



DEPARTMENT OF NEUROLOGY

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DIVISION OF PAIN MANAGEMENT

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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 1321 Executive Center Drive Suite 100 Tallahassee, FL 32301



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 ___

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: _____