DEAR _____, NEW PATIENT OF DR. DANIEL E. BATLAN
SPECIALIZED PAIN MANAGEMENT:

YOUR APPOINTMENT IS SCHEDULED FOR:

DATE: _____ MON TUE WED THUR FRI

TIME: _____ AM PM

LOCATION:

☐ **GREEN VALLEY OFFICE**
10885 S. EASTERN AVE SUITE #100
HENDERSON NV 89052
[IN THE EASTERN HILLS SHOPPING CENTER]

☐ **SUMMERLIN OFFICE**
10135 W. TWAIN AVE
LAS VEGAS NV 89147
[IN THE SOUTH HUALAPAI PAVILION W/THE BRONSTEIN HAND CENTER]

☐ **NORTHWEST OFFICE**
3150 N. TENAYA WAY UNIT #600
LAS VEGAS NV 89128
[NEXT TO THE MOUNTAIN VIEW HOSPITAL]

☐ **SOUTHWEST OFFICE**
5380 S. RAINBOW BLVD. SUITE #110
LAS VEGAS NV 89118
[NEXT TO THE SPRING VALLEY HOSPITAL]

☐ **EAST OFFICE**
3121 S. MARYLAND PKWY SUITE #101
LAS VEGAS NV 89109
[ACROSS FROM THE SUNRISE HOSPITAL]

MISSED APPOINTMENTS PREVENT US FROM HELPING OTHER PATIENTS ON A TIMELY BASIS. PLEASE BE ADVISED THAT FAILURE TO KEEP YOUR APPOINTMENT WILL RESULT IN A $30.00 "NO SHOW" CHARGE WHICH WILL BE YOUR RESPONSIBILITY TO PAY.

PLEASE COMPLETE THE ATTACHED FORM ***IN ITS ENTIRETY*** AND ***HAND IT*** TO THE RECEPTIONIST WHEN YOU MEET FOR YOUR INITIAL PAIN MANAGEMENT EVALUATION. YOU MAY USE AND ADDITIONAL SHEET OF PAPER IF YOU NEED ADDED SPACE.

TO ASSIST IN YOUR EVALUATION, WE WILL ASK YOUR REFERRING DOCTOR TO SEND US RELEVANT INFORMATION ABOUT YOUR CONDITION. IN ADDITION, PLEASE BRING WITH YOU ANY OF THE FOLLOWING THAT YOU MAY HAVE IN YOUR POSSESSION:

- **COPIES OF *DICTATED REPORTS* OF XRAYS, MRI OR CAT SCANS [NOT THE ACTUAL FILMS THEMSELVES]**
- **PHYSICIAN REPORTS**
- **ANY OTHER RELEVANT TEST REPORTS [E.G. NEUROLOGY TESTS, ETC…]**

REMEMBER TO ***BRING ALL OF YOUR INSURANCE CARDS*** SO THAT WE CAN COPY THEM FOR OUR RECORDS. IN ADDITION, ANY APPLICABLE COPAYS OR DEDUCTIBLES CAN BE CONVENIENTLY PAID BY CASH OR CREDIT CARD. WE ARE NO LONGER ACCEPTING PERSONAL CHECKS.

CO-PAYMENTS AND DEDUCTIBLES ARE ***DUE WHEN YOU ARRIVE*** FOR YOUR APPOINTMENT. WE LOOK FORWARD TO MEETING YOU AND HELPING WITH YOU WITH YOUR PAIN DISORDER.

-- ***THE STAFF AT SPECIALIZED PAIN MANAGEMENT***

SPECIALIZED

Please *PRINT* your answers.
Thank you for answering *ALL* Questions [*Leave nothing blank*]

Name: _____ DOB: ____/____/____ SSN: _____

Address: _____

Home Ph: _____ Work Ph: _____ Fax: _____

Referral Source [Dr/Friend/Yellowpages] Name: _____

Names of ALL Current/Recent Doctors [w/Specialty]: _____

_____

HISTORY

Chief Complaint: _____

Where is your pain located? _____

How long has the pain been present? _____

Does your pain travel anywhere? Where? _____

What makes your pain worse? _____

What makes your pain better? _____

Do you have numbness? Where? _____

Do you have weakness? Where? _____

Any injuries that caused pain? [When/ Where/ Describe Event]: _____

_____

Is a Lawyer involved w/your medical care or injury? Please circle: YES or NO If yes, please explain:

_____

Are you claustrophobic? _____ Any metal plates? _____ Do you have a pacemaker _____

PRIOR TREATMENT FOR YOUR PAIN PROBLEM

Level of Pain _____ [Out of 10 (**Worst**)]

Medication Trails [Name of Meds]: _____

Physical Therapy _ Swimming Theraphy ___ TENS _____ Chiropractic ___ Ostepathic ___ Psych _____
Surgery ___ Injections: Epidurals ___ [Cervical __ Thoracic __ Lumbar__ Caudal __]
Faucets ___ [Cervical _____Lumbar ___]

PAST MEDICAL HISTORY

Coronary Artery Disease __
__ Angina _
TIA [Reversible Stroke] ___
Asthma _
Hepatitis_____
Urinary Tract Infections___
Gastritis or Reflux_____
Diabetes_____ [Insulin ___ Pills __ Diet __]
Heart Attack _____

Stroke _____
Cancer _ [Where] _____

Thyroid Disease _[Hypo (LOW) __or Hyper (HIGH)__]
High Blood Pressure _____ Emphysema ____
Heart Murmur___
Seizures _____
Bronchitis_____
Other Liver___ [Describe] _____
Other Kidney ___ [Describe] _____
Depression _____
Kidney Stones __

Peptic Ulcers_____
Other Psych_____ [Explain] _____

Other Medical Problems: _____

Past Surgery History: _____

_____

Current Medications: _____

_____

Allergies: _____

FAMILY & SOCIAL HISTORY

Martial Status: _____ # of Children: _____

Alcohol [Drinks/wk]: _____ Tabacco [Packs/Day]: _____ x years _____

Employment: _____

Medical Diseases in Family: Mother: _____ Father: _____

Siblings: _____ Other Relatives: _____

History of Abuse/Addiction: Pls circle: YES or NO [Alcohol Rx Drugs [Name] IV Drugs [Name]

Highest Level of Education _____ Psych History _____

REVIEW OF SYSTEMS [PLEASE **CIRCLE** ALL THAT ARE **"*POSITIVE*"]**

MUSCULOSCKELETAL: Joint Pain/ Stiffness/ Spasms/ Back Ache/ Neck Ache/ Weakness/ Loss of Range of Motion
NEUROLOGICAL: Fainting/ Blackouts/ Seizures/ Paralysis/ Weakness/ Numbness/ Memory Loss
PSYCHOLOGICAL: Neverousness/ Tension/ Mood Changes/ Depression/ Anxiety
ENDOCRINE: Heat Intolerance/ Cold Intolerance/ Sweating/ Thirst/ Hunger/ Sweating
SKIN: Rash/ Lumps/ Itching/ Dryness/ Color Changes/ Hair Changes/ Nail Changes
GASTROINTESTINGAL: Trouble Swallowing/ Heartburn/ Indigestion/ Vomiting/ Diarrhea/ Pain/ Blood in Stool
GENITOURINARY: Pain w/Urination/ Blood in Urine/ Incontinence/ Urgency/ Hesitancy
EYES: Vision/ Glasses/ Pain/ Tearing/ Double Vision
EARS, NOSE, THROAT: Decreased Hearing/ Tinnitus/ Vertigo/ Sinusitis/ Colds/ Sore Throat
CARDIOVASCULAR: High Blood Pressure/ Murmurs/ Shortness of Breath/ Chest Pain/ Palpitations
RESPIRATORY: Cough/ Sputum/ Coughing up Blood/ Wheezing/ Asthma/ Bronchitis/ Chest Pain
HEMATOLOGY/ LYMPH: Bruising/ Bleeding/ Transfusion Reactions
ALLERGY/IMMUNOLOGIC: Drugs/ Product OR Other Allergies/ Childhood Immunizations

DO NOT WRITE BELOW THIS LINE

PHYSICAL EXAMINATION ["PERTINENT POSITIVES"] *A*

VITALS:

BP_____HR_____RR_____TEMP_____WT_____HT_____

P

Education

JOHNS HOPKINS MEDICAL INSTITUTIONS Baltimore, MD
Anesthesia Residency: Dept. of Anesthesiology and C. C. Medicine
July 1986 – June 1989
- ***Ranked #1 Hospital in the USA (2007 U.S. News & World Report)***

CLEVELAND CLINIC FOUNDATION Cleveland, OH
Invasive Pain Management Fellowship, July 1996 – June 1997
- ***Ranked #4 Hospital in the USA (2005 U.S. News & World Report)***
- ***Largest Pain Management Training Program in North America (American College of Graduate Medical Education)***

NEW YORK UNIVERSITY New York, NY
Leonard N. Stern School of Business
Master of Business Administration, January 2000
- ***#1 Part-time MBA program in USA (1999 U.S. News & World Report)***

UNIVERISTY OF PENNSYLVANIA Philadelphia, PA
Faculty of Arts and Sciences, B.A. in Biology, May 1981

LOYOLA UNIVERISTY/ STRTCH SCHOOL OF MEDICINE Chicago, IL
M.D. Degree, June 1985

Experience:

1989-1994 **MOUNT SINAI HOSPITAL** Baltimore, MD
Attending Anesthesiologist, Department of Anesthesiology
- Director of Quality & Risk Management, Dept, of Anesthesiology

1995 **LAGUARDIA HOSPITAL** Forest Hills, NY
Attending Anesthesiologist, Department of Anesthesiology
- Leader of a one year department effort culminating in the successful 1995 Survey by the Joint Commission on the Accreditation of Hospitals
- Member, the Medical Executive Committee

1997-1999 **THE ADVANCED PAIN INSTITUTE OF NORTHEAST OHIO** Cleveland, OH
Medical Director

2000 **SPECIALIZED PAIN MANAGEMENT** Las Vegas, NV
Founder & Medical Director

Additional:

- **Doubly Board Certified**
  - The American Board of Anesthesiology
  - The American Academy of Pain Management

SPECIALIZED PAIN MANAGEMENT
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