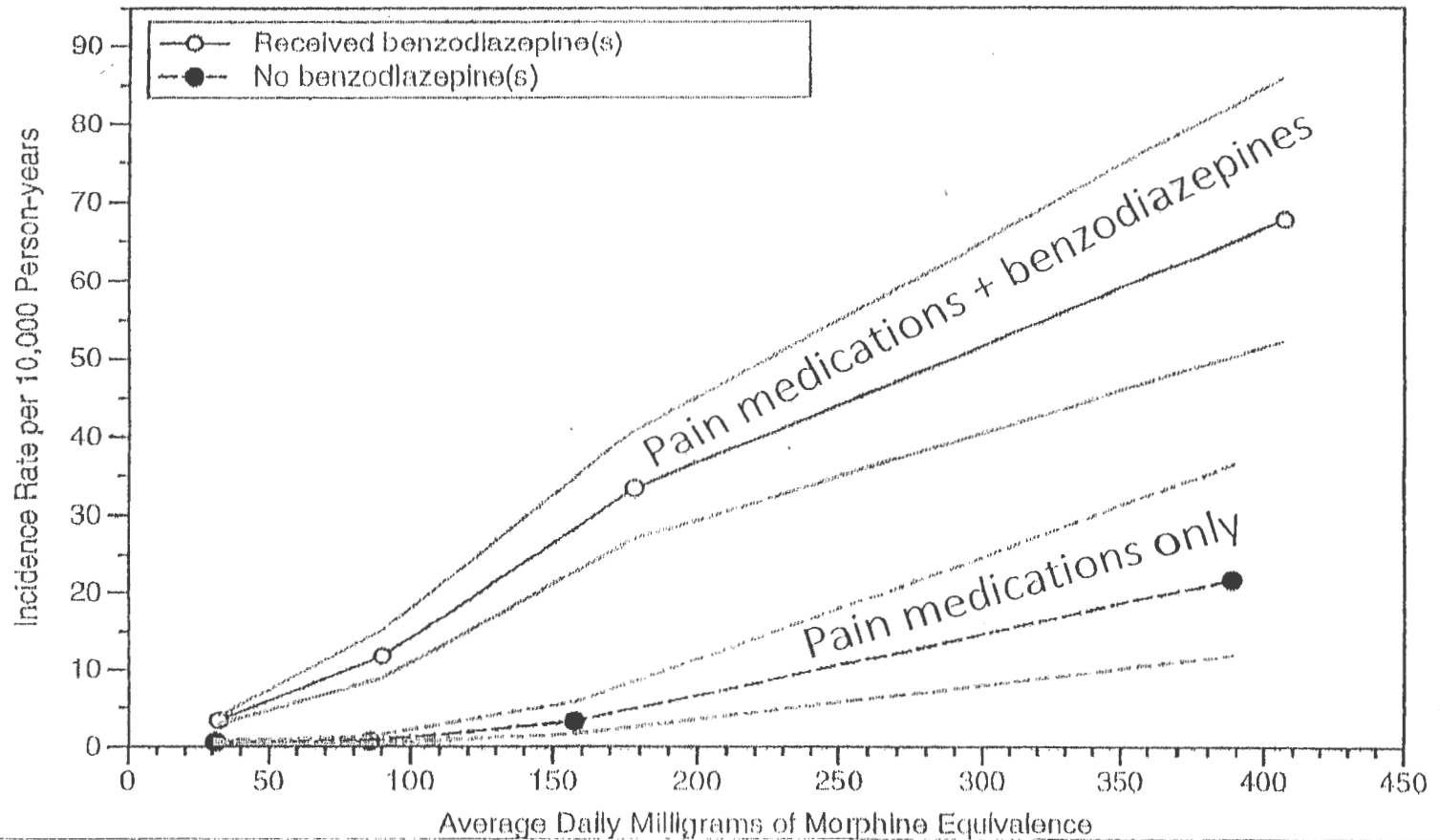


Circle a **FEW** words that best describe your pain

- | | | | | | |
|------------|------------|------------|-------------|-------------|-----------|
| Flickering | Pricking | Pinching | Tugging | Hot | Tingling |
| Quivering | Boring | Pressing | Pulling | Burning | Itchy |
| Pulsing | Drilling | Gnawing | Wrenching | Scalding | Smarting |
| Pounding | Stabbing | Cramping | Crushing | Searing | Stinging |
| Dull | Tender | Cool | Annoying | Spreading | Tight |
| Sore | Tiring | Cold | Troublesome | Radiating | Numb |
| Hurting | Exhausting | Freezing | Miserable | Penetrating | Drawing |
| Aching | Nagging | Unbearable | Intense | Piercing | Squeezing |

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This chart shows how much benzodiazepines (Xanax, Valium, Klonopin, Ativan) increase the risk for overdose with patients taking pain medications.



Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____



Patient Name: _____

Patient DOB: _____

Date: _____

Due to the continued pressure by the federal and state governing bodies, I feel it necessary to make a radical change in my practice. As of Jan. 1, 2018, we will no longer prescribe pain medication to patients who are also taking a benzodiazepine. Examples of benzodiazepines are the following: Valium, Xanax, Ativan, Klonopin, Restoril, and their respective generic equivalents such as the following: Alprazolam, Lorazepam, Clonazepam, Temazepam. Attached is a chart that shows the greatly increased risk to patients who are taking this combination of medication. In the past I have handled this risk on an individual basis with patients through informed consent. The "opioid crisis" is real and is something that doctors, legislators, law enforcement, etc. are coming to terms with and trying to make appropriate interventions. The doctor patient relationship, as sacred as it may be, is going to take a back seat to the public recommendations the Centers of Disease Control(CDC) and the FDA as well as the Oklahoma State Medical Association and the Oklahoma State Medical Board have put forth over the past 24 months. If you feel that weaning off the benzodiazepine is hazardous to your health in the case of a seizure disorder or other condition, I ask that you discuss it with your prescribing physician at your earliest convenience. Otherwise, start to wean down slowly and work with your prescribing physician of the benzodiazepine. A good rule of thumb is to go down by 10% per week. As difficult as it may be, it is possible. There are many good alternatives to benzos and we are willing to make recommendations as well as assist with medications that treat anxiety and insomnia. In the end, these recommendations have been made for the safety of the public and should result in patients being healthier and safer.

Thank you for your understanding and consideration.

S. Blake Kelly, MD

Patient Signature



PLEASE REMEMBER TO BRING...

- 1. RADIOLOGY REPORTS (MRI, CT, X-RAY, etc.)**
- 2. Copies of your RECORDS including any EKG reports, lab work, etc.**
- 3. INSURANCE INFORMATION/CARDS and DRIVERS LICENSE**
- 4. A full bladder for urine sample**
- 5. Wear loose-fitting clothing to your appointment in case examination is needed**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR
OFFICE AT 405-752-9600.**

THANK YOU!