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in Pain Management

WELCOME TO OUR OFFICE!

PLEASE BE ADVISED THAT YOUR FIRST VISIT IS FOR AN
INITIAL CONSULTATION ONLY

YOU AND THE DOCTOR WILL DECIDE ON THE BEST TREATMENT PLAN FOR YOU.

INSTRUCTIONS

- Please call us to verify that we have received your prior imaging from your referring physician. This is necessary for your appointment.
- Please do NOT bring children to your appointment. The doctor needs your undivided attention at this visit. Please call us to reschedule if you do not have alternate care for your child.
- A complete exam will take approximately 30-60 minutes depending on your problem. A report will be sent to your referring physician.
- We work strictly by appointment. If we experience any delays, we will keep you informed.
- Bring your current medications in the bottle for our doctors to verify the name and dose prescribed.

FEES

Consultations range in price depending on the complexity of the examination, diagnosis, treatment options, and time involved. Please note that we accept insurance assignment for Medicare, Medicaid, Blue Cross, Worker's Comp and some HMO's (contact us to verify our participation with your plan). **For us to file insurance for auto accident cases, you must bring all billing information with you. If there is an attorney involved in your case, please notify the receptionist.**

If you have any questions regarding our office or policies, please call us at (850)558-1260.

TO ASSIST YOU IN YOUR VISIT TO OUR OFFICE, WE ARE MAILING THESE FORMS PRIOR TO YOUR VISIT. PLEASE FILL THEM OUT AND BRING THEM WITH YOU TO THE APPOINTMENT. ALSO BRING YOUR INSURANCE CARDS AND YOUR CO-PAY. THIS WILL BE REQUIRED AT CHECK-IN.

Please feel free to call us if you need assistance completing these forms. If you cannot fill out the forms prior to your visit, please **come 30 minutes ahead of your appointment time so we may help with their completion.**

THANK YOU FOR YOUR COOPERATION!
WE LOOK FORWARD TO SEEING YOU ON:

DATE:_____ **TIME:**_____

DOCTOR:_____
Our address is 2160 Capital Circle NE Suite 200 Tallahassee, FL 32308

New Patient Information-Division of Pain Management

Name:_____ Birth Date:_____
Last First Middle

Social Security #:_____ Gender: ☐ Female ☐ Male

Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ Other of Undetermined

Preferred Language:_____ Race: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____

Work Phone:_____ Email:_____

How do you want to receive appointment reminders? ☐ Phone Call ☐ Text Message ☐ Email

Referring/Requesting Physician:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Contact Person in case of emergency: _____

Relationship to contact:_____ Contact Phone:_____

Insurance Information

***** Please give all insurance cards to the receptionist at the front desk*****

Was this related to an accident? ☐ Yes ☐ No If yes, ☐ Auto ☐ Work ☐ Other _____

If this was related to an accident, Date of Injury _____

If this was related to an auto accident were you treated within 14 days of the accident: ☐ Yes ☐ No

If yes, where were you treated? _____

I have completed this form completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services. Assignment of Benefits: I authorize payment of Medical benefits to Tallahassee Neurological Clinic for services rendered by any physician of Tallahassee Neurological Clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

*Signature of Patient or Responsible Party:*_____ *Date:*_____

Tallahassee Neurological Clinic Division of Pain Management
History Intake Form

PLEASE ANSWER **ALL** QUESTIONS OR WRITE ***N/A*** IF THE QUESTION DOES NOT APPLY

NAME:_____**Date of Birth**:_____**Date**:_____

Pharmacy:_____***Main*** Reason for visit: _____

Do you have any pain radiating into your: ARMS:_____RT;___LT? LEGS:____RT:____LT?

When did your pain/problem first begin? Give year or exact date:_____

How did pain begin?
____Accident at work ____Motor Vehicle Accident ____Illness (Explain)
____Accident at home ____Following Surgery (Explain) ____No explanation

Have you had any accidents or injuries before or since this pain began that may have had an effect on your current condition?_____Yes_____No

Have you had any of the following treatments for your pain:
____Pain Medication ____Epidural Injections ____Physical Therapy ____T.E.N.S.

____Surgery ____Chiropractor ____Trigger Point Injections
If Surgery, enter type of surgery and date; if epidural injection or physical therapy, specify date:
_____
_____
Did this help?_____Yes_____No If yes, how long?_____

SOCIAL HISTORY:
Are you presently working?____Yes____No Advanced Directives:___Yes___No Exercise:____Yes___No
Flu Shot?:_____Yes_____No If yes, date:_____Pneumonia:_____Yes_____No If yes date:_____
Current Smoker:____Yes____No If yes, packs per day:_____
Alcohol Use:____Yes____No If yes, drinks per week: _____
Date of last Colonoscopy:_____Date of Last Mammogram:_____Date of last PAP: _____

ALLERGIES: Are you allergic to any medications?_____Yes_____No
If so, which ones:
_____ Reaction:_____
_____ Reaction:_____
_____ Reaction:_____

IMAGING: Which of the following tests have you had to evaluate your pain problem in the past year?

TEST	**DATE**	**FACILITY**	**Was this test for back or neck?**
X-Ray	_____	_____	neck____back____other_____
MRI Scan	_____	_____	neck____back____other_____
	_____	_____	neck____back____other_____
CT Scan	_____	_____	neck____back____other_____
	_____	_____	neck____back____other_____
EMG /NCV	_____	_____	neck____back____other_____

REVIEW OF SYSTEMS: Please circle the **SPECIFIC** symptoms **IN EACH CATEGORY** below that pertain to you.

General—fever, chills, night sweats, weight loss, **Eyes**—
vision loss, blurry vision, light sensitivity **Gastro**—
nausea, abdominal pain, diarrhea, constipation
Urinary—painful urination, incontinence **Skeletal**—
back pain, neck pain, joint pain, muscle pain **Skin**—
rash, bruising, healing wound
Neuro—weakness, numbness, poor balance, headaches
Respiratory- shortness of breath, coughing, wheezing
Hematology- bleeding, abnormal bruising
Allergy- seasonal allergies, persistent infection **Psych**—
depression, anxiety, thoughts of violence/suicideIf none
apply, please circle: **NONE**

CURRENT *PAIN* MEDICATIONS (YOU MUST EITHER LIST ALL MEDS OR SUPPLY US WITH A LIST)	**DOSAGE**	**PRESCRIBED BY**	**HOW TAKEN**

OTHER CURRENT *PRESCRIBED* MEDICATIONS			

Authorization & Assignment of Benefits, Medical Release Information, Privacy Statement

Patient's Name**:** _____ _____Date of Birth**:**_____ _____

Emergency contact, Release of Medical Information, Prescription pick up and Appointment Information

Tallahassee Neurological Clinic physicians and medical staff have my permission to discuss my health information, including test results, schedule, confirm, cancel or reschedule my appointments, and pick up prescriptions, samples, refills, or anything that I have requested from Tallahassee Neurological Clinic, P.A., with the individuals listed below. I am denoting specific approvals next to each individual listed.

If patient is a minor, ALL parents, or legal guardians must be listed below.

1) Name:_____Relationship _____

Phone No.: _____( ) Home ( ) Work ( ) Cell

Emergency contact: ( )yes ( )no **Medical info**: ( )yes ( )no **Appointment info**: ( )yes ( )no **Prescriptions**: ( )yes ( )no

2) Name:_____Relationship _____

Phone No.: _____ ( ) Home ( ) Work ( ) Cell

Emergency contact: ( )yes ( )no **Medical info**: ( )yes ( )no **Appointment info**: ( )yes ( )no **Prescriptions**: ( )yes ( )no

Accident Relationship to Visit

Is this visit related to an accident? Yes No If yes: ( ) Auto ( ) Work ( ) Other _____

If yes: Date of injury: _____If Auto were you treated within 14 days of accident? Yes no

If yes, where were you treated? _____

Privacy Statement

I acknowledge receipt of the Notice of Privacy Practices from Tallahassee Neurological Clinic, P.A. I understand that it is my responsibility to read the information provided therein.

Authorization and Assignment of Benefits

I authorized the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Tallahassee Neurological Clinic, P.A. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Tallahassee Neurological Clinic, P.A. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered. Furthermore, I verify that all information provided by me on this document is accurate to the best of my knowledge at this time and that this information is good for one year from date of signature unless I request changes in writing.

Authorization to Review Prescription History

I agree, in order to assure that my medication history is accurate, Tallahassee Neurological Clinic physicians and medical staff have my permission to retrieve historically prescribed medications in the past year via Dr. First Medication Management.

Signature: _____ Date: _____