These questions are designed to help your physician to understand the nature of your pain, as well as which tests and treatments might have to be performed

Name: _____ **Date:** _____

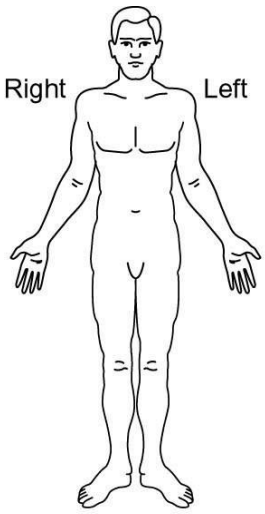
Referring Physician: _____ **Primary Physician:** _____

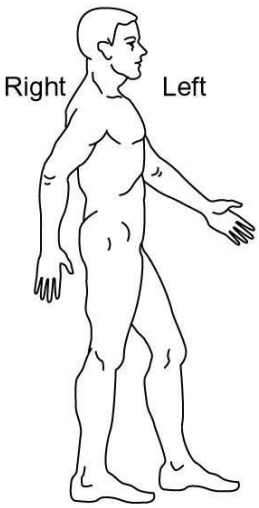
Please describe the pain for which you are seeking help in one sentence (Ex: My back hurts.):

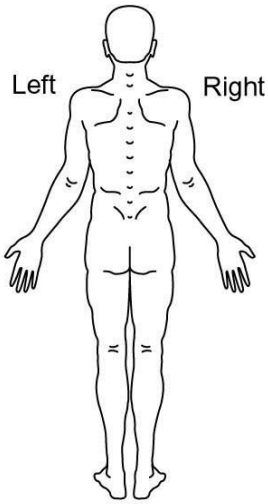
_____

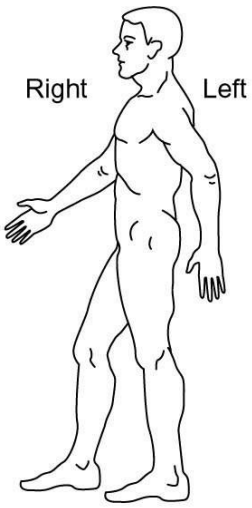
Please shade in the areas where you are having pain in the following pictures:

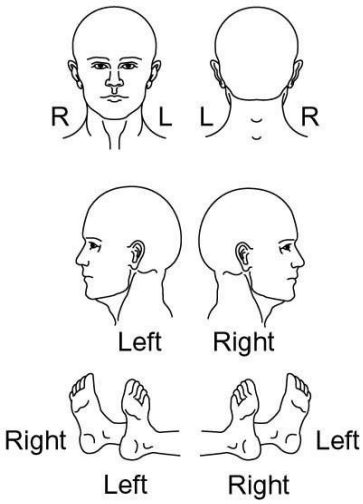
<u>Shade areas darker for more severe pain and lighter for less severe pain</u>











Which words describe your pain? <u>Please circle</u>

Sharp	Throbbing	Tender	Intermittent	Burning	Shooting
Aching	Sore	Dull	Cramping	Deep	Nagging
Stabbing	Unbearable	Constant	Miserable	Radiating	Exhausting

What makes your pain worse? <u>Please Circle</u>

Walking	Standing	Sitting	Bending	Lying down
Twisting	Heat	Cold	Anxiety	Bowel Movements
Sneezing	Coughing	Reaching	Lifting	Climbing Stairs

Other:

_____

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Phone: (954) 493 – 5048 · Fax: (877) 376 – 4036

Name: _____ **Date:** _____

What makes your pain better? <u>Please circle</u>

Heat Cold/Ice Rest Pain Medications Physical Therapy

Certain Positions: (Please describe) _____

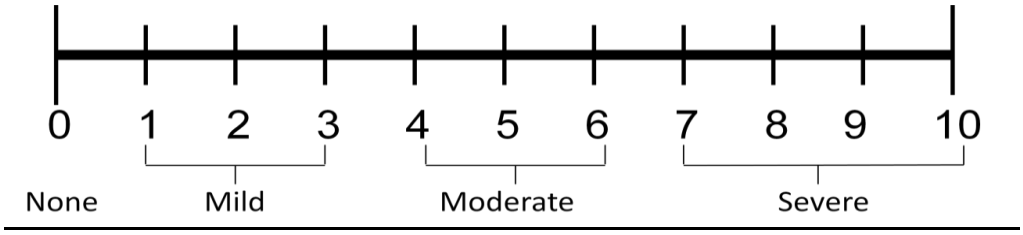
Other: _____

Are any of the following related to your pain? <u>Please Circle</u>

Numbness Weakness Problems with bowels related to pain

Tingling Pins & Needles Problems with bladder related to pain

Please mark on the scale below where your pain level is at its LEAST and Worst:



What is your pain like today? <u>From 0 – 10</u>: _____

What time of the day (Morning, Evening, etc.) is your pain worse? _____ **Better?** _____

Are you ever free from pain? _____ **Yes** _____ **No**

How long have you had your pain? _____

Did any particular event lead to the <u>onset</u> or <u>worsening</u> of your pain? _____ **Yes** _____ **No**

If yes, please explain:

_____

_____

Is your pain due to an automobile, work, slip and fall or any other type of accident? _____ **Yes** _____ **No**

If yes, what type of accident and when did it occur: _____

Are you currently involved in, or considering, any litigation or legal activity concerning your pain or events leading up to your pain? _____ **Yes** _____ **No**

For Doctor Use Only:

Diagnosis: _____

Plan of Treatment: _____

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Medication's List

My Pharmacy's name: _____ Phone: _____

Address: _____

My medication's list and dosages: Let us know if you need an extra page

_____

_____

_____

_____

_____

Allergies' List

_____

_____

Surgeries' List

_____

_____

Do you smoke? _____ Yes _____ No If yes, how many packages per day? _____

Height: _____ Weight: _____

Urinalysis

Fort Lauderdale Pain Medicine will select patients that are being prescribed with narcotic medications to collect a urine sample. This procedure will be **RANDOMLY** performed, as often as the provider considers, and without previous advice. The sample will be sent to an outside lab, who will bill the patient's insurance and/or the patient directly when applicable. Patients have the right to refuse to provide the sample; however, our office will not be able to prescribe any narcotic medication.

In the case the results are abnormal, the provider will determine if a confirmatory test is necessary, or if the patient is in breach of the opioid contract agreement by any misuse of the medication prescribed and/or use of any other schedule II medication not being prescribed by any of the practitioners of this medical practice or use of any schedule I drugs screened, the patient will be discharged from the future care of this medical practice.

Patient Name: _____

Patient Signature: _____ Date: _____

New Patient Information

Patient's Full Name: _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Secondary Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Authorization to Release Medical Records

I would like a copy of my medical records to be sent to the following physicians:

Referring Doctor's Name: _____

Phone: _____ **Fax:** _____

Primary Doctor's Name: _____

Phone: _____ **Fax:** _____

I allow the following people to access my medical information (i.e. this person can call and speak to the office about me and have access to my medical records) I understand that if I do not indicate a name the office will not release any information about me. Please indicate full name and a phone number

_____

_____

_____

_____

Appointment Reminder

I understand the office uses a third-party company to remind me about my future appointments and they might leave voice messages, send text messages, and/or e-mails to the information I have provided. If I do not agree, I will let the office staff know for them to remove my information from the list.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Patient's Portal Acknowledgment

I understand that Fort Lauderdale Pain Medicine, Inc. has provided me the information to access the patient's portal. It gives me access to the provider's reports and the ability to message them directly with questions related to my healthcare. I also understand that this interaction might be billable to my insurance.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Insurance Information

Primary Insurance: _____

Policy Number: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Secondary Insurance: _____

Policy Number: _____

Payment Policy

As a courtesy to our patients, we will file your insurance company. This does not relieve the patient of any responsibility. As a patient, I hereby agree that I am financially responsible for payment of all fees incurred from procedures performed at Fort Lauderdale Pain Medicine, Inc. We try our best to get the most accurate information regarding insurance eligibility and benefits for our patients. We want to make sure each patient coming to our office has coverage and that we are participating with their particular insurance plan. Unfortunately, due to constant changes and updates in insurance policies and plans it is impossible to always have the most up to date information. I understand that any remaining fees unpaid by my insurance carrier are my responsibility and hereby agree to pay promptly in full. I also agree that any insurance payments received directly by me will be forwarded to this office upon receipt. Any legal fees incurred in the collection of unpaid balances will be my expense.

By signing this I agree to the above terms and acknowledge that I have read this policy.

Patient Name: _____

Patient Signature: _____ Date: _____

Appointment Cancellation Fee

Lenchig Spine and Pain Institute will charge a fee to patients who do not cancel their appointment with at least twenty-four (24) hours prior notice:

Office Visit Fee: $50.00
Procedure Fee: 75% of procedure cost

****Payment due before booking another appointment****

Please help us to serve our patients better by calling our office if you have an issue after your appointment has been scheduled and avoid the imposition of the above referenced fees. You can also email us at info@lenchig.com if you are not able to comply with your appointment date and time.

Patient Name: _____

Patient Signature: _____ Date: _____

Credit Card on File Authorization Form

This form is to authorize Fort Lauderdale Pain Medicine, Inc. to keep my credit card information on file for the collection of remaining balances on my account.

Card Information:

Card Type (Circle): Visa / MasterCard / Discover / AmEx

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV Code (Security Code): _____ ZipCode: _____

Cardholder Signature: _____

****Please accompany this form with a copy of the cardholder driver's license.*

I hereby authorize Fort Lauderdale Pain Medicine; Inc. to charge the credit card listed above for the payment of any pending balance on my account. This credit card will be kept on file and will remain in effect until the expiration of the credit card account. Patient may revoke this credit card on file by submitting a written request. A new form must be submitted if any information needs to be updated. Patient agrees to pay the cost for any returned or challenged payments. Please refer to the Payment Policy provided in the New Patient Package for more information.

Patient Name: _____

Patient's Signature: _____

Date: _____

Card Holder Name: _____

Card Holder Signature: _____

Date: _____

Acknowledgment of Receipt of Fort Lauderdale Pain Medicine Inc.
Notice of Privacy Practices

By signing this document, I acknowledge that I have received a copy of Fort Lauderdale Pain Medicine, Inc.'s Notice of Privacy Practices.

Patient Name: _____
Print Name

Patient Signature: _____ **Date:** _____

Or

Patient Representative: _____ **Date:** _____

Relationship to Patient: _____

For Office Use Only

Date acknowledgement received: _____

Or

Reason acknowledgment was not obtained:

_____
_____
_____
_____

Practice Representative: _____

Signature: _____ **Date:** _____