PREMIER PAIN SPECIALISTS, LLC - CAPE CORAL (239) 945 1105 FAX (239) 945 4495

DEMOGRAPHIC INFORMATION / INFORMACION DEMOGRAFICA

DATE: _____ (FECHA) **NAME:** _____ (NOMBRE COMPLETO)

SS #: _____ (No. SEGURO SOCIAL) **DOB:** _____ (F. NACIMIENTO) **PHONE:** _____ (TELEFONO) **CELL:** _____ (CELULAR)

ADDRESS: _____ (DIRECCION COMPLETA)

E-MAIL: _____ (CORREO ELECTRONICO) **SEX:** M F **NATIONALITY:** _____ (PAIS DE NACIMIENTO)

MARITAL STATUS: ☐ SINGLE (SOLTERO) ☐ MARRIED (CASADO) ☐ DIVORCED (DIVORCIADO) ☐ WIDOW (ER) (VIUDO(A))

RACE: (RAZA) ☐ AMERICAN INDIAN/ ALASKAN (INDIO AMERICANO / ALASKA) ☐ ASIAN (ASIATICO) ☐ BLACK/AFRICAN AMERICAN (AFRO-AMERICANO/NEGRO) ☐ WHITE (BLANCO)
☐ NATIVE HAWAIIAN (NATIVO HAWAIANO) ☐ OTHER (OTROS) ☐ REFUSE TO REPORT (NO RESPONDE)

LANGUAGE: _____ (IDIOMA) **ETHNICITY:** ☐ HISPANIC/LATINO ☐ NON HISPANIC/LATINO (ETNIA)

DOMINANT HAND: (MANO DOMINANTE) ☐ RIGHT (DIESTRO) ☐ LEFT (ZURDO) ☐ AMBIDEXTROUS (AMBIDIESTRO)

MOTHER'S MAIDEN NAME: _____ (APELLIDO MATERNO)

EMPLOYER: _____ (EMPLEADOR/TRABAJO)

EMERGENCY CONTACT: _____ (CONTACTO DE EMERGENCIA) **PHONE #** _____ (TELEFONO)

PRIMARY CARE DOCTOR: _____ (MEDICO DE CABECERA / MEDICO DE FAMILIA)

REASON FOR VISIT: (MOTIVO DE SU VISITA) _____

_____

_____

HOW LONG HAS THIS BEEN A PROBLEM? _____ (CUANTO TIEMPO TIENE ESTE PROBLEMA?)

REFERRAL SOURCE: (RECOMENDADO POR:) ☐ PATIENT (PACIENTE) ☐ PHYSICIAN (MEDICO) ☐ OTHER (OTROS)

REFERRAL SOURCE NAME AND CONTACT INFORMATION:

_____ (NOMBRE Y DATOS DE CONTACTO DE QUIEN LO RECOMENDO/REFIRIO)

PHARMACY OF PREFERENCE: (PLEASE SPECIFY PHONE # AND ADDRESS) ***FARMACIA DE PREFERENCIA***

☐ PUBLIX ☐ WALGREENS ☐ CVS ☐ WALMART ☐ SAM'S CLUB ☐ COSTCO

☐ WINN DIXIE ☐ OTHER _____

ADDRESS (DIRECCION): _____

PHONE (TELEFONO): _____

RECEIVED PRIVACY POLICY / POLIZA DE PRIVACIDAD RECIBIDA

SIGNATURE: _____ (FIRMA) **DATE:** _____ (FECHA)

Authorization to Release Protected Health Information

HIPAA Compliant Request for Information

Premier Pain Specialists, LLC
1228 SE 8th Terrace
Cape Coral, Fl. 33990
Phone: 239-945-1105 Fax: 239-945-4495

Patient Name: _____

Patient Phone Number: _____

Street Address: _____

Social Security #: _____

Date of Birth: _____

I authorize the following to release my entire health record to Premier Pain Specialists, LLC

I hereby authorize Premier Pain Specialists to release and/or obtain written or oral, any or all information including HIV/AIDS, alcohol/drug abuse, occupational and mental health related information included within the medical records for the purpose of evaluation, treatment, prognosis, etiology and insurance matters to/from other health care providers, insurance companies, government agencies and other sources on a as needed basis.

This authorization is good for one year from the date signed unless otherwise noted.

I may revoke this authorization at any time by mailing or personally delivering a signed. Written notice of revocation to the healthcare provider at which this au6thorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment of my eligibility for benefits. The recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian or Personal Representative (attach proper documentation) Date

_____ _____
Witness Date

PREMIER
PainSpecialists
Effective pain care that gets you back to your life.
1228 SE 8th Terrace, Cape Coral, FL 33990
Phone: (239) 945 1105 Fax: (239) 945 4495

I / YO _____

agree to participate in a Program of Pain Management with the Physicians of Premier Pain Specialists, LLC. I may be provided with controlled substances, while actively participating in the Pain Management Program, only if I adhere to the following regulations

1. I will receive controlled substances from the Premier Pain Specialists, LLC. staff only.
2. I will use the medications within the parameters given by the Premier Pain Specialists LLC staff.
3. I will not receive replacements for lost, stolen, or destroyed medications.
4. I will not seek controlled substances from the Premier Pain Specialists, LLC staff if I decide to discontinue participation in the Pain Treatment Program.
5. I will agree to participate in a drug detoxification program if prescribed by a member of the Premier Pain Specialists, LLC Staff.
6. Should violation of this agreement occur, I will consider thirty days adequate notice for termination of controlled substances.
7. Should notice of termination occur, I agree to obtain an alternate source of physician care within thirty days.

I will under no circumstances hold any member of the Premier Pain Specialists LLC staff liable for any sequelae of discontinuance of controlled substances provided thirty days notice of termination is given.

me comprometo a participar en un programa para el manejo del dolor con los médicos de Premier Pain Specialists, LLC. Se me proveerá con prescripciones para sustancias controladas durante mi participación activa en el Programa para el manejo del dolor siempre y cuando siga la siguientes normas.

1. Sólo recibiré prescripción para sustancias controladas del personal de Premier Pain Specialists, LLC.
2. Sólo utilizaré los medicamentos dentro de los parámetros establecidos por el personal de Premier Pain Specialists, LLC.
3. No recibiré prescripción por motivo de sustitucion por perdida, robo o destrucción de medicamentos.
4. No solicitaré prescripción para sustancias controladas al personal de Premier Pain Specialists, LLC si decido finalizar mi participación en el programa terapéutico.
5. Me comprometo en participar en un programa de desintoxicación si fuese requerido y prescrito por un miembro del personal de Premier Pain Specialists, LLC.
6. De ocurrir una violación a este acuerdo, voy a considerar treinta días como suficiente aviso de terminación para prescripción de sustancias controladas.
7. De ocurrir un Aviso de Terminación, obtendré una fuente alternativa de atención médica dentro de un plazo de treinta días.

Bajo ninguna circunstancia, ningún miembro del personal de Premier Pain Specialists, LLC; será responsable por ninguna secuela de abstinencia por prescripción de sustancias controladas provistas pasados de los 30 días del plazo de terminación.

SIGNED / *FIRMA* _____

DATE / *FECHA* _____ / _____ / _____

PREMIER PAIN SPECIALISTS, LLC

ASSIGNMENT OF BENEFITS

I, _____ hereby authorize _____
(Patient) (Name of Insurance Carrier)

I, _____ hereby authorize _____
(Name of Financially Responsible Party) (Name of Insurance Carrier)

to make medical benefits payments, otherwise payable to me for services rendered by the physicians and staff payable to and mailed directly to: **Premier Pain Specialists, LLC, PO BOX 151460, Cape Coral, FL 33915-1460**

Furthermore, I hereby IRREVOCABLY ASSIGN to Premier Pain Specialists, LLC the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges, provided by Premier Pain Specialists, LLC.

Furthermore, the undersigned by these presents does hereby make, constitute and appoint Premier Pain Specialists, LLC and any of its duly authorized agents and employee as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Premier Pain Specialists, LLC's which checks, drafts or money orders are made payable for services which have been made by Premier Pain Specialists, LLC, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Premier Pain Specialists, LLC or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and other statements.

MEDICAL RELEASE

Furthermore, a photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Premier Pain Specialists, LLC's or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page.

FINANCIAL RESPONSIBILITY

Co-Pays, deductibles and fees for non covered services are due at the time of service. If after your claim has been filed with your insurance company, a patient responsibility amount is due you will receive a statement of your financial responsibility will be sent to you. Failure to pay the patient responsibility may result in your account being assigned to a collection agency. If your account is turned over to a collection agency, you will be responsible for your balance **and** the collection company's current fee. If collection efforts fail, your account may be turned over to an attorney for legal action.

CONSENT TO TREAT

I authorize Premier Pain Specialists, LLC to perform the treatments or procedures approved by my physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. The nature and purpose of the procedure, possible alternative methods of treatment and risks involved and the possibilities of complications have been fully explained to me.

By signing below I understand and agree to the policies listed above.

PATIENT'S SIGNATURE	PRINTED NAME	DATE
FINANCIALLY RESPONSIBLE PARTY'S SIGNATURE	PRINTED NAME	DATE
WITNESS SIGNATURE	PRINTED NAME	DATE

Premier Pain Specialists, LLC
1228 SE 8th Terrace
Cape Coral, Fl. 33990
Phone: 239-945-1105 Fax: 239-945-4495

CONSENT TO EXAMINATION AND TREATMENT AND STATEMENT OF FINANCIAL POLICY AND RESPONSIBILITY

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and / or an interpreter to help me in completing this form, and declined any aid.

By my signature below I hereby authorize the physicians of Premier Pain Specialists, LLC with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me. I further agree to undergo any examinations, x-rays, blood tests and / or any other diagnostic modalities that the physician may determine to be important and / or relevant to my care.

By my signature below I authorize the doctor to treat or correct any unexpected conditions or problem found during the examination, diagnostic procedure, and/or care, treatment, therapy or remedy listed above. I agree that the doctor will explain my medical condition(s), symptom, or trauma, if known, and will explain any proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I **agree to ask for clarification if needed.**

By my signature below I agree that the doctor will explain other relevant and available alternatives, including associated risks, to the examination, diagnostic procedure, and/or treatment proposed. I agree that I will be provided with the opportunity to discuss relevant and available alternatives. I **agree to ask for clarification if needed.**

By my signature below I understand that there are certain risks inherent to the diagnosis and treatment of any disease, physical trauma, or condition. I agree that the doctor will discuss the risks of the specific examination, diagnostic procedure, and/or treatment proposed, including risks that are specific to me. I further agree that the doctor will explain the risks of **not** having the examination / diagnostic procedure / treatment proposed. I **agree to ask for clarification if needed.**

By my signature below I agree that I am submitting to the examination, diagnostic procedure, and/or treatment of my own free will. I further agree that I can ask questions and raise concerns with the doctor about my condition, the risks inherent to the examination, diagnostic procedure, and/or treatment, and my treatment options. I agree that my questions and concerns will be discussed and answered to my satisfaction. I further attest that I understand that I may ask questions concerning my examination or treatment, and that I **may stop treatment at any time for clarification of treatment options.**

By my signature below I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have **not taken any undisclosed medications or drugs prior to examination and/or treatment.**

By my signature below I agree that the doctor or any individual employed by the physician has not provided me a guarantee or assurance that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy will cure or improve the condition(s) listed above. I further understand that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy may make my condition worse.

By my signature below I understand that as part of my treatment, PREMIER PAIN SPECIALISTS, LLC may determine that I should visit a specialists or other physician. In such circumstances Premier Pain Specialists, LLC will disclose my protected health information determined to be necessary to the specialist or other physician.

By my signature below I agree that, as part of the examination, diagnostic procedure, and/or care, treatment, therapy or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand that this will include a review, if necessary, of past, current or future health records, including records of procedures such as physical examinations, x-rays, blood or urine tests. I understand that further information will be gleaned, as necessary, from direct and telephonic conversations with the doctor and/or the doctor's health care staff, or from my responses to any questionnaire submitted prior to the initiation of the proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I understand that the information sought may include, but is not necessarily limited to, the following:

Documentation of past medical history
Records of physical exams and procedures
Laboratory, X-ray, MRI, and other test results
Records of medication or drug usage
Records of implanted or external medical devices
Information related to diagnosis and treatment of a mental health condition
Information about HIV / AIDS
Information about hepatitis infection
Information about sexually transmitted diseases
Information about infectious diseases that must be reported to Public Health authorities

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that the physician listed above has elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

By my signature below **I understand and agree to pay all deductibles, co-payments, and fees due, less insurance payments.** As a courtesy to you, we will submit your claim to your insurance company. Any portion not covered by your insurance company such as your co-insurance and/or deductible amount is due and payable at the time of service. Additionally, some insurance companies do not cover supplies necessary for your treatment. You are responsible for these non-covered services.

Failure to make payment in full or failure to make arrangements for payment may result in your account being placed with a collection agency. Should it become necessary to send your account to the collection agency, collection costs may include, but are not limited to, collection agency fees, court costs, attorney fees, interest on unpaid balances and any other fees or costs associated with the collection of unpaid balance. A $25.00 returned check fee will be added to your account for all returned checks.

HMO Patients: You are responsible for notifying your Primary Care Physician of your office visit. You must bring the authorization for the visit with you and present it prior to being seen by the physician. We will have to reschedule your visit if prior approval is not received.

Forms: We require a 24-48 hour notice for forms completion. There is a $8.00 fee per form and payment must be received IN ADVANCE.

Prescription Refills: We require a 24-48 hour notice for refill requests. Requests will not be considered during non-working hours. Please have the medication name, strength, pharmacy name and phone number available when requesting refills. Please call your pharmacy to verify that the prescription is ready.

Due to the nature of our specialty, there may be times when an emergency patient visit causes our schedule to run behind. Many times patients are taken out of order due to nursing services. Please bear with us, every patient's care is important to us.

By my signature below the undersigned patient hereby assigns the rights and benefits of insurance under the applicable insurance policy for any service and/or charges provided by Premier Pain Specialists, LLC. I hereby direct the benefits be paid directly to the physician on my behalf for any services furnished to me by Premier Pain Specialists, LLC.

By my signature below I hereby certify that I have read and fully understand all of the words and information contained in this form, and reaffirm my consent to the examination, diagnostic procedure, and/or care, treatment, therapy or remedy proposed.

MISSED APPOINTMENT OR NO SHOW: You will be charged a $30.00 fee for any missed appointment or no show if the office is not notified 24 hours prior to that scheduled appointment.

By my signature below, I permit a copy/fax of this form to serve as an original signature of authorization.

_____ _____

Patient or Patient's Representative Signature Date

Print Patient's Name: _____

If signed by Representative, state name of

Representative: _____

Relationship to Patient:_____

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Effective pain care that gets you back to your life.

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Phone: (239) 945 1105 Fax: (239) 945 4495

Name: _____ **Age:** _____ **Height:** _____ **Weight:** _____
Nombre *Edad* *Altura* *Peso*

Describe the pain that brings you to the Pain Center; _____
Describa el dolor que lo trae a esta consulta

_____

How long have you had this pain? _____
Cuanto tiempo ha tenido este dolor?

Have you had any weight loss or gain in the past year? ☐ Yes ☐ No
Ha sufrido de perdida o ganado peso en el ultimo año?

If yes, explain _____
Si, por favor explique

MEDICAL HISTORY: (Check any of the following conditions you have or have had in the past)
Historia Medica (Marque una o mas de las condiciones que tiene o ha tenido en el pasado)

☐ **Diabetes** *Diabetes*	☐ **Asthma** *Asma*	☐ **Cancer** Cancer	☐ **Arthritis** Artritis
☐ **High Blood Pressure** *Presion Alta*	☐ **Emphysema** *Efisema*	☐ **Ulcer** Ulcera	☐ **Bleeding Problems** Problemas de Sangrado
☐ **Kidney Problems** *Problemas en Riñones*	☐ **Neurological Problem** *Problema Neurologico*	☐ **Liver Problems** Problemas de Higado	☐ **Inmune Problems** Problemas Inmunologicos
☐ **Heart Problems** *Problemas Cardiacos*	☐ **OTHER (describe)**		

_____
Otro (describa)

SURGICAL HISTORY: *Historia Quirurgica* **List any general surgeries you have had:** _____
Enumere cualquier cirugia que haya tenido

_____

List any surgical procedures for pain relief: _____
Enumere cualquier procedimiento para alivio del dolor

_____

MEDICATION ALLERGIES: _____
Alergia a Medicamentos

Please, list all current PRESCRIBED medications: _____
Favor, enumere el listado de sus medicamentos a la fecha

_____

Please, list all medications taken in the past: _____
Favor, enumere el listado de los medicamentos tomados en el pasado

_____

Are you taking OVER THE COUNTER medications? ☐ Yes ☐ No
Toma medicamentos de acceso libre?

If yes, please list _____
Si, por favor enumere

Are you taking Anticoagulants (Blood Thinner)? ☐ Yes ☐ No ☐ Aspirin ☐ Coumadin
Toma Anticoagulantes (Diluyente Sanguineo)?

If yes, please list _____
Si, por favor enumere

PATIENTS NAME: _____ DATE: _____

DO YOU SMOKE? ☐ YES ☐ NO If yes, how often? _____
USTED FUMA? Si? Con que frecuencia?

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO If yes, how often? _____
TOMA BEBIDAS ALCOHOLICAS? Si? Con que frecuencia?

HAVE YOU USED RECREATIONAL DRUGS? ☐ YES ☐ NO If yes, how often? _____
HA UTILIZADO DROGAS RECREACIONALES? Si? Con que frecuencia?

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO If yes, how often? _____
EJERCITA REGULARMENTE? Si? Con que frecuencia?

MEDICAL HISTORY INFORMATION (PLEASE CHECK ALL THAT APPLY)
HISTORIA MEDICA (FAVOR MARQUE TODAS LAS QUE APLIQUEN)

CONSTITUTIONAL
- ☐ FEVER / FIEBRE
- ☐ CHILLS / ESCALOFRIOS

EYES *OJOS*
- ☐ CATARACTS / CATARATAS
- ☐ GLAUCOMA
- ☐ CHANGES IN VISION / CAMBIOS
- ☐ DOUBLE VISION / DOBLE VISION
- ☐ HALOS / LUCES CIRCULARES
- ☐ OTHER/OTROS

_____

CARDIOVASCULAR
- ☐ HIGH BLOOD PRES. / P. ALTA
- ☐ HIGH COLESTEROL /COL. ALTO
- ☐ HEART DISEASE / ENFERMEDAD ♥
- ☐ HEART ATTACK/ INFARTO
- ☐ ANGINA
- ☐ HEART FAILURE / FALLO ♥
- ☐ HEART VALVE PROB / VALVULA
- ☐ HEART RHYTHM PROB / RITMO
- ☐ PHLEBITIS / FLEBITIS
- ☐ CHEST PAIN / DOLOR DE PECHO
- ☐ JAW PAIN / DOL. MANDIBULA
- ☐ ARM PAIN / DOLOR BRAZO
- ☐ IRREG. PULSE /PULSO IRREGUL
- ☐ APNEA
- ☐ OTHER / OTRO

_____

DERMATOLOGICAL
- ☐ BREAKDOWN / ACNE
- ☐ RASH / ZARPULLIDO
- ☐ INFECTION
- ☐ MOOD CHANGE / CAM. HUMOR
- ☐ OTHER/OTRO

_____

EARS, NOSE, MOUTH &THROAT
OIDO, NARIZ, BOCA Y GARGANTA
- ☐ DIFFICULTY HEARING / SORDERA
- ☐ EAR PAIN &/OR DRAINAGE / DOLOR DE OIDO
- ☐ NOSE BLEEDS / SANGRADO DE NARIZ
- ☐ MOUTH SORES / LLAGAS EN LA BOCA
- ☐ FREQUENT SORE THROAT / DOLOR DE GARGANTA
- ☐ OTHER / OTRO

_____

RESPIRATORY
RESPIRATORIOS
- ☐ BRONCHITIS / BRONQUITIS
- ☐ ASTHMA - EMPHYSEMA /ASMA -EFISEMA
- ☐ COUGH / TOS
- ☐ SHORTNESS OF BREATH / FALTA
- ☐ PAIN W/BREATHING / DOLOR AL RESPIRAR
- ☐ WHEEZING / RUIDO SIBILANTE
- ☐ COUGHING UP BLOOD / TOSE SANGRE
- ☐ NIGHT SWEATS / SUDORACION NOCTURNA

GENITOURINARY URINARIO
- ☐ KIDNEY - BLADDER STONES / CALCULOS
- ☐ OSTOMY / OSTOMIA
- ☐ DIALYSIS
- ☐ PAIN ON URINATION / DOLOR URINARIO
- ☐ BLOOD IN URINE / SANGRE EN ORINA
- ☐ FREQUENCY OF URINATION / FREQUENCIA
- ☐ BREAST LUMP -DISCH/LIQUIDO DEL SENO
- ☐ INCONTINENCE / INCONTINENCIA
- ☐ SELF CATHETERIZATION / AUTO DRENADO
- ☐ FOLEY CATHETER / KIT DE SONDA

MALE ONLY SOLO HOMBRES
- ☐ PROSTATE PROBLEM / PROSTATA
- ☐ PENILE PROSTHESIS / PROTESIS
- ☐ URINARY SPHINCTERS /ESFINTERES
- ☐ ABNORMAL URIN. STREAM / FLUIDEZ

GYN SOLO MUJERES
- ☐ MENOPAUSE / MENOPAUSIA
- ☐ # PREGNANCIES / # EMBARAZOS ____
- ☐ # CHILDREN / # HIJOS _____
- ☐ VAGINAL DISCHARGE / DESCARGA VAG.
- ☐ LAST PAP TEST / PAPANICOLAL

_____

- ☐ LAST MENSTRUAL PERIOD / ULT. PERIODO

_____

GASTROINSTESTINAL
- ☐ ULCER - GASTRITIS / ULCERAS
- ☐ HEPATITIS
- ☐ PANCREATITIS
- ☐ DIVERTICULI
- ☐ FEEDING-PEG TUBE / ALIMT. X SONDA
- ☐ HEARTBURN / ACIDEZ
- ☐ ABDOMINAL PAIN / DOLOR ABDOMINAL
- ☐ LOSS OF APPETITE / PERDIDA DE APETITO
- ☐ WEIGHT LOSS / PERDIDA DE PESO
- ☐ NAUSEA - VOMITING
- ☐ VOMITING BLOOD / VOMITA SANGRE
- ☐ DIARRHEA
- ☐ CONSTIPATION / EXTREÑIMIENTO
- ☐ RECTAL BLEEDING / SANGRADO ANAL
- ☐ BLACK STOOLS / HECES NEGRAS
- ☐ DIFFICULT CHEWING / DIFICIL MASTICAR
- ☐ DIFFICULT SWALLOWING / DIFICIL TRAGAR
- ☐ REGULAR USE OF LAXATIVES/LAXANTES
- ☐ OSTOMY (TYPE) / OSTOMIA (TIPO)

_____

MUSCULOSKELETAL
- ☐ JOINT PAIN /DOL. ARTICULACIONES
- ☐ SWOLLEN JOINTS/INFLAM. ARTICUL.
- ☐ NECK-BACK PAIN/DOLOR CUELLO-ESPALDA
- ☐ MUSCLE WEAKNESS/DEBILIDAD MUSCULAR
- ☐ ARTHRITIS (TYPE)

_____

ENDOCRINE ENDOCRINO
- ☐ DIABETES
- ☐ THYROID PROBLEMS / TIROIDES
- ☐ EXCESS THIRST-URINATE/EXCESO SED-ORINA
- ☐ SENSITIVE HEAT-COLD/SENSIBLE CALOR-FRIO
- ☐ MOOD SWINGS / CAMBIO DE HUMOR
- ☐ OTHER/OTRO:

_____

OTHER
OTROS
- ☐ DIFFICULTY SLEEPING / INSOMNIA
- ☐ REG. USE SLEEPING PILLS / USA PASTILLAS PARA DORMIR
- ☐ BACK-NECK PROBLEMS / PROB.DE CUELLO Y ESPALDA
- ☐ HIV-AIDS / SIDA
- ☐ BLOOD TRANSFUSION / TRANSFUSION DE SANGRE
- ☐ BLOOD TRANSF. REACTION / REACCION A TRANSFUSION
- ☐ USUAL BED TIME / HORA DE DORMIR _____

ALLERGIC
ALERGIAS
- ☐ HAY FEVER / FIEBRE DE HENO
- ☐ BEE STING / PICADURA DE ABEJA
- ☐ HIVES / URTICARIA
- ☐ OTHER / OTRO

_____

NEUROLOGIC NEUROLOGICO
- ☐ STROKE / INFARTO
- ☐ SEIZURES / CONVULSION
- ☐ FAINT-DIZZY / DESMAYO-MAREO
- ☐ HEAD INJURY / LESION EN CABEZA
- ☐ HEADACHES / DOLOR DE CABEZA
- ☐ BALANCE PROBLEM/PROB.EQUILIBRIO
- ☐ MEMORY LOSS/PERDIDA DE MEMORIA
- ☐ OTHER/OTRO

_____

CANCER
- ☐ CHEMOTHERAPY / QUIMIOTERAPIA
- ☐ RADIATION / RADIACION
- ☐ SURGERY / CIRUGIA
- ☐ CANCER WHERE / EN QUE PARTE

_____

PSYCHOSOCIAL PSICOSOCIAL
- ☐ DEPRESSION
- ☐ SUBSTANCE ABUSE / ADICCION
- ☐ RECENT LIFE CHANGE / CAMBIOS DE VIDA
- ☐ SEXUAL CONCERNS RELATED TO ILLNESS / PREOCUP. SEXUAL POR LA ENFERMEDAD.

_____

PATIENTS NAME: _____ **DATE:** _____

NOMBRE COMPLETO DEL PACIENTE

FAMILY HEALTH HISTORY ***HISTORIA DE SALUD FAMILIAR***
(BLOOD RELATIVES ONLY) *(SOLO FAMILIA DIRECTA)*

FATHER: ☐ Alive ☐ Deceased	**Present Health or Cause of Death** ***(Salud o Causa de Muerte)***	**Age?**
MOTHER: ☐ Alive ☐ Deceased	**Present Health or Cause of Death** ***(Salud o Causa de Muerte)***	**Age?**
BROTHERS: ___ # Alive ___ # Deceased	**Present Health or Cause of Death** ***(Salud o Causa de Muerte)***	**Age?**
SISTERS: ___ # Alive ___ # Deceased	**Present Health or Cause of Death** ***(Salud o Causa de Muerte)***	**Age?**
CHILDREN: ___ # Alive ___ # Deceased	**Present Health or Cause of Death** ***(Salud o Causa de Muerte)***	**Age?**

Which of the following treatments have you had for your pain problems?

Cual de estos tratamientos le han hecho para su condicion?

TREATMENT/ TRATAMIENTO	**CHECK DATE/FECHA**
NERVE BLOCKS/BLOQUE NEURAL	_____
TENS UNITS/EST. TRANSCUTANEA	_____
OT-PT / TERAPIA FISICA	_____
BIOFEEDBACK/RETROALIMENT.	_____
HYPNOSIS	_____
COUNSELING/TERAP. PSICOLOGICA	_____
CHIROPRACTOR/QUIROPRACTICO	_____

Which of the following tests have you had to evaluate your pain problems?

Cual de estos tests le han hecho para evaluar su condicion?

TEST	**CHECK DATE/FECHA**
X-RAY / RAYOS X	_____
CT SCAN / TOMOGRAFIA	_____
MRI / RESON. MAGNETICA	_____
EMG / ELECTROMIOGRAFIA	_____
MYELOGRAM / MIELOGRAMA	_____
THERMOGRAM/TERMOGRAMA	_____
OTHER/OTRO	_____

ARE YOU EXPERIENCING ONE OR MORE OF THE FOLLOWING SYMPTOMS?

ESTA EXPERIMENTANDO UNO O MAS DE LOS SINTOMAS A CONTINUACION?

LOWER BODY ***(CINTURA PARA ABAJO)***

- ☐ Numbness in feet / Pies entumecidos
- ☐ Numbness in Leg(s)/ Pierna(s) entumecida
- ☐ Tingling in feet / Hormigueo en pies
- ☐ Tingling in leg(s) / Hormigueo en Pierna(s)
- ☐ Burning in feet / Ardor en pies
- ☐ Burning in leg(s) /Ardor en Pierna(s)
- ☐ Pain in feet / Dolor en los pies
- ☐ Pain in leg(s) /Ardor en la Pierna(s)
- ☐ Pain in Lower back / Dolor en la espalda baja
- ☐ Weakness in Leg(s) or Feet / Debilidad en pies o pierna(s)
- ☐ Pain radiating down leg(s)from lower back / Dolor irradiando hacia la pierna(s) desde la espalda baja

UPPER BODY ***(CINTURA PARA ARRIBA)***

- ☐ Numbness in hand(s) / Mano(s) entumecida
- ☐ Numbness in Arm(s)/ Brazo(s) entumecido
- ☐ Tingling in hand(s) / Hormigueo en mano(s)
- ☐ Tingling in arm(s) / Hormigueo en Brazo(s)
- ☐ Burning in hand(s)/ Ardor en mano(s)
- ☐ Burning in arm(s) /Ardor en Brazo(s)
- ☐ Pain in hand(s) / Dolor en la mano(s)
- ☐ Pain in Arm(s) /Ardor en el brazo(s)
- ☐ Pain in Neck / Dolor en el cuello
- ☐ Weakness in Arm(s) or Hand(s) / Debilidad en Brazo(s) o mano(s)
- ☐ Pain radiating down Arm(s)from Neck/ Dolor irradiando hacia el brazo(s) desde el cuello

PREMIER
PainSpecialists
Effective pain care that gets you back to your life.

DR. JULES A. PREUDHOMME, MD

1228 SE 8TH TERRACE, CAPE CORAL, FL 33990
Phone: 239 945 1105 Fax: 239 945 4495

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize ***PREMIER PAIN SPECIALISTS, LLC*** to

disclose my Protected Health information to me and the following:

Name: _____

Date of Birth: _____

Contact Number: _____ Relationship: _____

Name: _____

Date of _____

Contact Number: _____ Relationship: _____

OR

☐ I request that all my Protected Health Information be disclosed ONLY to me and no other person

I understand that I may revoke or change this authorization at any time by filling out another "Consent to Disclose Medical Information" form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that the information used or disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by Federal and State Privacy laws. I understand I have the right to receive a copy of this authorization if I request it. I also understand this authorization expires only if revoked.

Signature of Patient or Representative Date

Print name if not signed by Patient Relationship/Authority to act on behalf of the Patient