Unifour Pain Treatment Center
IMPORTANT – READ THIS & COMPLETE IMMEDIATELY

In order that we may better serve you on your first visit with us, we ask that you complete the short form below, sign & date the attached consent form, and mail them both in the stamped envelope **TODAY**. This will give us a better chance of obtaining pertinent medical records prior to your visit.

The enclosed *Patient Data Form* needs to be completed and brought with you on your first visit.

Please indicate tests/procedures for ***current*** *pain problem ONLY*:

Type of Study/Procedure (check all that apply)		**Name of Facility/City**	**Year Performed**
MRI	_____	_____	_____
CT Scan	_____	_____	_____
Myelogram	_____	_____	_____
EMG/Nerve Study	_____	_____	_____
Plain X-rays	_____	_____	_____
Bone Scan	_____	_____	_____
Ultrasound	_____	_____	_____
Blood Flow Study	_____	_____	_____
Nerve Block/Steroid Inj.	_____	_____	_____
Surgery	_____	_____	_____
Surgery	_____	_____	_____
Other: _____	_____	_____	_____

YOUR NAME: _____ DATE OF BIRTH: ____/____/____
(please print)

PLEASE BE SURE TO SIGN & ATTACH *AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION* FORM AND HAVE A WITNESS SIGN.