

Johnston Pain Management Patient Information Sheet

Last Name: _____		First Name: _____	
Middle Initial: _____	Date of Birth: _____ / _____ / _____	Social Security #: _____ - _____ - _____	
Mailing Address: _____		Apt. #: _____	
City: _____	State: _____	Zip: _____	
Address Type: (Circle One) Home / Work / Other. If Other, specify _____ Birth State: _____			
Home #: _____	Cell #: _____	Work #: _____	
Communication Preference: (Circle One) Home / Cell / Work		Cell Phone Carrier: _____	
E-mail Address: _____		Mother's Maiden Name: _____	
Primary Language: (Circle One) English / Spanish / Other: _____			
Race: _____	Ethnicity: _____	Gender: (Circle One) Male / Female	
Emergency Contact Name: _____		Relationship: _____	
Mailing Address: _____		Apt. #: _____	
City: _____	State: _____	Zip: _____	
Phone #: _____	Alternative Phone #: _____		
Employer: _____	Phone #: _____		
Address: _____			
City: _____	State: _____	Zip: _____	
Referring Physician: _____		Phone#: _____	
Family Physician: _____		Phone#: _____	

Welcome to Johnston Pain Management. Our goal is to provide you with quality medical care in a friendly, safe and caring environment. Although we take pride in the quality of our services, we know there is always room for improvement. If you have suggestions or concerns related to your care or the service you receive, please request a patient survey or request to speak to the office manager. Johnston Pain Management is committed to maintaining the very highest standards of ethics and integrity. We are committed to ensuring that all affairs are conducted in accordance with all applicable laws, rules, regulations, policies and procedures. We are committed to the care and improvement of our patients. We consider you a partner in your own medical care. When you are well informed, when you participate in treatment decisions, and when you communicate openly with your doctor and other healthcare professionals, you help make your care as effective as possible. You have the right to consent to or refuse a treatment as permitted by law, throughout your treatment. You have the right to privacy. We will protect your privacy as much as possible as outlined in our privacy notice. You are responsible for providing information about your health, including past illnesses, hospital stays, and use of medicine. You are responsible for asking questions when you do not understand information or instructions. If you believe you can't follow through with your treatment, you are responsible for telling your doctor. You are responsible for following instructions for your planned course of treatment.

I agree that the above information is true and correct to the best of my knowledge. This form is required to be updated annually and when patient or insurance information changes.

You are requested NOT to bring your children to your clinic visit at Johnston Pain Management.

Patient Signature: _____ Date: _____

Office Staff Only: Entered on _____ Staff Initials: _____