Shepherd Center
SPINE AND PAIN INSTITUTE

Dear Prospective Patient:

At the Shepherd Spine and Pain Institute, we specialize in the evaluation, diagnosis and application of non-interventional and interventional treatments for pain management and related conditions. By using a multidisciplinary approach and latest medical technologies, we provide our patients with the best opportunity to maintain a healthy lifestyle.

We believe the patient should take an active role in his/her treatment plan. We encourage your involvement in the medical decision-making process and invite questions regarding treatment options. Your first visit with us is a **consult only**. Please understand, there will be **no pain medications neither prescribed nor refilled and no procedures will be performed at your first office visit.** If you are in need of a medication, please follow up with your primary care physician or referring provider.

In order for us to provide you with the most comprehensive care possible, it is essential we learn all we can about you and your current spine and/or pain condition(s). Attached is a list of the medical records required from your treating provider(s) prior to scheduling a new patient appointment. For your benefit, there is a medical release form to give to your primary care physician, pain specialist, and other medical providers to have your records sent directly to Shepherd Spine and Pain Institute. It is your responsibility to ensure all pertinent medical records have been sent. Please allow up to 10 business days after all required documents have been received and reviewed to be contacted by Shepherd Spine and Pain Institute.

On the day of your new patient evaluation, it is important to arrive no later than 30 minutes prior to your designated appointment time to allow for registration. You are excused one cancellation or rescheduled appointment for the initial new patient visit.

Thank you in advance for your cooperation and we look forward to providing you with individualized, comprehensive, state-of-the-art care you deserve.

Sincerely,
New Patient Coordinator
Shepherd Spine and Pain Institute
Phone: (404) 603-4203
Fax: (404) 603-4418
painreferrals@shepherd.org
www.shepherdpaininstitute.org

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Patient Questionnaire

Last Name: _____ First Name: _____

Initial: _____ DOB: _____ Date: _____

1. What is the purpose of your visit with the Shepherd Spine and Pain Institute? Please check all that apply:

   □ Current pain provider does not provide a specific medical treatment.
   □ Second Opinion
   □ Want to change pain providers
   □ Prolotherapy
   □ Ketamine Infusions
   □ Intrathecal Pump
   □ Spinal Cord Stimulator
   □ Other: _____

2. Are you diagnosed with any of the following conditions? Please check all that apply:

   □ Catastrophic Injury
   □ Central Nerve Pain
   □ Chronic Regional Pain Syndrome (CRPS)/Reflex Sympathetic Dystrophy (RSD)
   □ Failed Back
   □ Other: _____

3. Do you currently have a pain provider? If yes, what is the name and contact number of the provider?

   □ No
   □ Yes, Provider Name: _____
   Phone #: _____ Fax #: _____

4. Have you previously been treated by a pain provider? If yes, please explain why you are no longer under the care of the pain provider?

   □ No
   □ Yes, Provider Name: _____
   Phone #: _____ Fax #: _____

2020 Peachtree Road, NW. Atlanta, Georgia 30309

_____

_____

_____

5. Have you been diagnosed with a psychological disorder? If yes, what is the diagnosis?

   □ No □ Yes:

   _____

6. If yes to question 5, please provide the psychiatrist and/or psychologist name(s) and contact number(s).

   Psychiatrist Name: _____

   Phone #: _____ Fax #: _____

   Psychologist Name: _____

   Phone #: _____ Fax #: _____

7. Do you have an intrathecal pump for pain control?

   □ No

   □ Yes, Brand: _____

8. Do you have an open litigation or lawyer pertaining to your pain issue?

   □ No

   □ Yes, Explain: _____

   _____

   _____

   _____

   _____

   _____.

Date: _____

Last Name: _____ First Name: _____

Initial: _____ DOB: _____ SS #: _____

Marital Status: _____ Language: _____

Religion: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email: _____

Ok to use email for communication? □ Yes □ No

Emergency Contact Name: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

Insurance Information

Primary Insurance: _____ Policy #: _____

Group #: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____ DOB: _____

SS # of Policy Holder: _____

Secondary Insurance: _____ Policy #: _____

Group #: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Name: _____ DOB: _____

SS # of Policy Holder: _____

- Please provide a copy of the front and back of your insurance card(s).

- Please complete forms and return by mail, fax, or email:

Shepherd Spine and Pain Institute	Phone: 404-603-4203
Attn: New Patient Coordinator	Fax: 404-603-4418
2020 Peachtree Road, NW	Email: painreferrals@shepherd.org
Atlanta, Georgia 30309	

- For questions, please contact our New Patient Coordinator by phone 404-603-4203 or email painreferrals@shepherd.org