FLORIDA PAIN MANAGEMENT ASSOCIATES

To help us meet all of your healthcare needs, please answer the following questions as completely as possible. Thank you.

PATIENT INFORMATION: **DATE:___________________**

NAME:________________________________ SEX: M F AGE:_________________

SSN:_____________________ BIRTHDATE:_____________ MARITAL STATUS:______

ADDRESS:_____________________CITY/ STATE:_______________ ZIP CODE:________

HOME #: _________________ CELL #: _________________ WORK #: _________________

E-MAIL ADDRESS: ____

PRIMARY CARE: __________________ SOURCE OF REFERRAL:___________________

ARE YOU PRESENTLY: EMPLOYED / RETIRED / DISABLED / UNEMPLOYED

WHAT WAS OR IS YOUR OCCUPATION? ___________________________________

IS THEIR A LAWYER INVOLVED WITH YOUR INJURY? __________________
NAME OF LAWYER: ____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____________________________
PHONE #: ______________________________
RELATION: ___ __________________________
PHARMACY NAME: ______________________ LOCATION:________________
PHARMACY PHONE#:____________________

CIRCLE ONE: MEDICARE AUTO WORK COMP SELF-PAY OTHER
Please bring your insurance cards and a photo ID with you to your appointment

Primary Insurance: __________________ Secondary Insurance:___________________

***IF AUTO OR WORK COMP. PLEASE FILL OUT INFORMATION BELOW:**
Auto/ Work Comp Insurance:___________________________
Adjuster Name: _______________________________________
Phone #: _____________________________ Ext.____________
Billing Address: _______________________ City:________________ Zip Code:___________
Claim #: _____________________________ Date of Accident: _______________________

I AUTHORIZE THE RELEASE OF NEEDED INFORMATION TO MY INSURANCE CARRIER, AND I AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS TO FLORIDA PAIN MANAGEMENT ASSOCIATES.

________________________________ ___________________________
PATIENT SIGNATURE **DATE**

FLORIDA PAIN MANAGEMENT

Patient Name:______________________________ Date:________________

Height________________ Weight_______________

___ Yes ___ No **Problems with Anesthesia?**

___ Yes ___ No **Diabetes? Controlled with (circle): Insulin Pills Diet**

___ Yes ___ No **Heart Problems? Circle the one that applies:**
Heart attack (year)_________; Coronary heart disease;
Pacemaker/Defibrillator; Irregular heart beat; Palpitations;
Other___________

___ Yes ___ No **High Blood Pressure?**

___ Yes ___ No **Breathing Problems? (circle) On oxygen; Asthma; COPD;**
Emphysema; Chronic Cough; Sleep Apnea; Bronchitis;
Other____________

___ Yes ___ No **Smoker? _____ packs per day**

___ Yes ___ No **Stomach or Digestion problems? GERD/ Reflux**

___ Yes ___ No **Stroke: year of stroke______ Weakness-where__________**

___ Yes ___ No **Seizures? How often?___________________________**

___ Yes ___ No **Kidney/ Urinary Problems? Describe: ________________**

___ Yes ___ No **Liver/ Thyroid Problems? Describe:__________________**

___ Yes ___ No **Blood Thinners?(circle) Coumadin Warfrin Plavix Aspirin**
81mg 325mg Other________

___ Yes ___ No **Do you have Cancer? Where?_________ When?_______**
Undergoing treatment now?_________________________

___ Yes ___ No **Arthritis? ____**

___ Yes ___ No **Psychiatric Problems?_______________________________**

___ Yes ___ No **Substance Abuse?___________________________________**

___ Yes ___ No **Drink Alcohol? _____ drinks per day _____ per week**

Is there any other medical problem we should know about?

____
____
____

List Surgeries:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

ALLERGIES to drugs, foods, dyes, preservatives: _______________ ____________
__________________ ____________ ______________ _____________ ____________
______________ _________________ _____________ _____________ ____________
_____________ ______________ _______________ ___________ _______________

List Prescription Medications Strength and Frequency:

_____________________x day_________ ____________________x day___________
_____________________x day_________ ____________________x day___________
_____________________x day_________ ____________________x day___________
_____________________x day_________ ____________________x day___________
_____________________x day_________ ____________________x day___________
_____________________x day_________ ____________________x day___________

List over the counter medicines (non-prescription, Vitamins-Aspirin etc)

_________________________________ ________________________________
_________________________________ ________________________________
_________________________________ ________________________________

______________________________ __________________________
Patient Signature **Date**