

**GULF-TO-BAY ANESTHESIOLOGY ASSOCIATES, P.A.**  
**DIVISION OF PAIN MEDICINE**

**Administration Office**  
118 S. Oregon Ave.  
Tampa, FL 33606

Tel 813.253.2273  
Fax 813.253.2279

**PLEASE PRINT CLEARLY**

Today's Date \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Phone \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Gender:  Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Other \_\_\_\_\_

May we leave detailed messages at the above listed numbers?  Yes  No

***In Case of an Emergency please contact:***

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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**Primary Ins. Co** \_\_\_\_\_ **Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Policy Holder** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **DOB** \_\_\_\_\_

**2<sup>nd</sup> Ins. Co** \_\_\_\_\_ **Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Policy Holder** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Auto Related Injury?**

**Auto Accident Carrier** \_\_\_\_\_

**Claim #** \_\_\_\_\_ **Adjuster Name & Phone #** \_\_\_\_\_

**Date of Accident** \_\_\_\_\_ **State of Accident** \_\_\_\_\_

**Workers' Compensation Related Injury?**

**Workers' Comp. Ins. Carrier** \_\_\_\_\_

**Claim #** \_\_\_\_\_ **Adjuster Name & Phone #** \_\_\_\_\_

**Date of Injury** \_\_\_\_\_

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**Primary Care Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Pharmacy Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Pharmacy Location** \_\_\_\_\_

**For Office Use Only:**

**System Updated:** Yes No N/A **Employee Initials:** \_\_\_\_\_ **Date :** \_\_\_\_\_

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred By: Physician \_\_\_\_\_ Attorney \_\_\_\_\_ Other \_\_\_\_\_

Address of Referral Source: \_\_\_\_\_

**Chief Complaint:**

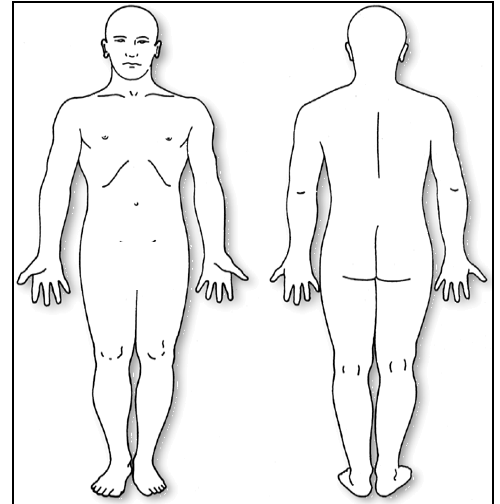
What is the reason for your visit today? \_\_\_\_\_

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 RIGHT NOW.

**No pain** 0 1 2 3 4 5 6 7 8 9 10 **Intolerable**

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			

<b>Past Medical History</b> (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 your 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.**

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

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

**General Medical Questions**

**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

    If you answered yes: How many drinks per day? \_\_\_\_\_

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

**Past Family History:** Diabetes    Cancer    Hypertension    Other: \_\_\_\_\_

Mother \_\_\_\_\_ Father \_\_\_\_\_

**Name all current 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

118 S. Oregon Avenue  
Tampa, FL 33606

Telephone: (813) 253-2273  
Fax: (813) 253-2279

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

\_\_\_\_\_ (Name of Insurance Company)

and assign directly to **Gulf-to-Bay Integrative Pain Medicine** 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 may disclose such information to the above-named insurance Company/Companies 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 in one year from the date signed below.

\_\_\_\_\_  
Signature of Beneficiary, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent or Guardian

\_\_\_\_\_  
Relationship

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you.

**2. OUR LEGAL DUTY**

Law Requires Us To:

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have The Right To:

1. Change out privacy practices and terms of this notice, provided changes are permitted by law.
2. Changes that are made will effect all medical information, including previously received information.

If any changes are made, the new notice will be available upon request.

**3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following are ways that we will be using and disclosing your medical information

**FOR TREATMENT:** We may share medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. When billing your insurance company, the information on, or accompanying the bill may include your medical information.

**FOR HEALTH CARE OPERATIONS:** We may use your medical information for our health care operations. This might include: quality improvement, training programs, evaluating the performance of employees etc.

**4. YOUR INDIVIDUAL RIGHTS**

You Have a Right to:

1. Look at, or get copies of your medical information. You must make your request in writing. You may obtain this form from our office's front desk.
2. Receive a list of all the times we have shared your medical information for purposes other than treatment, payment and health care operations.
3. Request that we place additional restrictions on our use or disclosure of your medical information.
4. Revoke your authorization to share your medical information at any time by notifying our office in writing, and the authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit request involving any of your rights in Section 4 of this notice by writing to the following address:

**Gulf-to-Bay Integrative Pain Medicine**

**118 S. Oregon Avenue**

**Tampa, FL 33606**

**813-253-2273 (phone)**

**813-253-2279 (fax)**

**PRIVACY PRACTICES ACKNOWLEDGMENT**

**ACKNOWLEDGEMENT STATEMENT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

**PATIENT RECORD OF DISCLOSURE**



Initials	
	1. I understand that Opioid medications are strong medications for pain relief and I have been informed of the risks and side effects involved with taking them.
	2. I understand that opioid medications could cause physical dependence. If I suddenly stop or decrease the medication, I could experience withdrawal symptoms that may occur within 24-48 hours of the last dose. Therefore, it is my responsibility to make sure I do not run out of my medications on weekends or holidays. <b>*Prescriptions will not be refilled without an appointment*</b>
	3. I understand that if I am pregnant or become pregnant while taking opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life-threatening for my baby.
	4. I understand that if the medication causes drowsiness, sedation, or dizziness, I should not drive a motor vehicle or operate heavy machinery that could put my life or someone else's life in danger.
	5. I understand that it is my responsibility to notify the physician of any/all side effects I am experiencing from the medication(s).
	6. I agree to take this medication <b>only as prescribed</b> by my physician, and that I will not change the amount or frequency of the medication without discussing it with the prescribing physician.
	7. I agree that my opioid medication(s) will be prescribed by only <b>Gulf-to-Bay Pain Management</b> , and I agree to fill my prescriptions at only one pharmacy. (** We understand that in rare instances, your designated pharmacy may experience a medication shortage. In that instance, please <u>notify us</u> & we will obtain approval from the physician to use your second pharmacy of choice**) 8. I agree not to take any pain medications prescribed by any other physician without first discussing it with Gulf-to-Bay. I give permission to Gulf-to-Bay to verify that I am not seeing other physicians for opioid medication.
	9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
	10. I agree not to sell, lend, or in any way give my medication to any other person.
	11. I agree not to drink alcohol or take mood altering drugs while I am taking opioid medication. I agree to submit a urine specimen at any time that my doctor requests, and give my permission for it to be tested for alcohol and/or drugs.
	12. I agree that I will attend all of my required follow-up visits with the doctor to monitor this medication, and I understand that failure to do so will result in discontinuation of this treatment.
	13. I will not go the emergency room for pain management for my chronic condition for which Gulf-to-Bay is treating me. <b>* This agreement does not restrict me from going to the emergency room for new acute pain of any nature. I shall report to Gulf-to-Bay within one week of such an ER visit.*</b>
	14. I understand that pain medications are only one aspect of my pain treatment plan. I also agree to follow other modalities of treatment as recommended by my physician. Failure to follow the treatment plan may indicate that I no longer respect the treatment suggestions of Gulf-to-Bay, and may result in my discharge from the care of Gulf-to-Bay Pain Management.

**The Pharmacy at which I will fill all of my Controlled Substance prescriptions is:**

Name of Pharmacy : \_\_\_\_\_ Pharmacy phone # \_\_\_\_\_

2<sup>nd</sup> Pharmacy of Choice\*: \_\_\_\_\_ Pharmacy Phone# \_\_\_\_\_

( Only to be used in the event of a medication shortage at your primary pharmacy)

***This agreement shall remain in effect until either party withdraws from it in writing, or until I violate the agreement.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date