Anesco Interventional Pain Institute

2964 N. State Road 7, Suite 206, Margate, FL 33063
Phone: (954) 580-8838 • Fax: (954) 580-8839

TODAY'S DATE ______________________

PATIENT NAME ____________________________________ DATE OF BIRTH ______________________

ADDRESS ____ APT# _____________________________

CITY ______________________________________ STATE _________ ZIP CODE __________________

HOME PHONE ___________________________ **CELL PHONE** ________________________________

PREFERRED CONTACT NUMBER ____

SOCIAL SECURITY # __________________________________ ❒ MALE ❒ FEMALE

❒ CAUCASIAN ❒ AFRICAN AMERICAN ❒ ASIAN/PACIFICA ISLANDER ❒ HISPANIC/LATINO

SPOUSE NAME ____________________________________ DATE OF BIRTH _______________________

SPOUSE'S EMPLOYER'S ____

PRIMARY CARE PHYSICIAN __________________________________ PHONE # ___________________

PRIMARY INSURANCE _____________________________________ I.D.# _______________________

SECONDARY INSURANCE ___________________________________ I.D.# _______________________

RESPONSIBLE PARTY ____________________________ DATE OF BIRTH __________________________

SOCIAL SECURITY # OF RESPONSIBLE PARTY ____

RELATIONSHIP TO RESPONSIBLE PARTY ____

IN CASE OF EMERGENCY CONTACT ____

RELATIONSHIP ____________________________________ PHONE NUMBER ______________________

ASSIGNMENT AND RELEASE

I hereby assign my insurance benefits to be paid directly to Anesco Interventional Pain Group. I understand that I am financially responsible for any non-covered services. I authorize the provider to release any information necessary to process the claim. I authorize the office to release ALL medical information necessary to any hospital, other medical provider, or insurance company acting on my behalf concerning advise, care, treatment, services, including drug, alcohol, mental, or nervous treatment unless specifically excluded by me below, for purposes of medical treatment, evaluating, or administering claims.

SIGNATURE x ____ DATE ___________________________

MEDICATIONS - PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

	NAME OF MEDICATION	DOSE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❒ NO ❒ YES

DO YOU HAVE ANY ALLERGIES? ❒ NO ❒ YES

PLEASE LIST ALL YOUR ALLERGIES BELOW

	ALLERGY	REACTION
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

FORM REVISED MAY 2016

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PAST MEDICAL HISTORY (PLEASE CHECK/LIST ALL MEDICAL PROBLEMS)

HEART ☐HIGH BLOOD PRESSURE ☐HIGH CHOLESTEROL ☐HEART ATTACK ☐IRREGULAR HEART BEAT

LUNG ☐ASTHMA ☐COPD (EMPHYSEMA) ☐SLEEP APNEA OTHER ____________

BRAIN ☐ SEIZURE ☐STROKE OTHER____________

ENDOCRINE ☐DIABETES ☐THYROID (HYPER / HYPO)

KIDNEY ☐KIDNEY FAILURE ☐DIALYSIS OTHER ____________

LIVER ☐LIVER FAILURE ☐HEPATITIS A B C OTHER ____________

BLOOD ☐H.I.V. ☐BLEEDING DISORDERS OTHER ____________

CANCER TYPE____________

PSYCHOLOGICAL ☐DEPRESSION ☐ANXIETY ☐BIPOLAR ☐SCHIZOPHRENIA

PAST SURGICAL HISTORY (LIST ALL SURGERIES YOU HAD IN THE PAST, INCLUDING YEAR)

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________

SYMPTOMS YOU HAVE ENCOUNTERED (PLEASE CHECK ALL THAT APPLY)

CONSTITIONAL ☐FEVER ☐SWEATS ☐CHILLS ☐FATIGUE ☐WEIGHT CHANGES ____________

EYES ☐LOSS OF VISION ☐DOUBLE VISION ____________

ENT ☐HEARING LOSS ☐TINNITIS ☐EAR PAIN ☐DRAINAGE: (EAR) (NOSE) ☐SORE THROAT ☐HOARSENESS____________

CV ☐CHEST PAIN ☐PALPITATIONS ☐SHORTNESS OF BREATH WHILE LAYING FLAT

RESPIRATORY ☐SHORTNESS OF BREATH ☐WHEEZING ☐COUGH ☐SPUTUM PRODUCTION

GI ☐CONSITPATION ☐DIARRHEA ☐NAUSEA ☐VOMITING

GU ☐PAIN WHEN URINATING ☐BLOOD IN URINE ☐URINE INCONTINUENCE

MUSCULOSKELETAL ☐JOINT OR MUSCLE PAIN ☐JOINT SWELLING

PSYCHOLOGICAL ☐DEPRESSION ☐ANXIETY ☐SUICIDAL THOUGHTS

ENDOCRINE ☐FREQUENT URINATION ☐FREQUENT THIRST ☐HEAT INTOLERENCE

HEM/LYMPH ☐BRUISE EASILY ☐BLEED EASILY ☐SWOLLEN GLANDS

WHERE IS YOUR PAIN LOCATED? (PLEASE CHECK ALL LOCATIONS)

NECK - ☐FRONT ☐BACK

HEAD - ☐FRONT ☐BACK

ARMS - ☐LEFT ☐RIGHT

LEGS - ☐LEFT ☐RIGHT

LOWER BACK -

WHAT MEDICATION(S) HAVE YOU TAKEN FOR YOUR PAIN SYMPTOMS?

	NAME OF MEDICATION	DOSE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

HAVE YOU HAD ANY PHYSICAL THERAPY FOR YOUR PAIN? ☐ NO ☐ YES

IF YES, WHEN WAS THE LAST SESSION? ____________________

HAVE YOU HAD ANY INJECTIONS FOR YOUR PAIN? ☐ NO ☐ YES

IF YES, WHAT TYPE OF INJECTION? ____________________

WHEN WAS YOU LAST INJECTION? ____________________

HAVE YOU HAD SURGERY FOR YOUR PAIN? ☐ NO ☐ YES

IF YES, WHEN WAS THE LAST SURGERY?____________________

HAVE YOU TRIED A SPINAL CORD STIMULATOR? ☐ NO ☐ YES