

GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES., PA
DIVISION OF PAIN MEDICINE

Patient Information	Insurance
Date _____	Ins. Co. _____
Patient _____	Subscriber Name _____
Address _____	Relationship to patient _____
_____	Birth date _____ SS# _____
Phone Numbers	ID# _____ Group # _____
Home __ (____) _____	Is patient covered by additional insurance <input type="checkbox"/> Yes <input type="checkbox"/> No
Work __ (____) _____	Ins. Co. _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birth date _____	Subscriber Name _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/ed	Birth date _____ SS# _____
Patient SS# _____	Ins. Co. _____
Occupation _____	ID# _____ Group # _____
Employer _____	Is this a work related injury <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer Address _____	Date of Accident _____
_____	Case Manager _____
Spouse/Significant other:	Address _____
Name _____	_____
DOB _____ SS# _____	Phone _____ Ext _____
Occupation _____	Claim Number _____
Spouse's Employer _____	Is this injury related to a car accident <input type="checkbox"/> Yes <input type="checkbox"/> No
Children _____	Date of Accident _____
_____	Case Manager _____
Whom may we thank for referring you? _____	Address _____
_____	_____
	Phone _____ Ext _____
	Claim Number _____
	Do you have legal representation <input type="checkbox"/> Yes <input type="checkbox"/> No
IN CASE OF EMERGENCY, CONTACT	Name _____ Phone _____
Name _____	
Relationship _____	Do you have a living will or advance directives? May we have a copy for your chart <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone _____	

General Information:

Patient name: _____

Date: _____

Referred By: Physician _____ / Attorney _____

Name of Primary Care Physician _____

Address of Referral Source: _____

Chief Complaint:

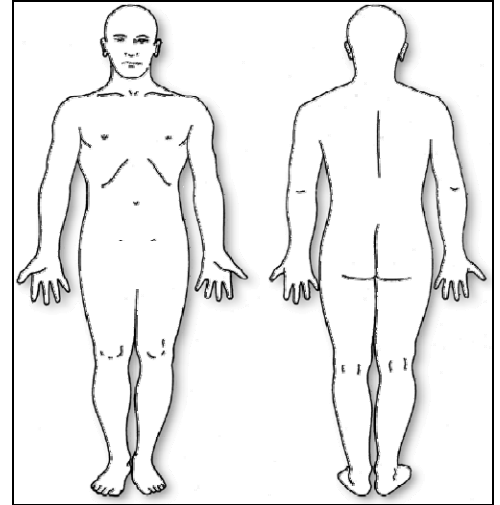
What is the reason for your visit today?

Age of Patient: _____

Male Female

Please provide some background information about this problem.

Indicate your area of pain on the diagrams to the right, try to be specific.



Please check one box per line that describes your pain in words and severity.

Throbbing	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Shooting	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Stabbing	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Sharp	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Cramping	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Gnawing	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Hot-Burning	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Aching	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Heavy	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Tender	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Splitting	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Tiring-Exhausting	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Sickening	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe
Punishing-Cruel	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe

Rate your pain intensity by circling the number that best describes your pain
No pain 0 1 2 3 4 5 6 7 8 9 10 **Intolerable**

RIGHT NOW

The pain: is always present comes and goes has variable intensity.

What aggravates your pain? Massage Anxiety Lying down Sitting Walking
 Coughing Sex Running Cold Heat Straining Standing

What alleviates your pain? _____

What caused this problem?

Cancer Disease Surgery Injury Other _____

How long ago did your pain begin? _____

Have you had any steroid/cortisone injections for this problem?

Type of injection	When?	Doctor	Effectiveness
1.			
2.			
3.			
4.			

What other treatment have you received for this problem?

Treatment Modality	Y / N	When?	Effectiveness
Physical therapy			
Occupational therapy			
Massage therapy			
Chiropractic care			
TENS			
Counseling			
Surgery			

Past Medical History (Please list diagnosed medical problems like hypertension, diabetes etc.)

1.	6.
2.	7.
3.	8.
4.	9.

Past Surgical History

1.
2.
3.
4.
5.

List all Medication Allergies

1. Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No	4.
2.	5.
3.	6.

Please list the medications you are currently taking for you PAIN ONLY.

Medication	Dose and Frequency	Effectiveness	Prescribing Doctor
1.			
2.			
3.			
4.			

Please list all previous medications for pain

Medication	Dose and Frequency	Effectiveness	Side effects
1.			
2.			
3.			
4.			
5.			

List all other medications

Medication		
1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

General Medical Questions

General <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Malaise <input type="checkbox"/> Dizziness <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Loss of sleep	Eye, Ear, Nose, Throat <input type="checkbox"/> Eye problems <input type="checkbox"/> Double vision <input type="checkbox"/> Hay fever <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Sinus problems <input type="checkbox"/> Earache	Cardiovascular <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Poor exercise ability	Gastrointestinal <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating <input type="checkbox"/> Diarrhea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting /Nausea <input type="checkbox"/> Appetite poor <input type="checkbox"/> Liver problems	Genito-Urinary <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful urination <input type="checkbox"/> Kidney problems Skin <input type="checkbox"/> Cancer <input type="checkbox"/> Disease
Muscle/Bone/Joints <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Neck pain <input type="checkbox"/> Arm pain <input type="checkbox"/> Back pain <input type="checkbox"/> Leg pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Other pain	Neurological <input type="checkbox"/> Stroke <input type="checkbox"/> Nerve damage <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Seizures Cancer <input type="checkbox"/> Prostate <input type="checkbox"/> Breast <input type="checkbox"/> Other	Hematological <input type="checkbox"/> Blood disorder <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Bleeding gums do you take <input type="checkbox"/> Caumadin <input type="checkbox"/> Lovenox <input type="checkbox"/> Plavix <input type="checkbox"/> Heparin <input type="checkbox"/> Other anticoagulant	Psychiatric <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Addiction <input type="checkbox"/> Nervousness Endocrine <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Take cortisone	Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Do you use oxygen Allergy / Immunology <input type="checkbox"/> Shellfish allergy <input type="checkbox"/> environmental allergies <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis B/C

Social History

Marital Status: Single Divorced Widowed Married

Highest level of education: _____

Present Source of financial support:

Disability Workman’s Comp Insurance Personal Earnings
 Pension Spouses Earnings None Other: _____

Do you work? Yes No

 If you answered yes: Full time _____ Part time _____ Retired _____

Do you smoke? Yes No

 If you answered yes: how much do you smoke per day? _____

Do you drink alcohol? Yes No _how much _____

Do you have a history of use or abuse of illicit drugs? Yes No

Past Family History: Diabetes Cancer Hypertension other: _____

 Mother _____ Father _____

Name all your doctors

Doctor	Specialty	Telephone

CERTIFICATION

- To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health information.
- I understand that if I fail to cancel an appointment or don’t give 24 hours notice of cancellation before a scheduled procedure I can be charged a \$100.00 failure to cancel fee.
- I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.
- I permit a copy of this to be used in place of the original.

Signature of Beneficiary, Guardian or Personal Representative

Date

Please print name of Patient, Parent or Guardian

Relationship

INSURANCE ASSIGNMENT AND RELEASE

**Gulf-to-Bay Anesthesiology Associates, PA
DIVISION OF PAIN MEDICINE**

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Tampa, FL 33606

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Fax: (813) 253-2279

I certify that I , and/or my dependant (s) have insurance coverage with:

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize the use of my signature on all insurance correspondence and submissions. I permit a copy of this to be used in place of the original.

The above named physician may use my health care information and my disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for such services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Beneficiary, Guardian or Personal Representative

Date

Please print name of Patient, Parent or Guardian

Relationship