DEAR ______________________________, NEW PATIENT WITH THE OFFICE OF DR. DANIEL E. BATLAN - SPECIALIZED PAIN MANAGEMENT.

YOUR UPCOMING APPOINTMENT IS SCHEDULED FOR:

DATE: ____________________________ MON TUE WED THUR FRI

TIME: ____________________________ AM PM

AT THE FOLLOWING **LOCATION**:

☐ **GREEN VALLEY OFFICE**
1661 W HORIZON RIDGE PKWY #270
HENDERSON, NV 89012
[IN THE HIGHLAND PLAZA]
[HORIZON RIDGE & VALLE VERDE]

☐ **CENTENNIAL OFFICE**
6850 N DURANGO DR. #216
LAS VEGAS, NV 89149
[CENTENNIAL HILLS HOSPITAL MEDICAL BUILDING]
[DURANGO & DEER SPRINGS]

☐ **SUMMERLIN OFFICE**
653 N TOWN CENTER DR. #204
LAS VEGAS, NV 89144
[SUMMERLIN HOSPITAL MEDICAL BUILDING]
[TOWN CENTER & HUALAPAI]

☐ **EAST OFFICE**
3006 S. MARYLAND PKWY #465
LAS VEGAS, NV 89109
[LOCATED BEHIND SUNRISE HOSPITAL]
[MARYLAND PKWY & DESERT INN]

PLEASE COMPLETE THE ATTACHED FORM ***IN ITS ENTIRETY IN BLACK INK*** AND HAND IT TO THE RECEPTIONIST WHEN YOU MEET FOR YOUR INITIAL PAIN MANAGEMENT EVALUATION. YOU MAY USE AN 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, ETC… [*NOT THE ACTUAL FILMS/PHOTOS THEMSELVES*]**
- **PHYSICIAN DICTATION REPORTS**
- **ANY OTHER RELEVANT TEST REPORTS [E.G. NEUROLOGY TESTS, ETC…]**

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/ LESS THAN 24HR CANCELLATION NOTICE*" FEE, WHICH WILL BE YOUR RESPONSIBILITY TO PAY.

REMEMBER TO ***BRING A VALID, GOVERNMENT ISSUED IDENTIFICATION CARD (I.D.) AND INSURANCE CARD(S)***, COPIES BROUGHT WILL NOT BE ACCEPTED, OUR OFFICE WILL MAKE COPIES FOR OUR RECORDS.

IN ADDITION, CO-PAYMENTS AND DEDUCTIBLES ARE ***DUE AT THE TIME OF YOUR OFFICE VISIT***.
ANY APPLICABLE COPAYS OR DEDUCTIBLES CAN BE CONVENIENTLY PAID BY CASH OR CREDIT CARD.
WE ARE NO LONGER ACCEPTING PERSONAL CHECKS AND AMERICAN EXPRESS.
WE LOOK FORWARD TO MEETING YOU AND HELPING WITH YOU WITH YOUR PAIN DISORDER.

- THANK YOU! DR. BATLAN & STAFF AT SPECIALIZED PAIN MANAGEMENT

SPECIALIZED PAIN MANAGEMENT
Daniel Batlan, MD, MBA – *Founder & Medical Director*
Tel: 702-838-8004 Fax: 702-838-5085
Website: www.treatpainlv.com

Dear Patient,

Please take this moment and fill out all possible information below to the best of your knowledge. We would like to make sure that your chart is accurate and most up-to-date. *Thank you!* [***PLEASE USE BLACK INK & PRINT!***]

PATIENT DEMOGRAPHIC

NAME: ______________________________ **SEX:** ☐ MALE ☐ FEMALE
SSN: ______________________ **BIRTHDATE:** (MMDDYYYY) ______________
HOME: ____________ **CELL:** ____________ **OTHER/FAX:** ______________
MAILING ADDRESS: ____
____
EMPLOYER: ______________________________ **PH#:** ______________
NAME OF REFERRING PHYSICIAN: ______________________ **PH#:** ______________

EMERGENCY CONTACT

NAME: (Last, First, MI) ______________________ **RELATIONSHIP:** ______________
HOME: ____________ **CELL:** ____________ **OTHER/FAX:** ______________

CURRENT DOCTORS

PRIMARY CARE PHYSICIAN:
NAME: ______________________________ **PH#:** ______________

SPECIALTY PHYSICIAN(S):
NAME: ______________ **SPECIALTY:** ______________ **PH#:** ______________
NAME: ______________ **SPECIALTY:** ______________ **PH#:** ______________
NAME: ______________ **SPECIALTY:** ______________ **PH#:** ______________

INSURANCE COVERAGE(S)

PRIMARY: ______________________________ **PH#:** ______________
POLICY HOLDER: ______________ **DOB:** ____________ **SSN:** ______________
SECONDARY: ______________________________ **PH#:** ______________
POLICY HOLDER: ______________ **DOB:** ____________ **SSN:** ______________
TERTIARY: ______________________________ **PH#:** ______________
POLICY HOLDER: ______________ **DOB:** ____________ **SSN:** ______________

The above information is true to the best of my knowledge. I understand that it is my responsibility to inform any changes and/or updates to the office of Dr. Daniel Batlan and Staff at Specialized Pain Management.

______________________________ ______________________
PATIENT SIGNATURE DATE

PATIENT HISTORY AND PHYSICAL

Please USE BLACK INK & *PRINT* your answers and feel free to use the back of the form if you need to provide more information. Thank you for answering *ALL* questions [*Please leave nothing blank*]

Name: ______________________ DOB: ______________ SSN: ________________

Address: ____

Home Ph: ________________ Work Ph: ________________ Fax: ________________

Referral Source: ____

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 cause you pain? [When/ Where/ Describe Event]: ______________________________

____

Is a lawyer involved w/your medical care or injury? YES or NO

If yes, please explain: ____

Are you claustrophobic? YES or NO Any metal plates? YES or NO Do you have a pacemaker? YES or NO

PRIOR TREATMENT FOR YOUR PAIN PROBLEM

Please rate your level of pain from a scale of 1-10 (with 10 being the ***WORST***) ________________

Medication Trials [Name of Meds]: ____

Please check the following that may apply:

☐ Physical Therapy ☐ Swimming Therapy ☐ TENS ☐ Chiropractic ☐ Osteopathic ☐ Psych ☐ Surgery

☐ Epidural Injections (*If checked please circle the following*: *CERVICAL / THORACIC / LUMBAR / CAUDAL*)

☐ Facet BLOCKS (*If checked please circle the following*: *CERVICAL / LUMBAR*)

☐ Stimulator Trials (*If checked please circle the following*: *CERVICAL / LUMBAR*)

PAST MEDICAL HISTORY

Please check the following that may apply:

☐ Coronary Artery Disease ☐ High Blood Pressure ☐ Emphysema ☐ Angina ☐ TIA [Reversible Stroke]

☐ Heart Murmur ☐ Asthma ☐ Seizures ☐ Hepatitis ☐ Bronchitis ☐ Urinary Tract Infections

☐ Gastritis or Reflux ☐ Heart Attack ☐ Kidney Stones ☐ Stroke ☐ Peptic Ulcers ☐ Depression

☐ Thyroid Disease Hypo (*If checked please circle the following*: *HYPO*(*LOW*) /*HYPER* (*HIGH*)

☐ Diabetes (*If checked please circle the following*: *INSULIN / PILLS / DIET*)

☐ Allergies (*If checked please explain*: ______________________________________)

☐ Cancer (*If checked please indicate where*: ______________________________________)

- ☐ Other Liver (*If checked please explain*: ______________________________)
- ☐ Other Kidney (*If checked please explain*: ______________________________)
- ☐ Other Psych (*If checked please explain*: ______________________________)

Other Medical Problems: ______________________________

Past Surgery History: ______________________________

Current Medications: ______________________________

FAMILY & SOCIAL HISTORY

Martial Status: SINGLE / MARRIED / WIDOWED   Children: YES or NO (*If circled YES please indicate #:* _________)

Highest Level of Education: HIGH SCHOOL/ GED/ COLLEGE / GRADUATE / OTHER: ______________________________)

Employment: YES or NO (*If YES please list your Employer*: ______________________________)

Alcohol: YES or NO (*If circled YES please indicate how many drinks*/wk: ______________________________)

Smoking: YES or NO (*If circled YES please indicate how many packs*/day: ___________ x years ___________)

Medical Diseases in Family:

Mother: ______________________________ Father: ______________________________

Siblings: ______________________________ Other Relatives: ______________________________

History of Abuse/Addiction: YES or NO ______________________________

(*If 'yes' please explain and indicate what type of abuse/addiction, i.e. RX DRUG(s) [name(s)] / IV DRUG(s)* [*name(s)*] / *ALCOHOL)*

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:	Nervousness/ 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"]

VITALS:

BP: ____________________

HR: ____________________

RR: ____________________

TEMP: ____________________

WT: ____________________

HT: ____________________

Dr. Daniel E. Batlan, MD, PC

1930 Village Center Circle #3-710
Las Vegas NV 89134

EDUCATION:

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

July 1996 – June 1997 — Cleveland, OH
CLEVELAND CLINIC FOUNDATION
Invasive Pain Management Fellowship
- ***Ranked #4 Hospital in the USA (2007 U.S. News & World Report)***
- ***Largest Pain Management Training Program in North America (American College of Graduate Medical Education)***

January 2000 — New York, NY
NEW YORK UNIVERSITY
Leonard N. Stern School of Business
Master of Business Administration,
- ***#1 Part-time MBA program in USA (2007 U.S. News & World Report)***

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

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

EXPERIENCE:

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

Jan 1995 - Sept 1995 — Forest Hills, NY
LAGUARDIA HOSPITAL
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

Jul 1997 – Jul 1999 — Cleveland, OH
ADVANCED PAIN INSTITUTE OF NORTHEAST OHIO
- Medical Director

Jan 2000 - Present — Las Vegas, NV
SPECIALIZED PAIN MANAGEMENT
- Founder & Medical Director

ADDITIONAL:

Double Board Certified
- The American Board of Anesthesiology
- The American Academy of Pain Management

SPECIALIZED PAIN MANAGEMENT
DANIEL E. BATLAN, MD
Founder & Medical Director
1930 Village Center Circle #3-710 Las Vegas, NV 89134
TELEPHONE: 702-838-8004 FAX: 702-838-5085

CENTENNIAL	SUMMERLIN	GREEN VALLEY	EAST	SOUTHWEST