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SPINE & PAIN CENTER

MANUEL LOPEZ, MD
Board Certified Pain Management
& Rehabilitation Physician
4863 Palm Coast Parkway NW | Units 2 & 3
Palm Coast, FL 32137
TEL: (386) 222-7746 | **FAX:** (386) 310-2381
www.seasidepain.com

WELCOME TO OUR OFFICE

Enclosed you will find forms to be completed in their entirely and given to us at the time of your visit. This will save you considerable amount of time on the day of the examination.

Please bring the following items with you to the appointment:

1] **Photo ID and Insurance Card(s):** These will be photocopied. Without these cards we will not be able to see you on your appointment date and will be rescheduled.

2] **List of Medications:** Just a list, you do not need to bring in the actual medications.

3] **Previous Tests (MRI, Xray, CT-Scan, Etc):** If you have been tested previously and have the results of those examination, please bring them with you. They will be helpful in assessing your case.

4] **Co-Payments:** If your insurance requires a co-payment, they are expected at the time of your visit. **Your co-pay is usually printed on the front of your insurance card.**

If you have any questions, please feel free to call us at (386) 222-7746

Thank you,
Seaside Spine & Pain Center Staff

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NO SHOW FEE and 24-Hour Cancellation Policy

Dear Patient,

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively, we have developed an appointment system that sets aside ample time for a patient.

"No shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy and it is effective immediately.

Our policy is as follows:

1. We request you to give our office at least a 24 hour notice in the event you need to reschedule your appointment. **Our office number is (386) 222-7746**
2. If you miss an appointment and DO NOT contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a fee will be assessed to you.

   $50 – Late cancellations and "No shows"
   $75 – Procedure / Injections

3. If you are late for an appointment, we will try to see you but there is a possibility that your appointment will be rescheduled.
4. Our office makes reminder calls prior to appointment date(s). It is ultimately the patient's responsibility to remember their scheduled appointment(s).

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

We thank you for trusting Seaside Spine and Pain Center with your medical care.

I _____ have read and understand the NO SHOW FEE and 24 Hour Cancellation Policy and agree to the terms of this policy.

_____ _____

Signature Date

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BASIC INFORMATION

Full Name _____ ☐ M ☐ F Date of Birth ___ / ___ / _____
Drivers License Number _____ Social Security Number _____
Address _____ City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____ Email Address _____
Emergency Contact _____ Phone _____ Relationship _____
Referred By (Physician, Family, Friend, Etc) _____

RACE/ETHNICITY

☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic/Latino ☐ Other
☐ Native American ☐ Pacific Islander ☐ Decline to Specify
Primary Language _____

EMPLOYMENT

Current Status ☐ Working ☐ Not Working Employer _____
Were you injured at work? ☐ Yes ☐ No Employer Phone _____
Employer Address _____ City_____ State_____ Zip Code_____

INSURANCE

Primary Insurance _____ Policy # _____ Group # _____
Subscriber Name _____ Date of Birth _____ / _____ / _____
Secondary Insurance _____ Policy # _____ Group # _____
Subscriber Name _____ Date of Birth _____ / _____ / _____

AUTO ACCIDENT

Is injury covered by Auto Accident Insurance? ☐ Yes ☐ No Date of Injury _____ Claim# _____
Insurance Carrier _____ Carrier Address _____
Name of Insured _____
Adjuster _____ Adjuster Phone _____
Lawyer _____ Lawyer Phone _____

WORKERS COMPENSATION

Is injury covered by Workers Compensation? ☐ Yes ☐ No Date of Injury _____ Claim# _____
Insurance Carrier _____ Carrier Address _____
Name of Insured _____ Adjuster _____ Adjuster Phone _____
Do you have attorney for this injury? ☐ Yes ☐ No
Attorney Name_____ Attorney's Address _____

PHARMACY

Pharmacy Name _____ Phone _____
Address _____ City _____ State _____ Zip Code _____

Full Name _____ Date of Birth _____ / ____ / ____

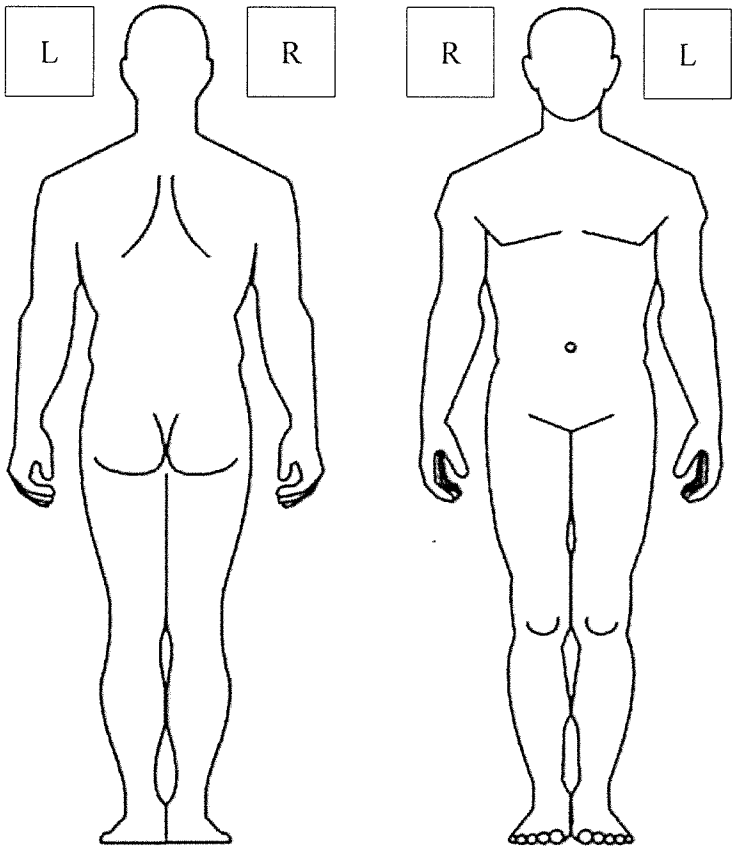
Height _____ Weight _____Lbs Are you right or left handed? ☐R ☐L

What is your current problem? _____

_____

_____

Shade in the area(s) below where you experience pain:



Place and X on the line below that represents your pain today:

No Pain _____Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Place an X on the line below that represents your pain during the past week:

No Pain _____Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Do you need assistance with daily living? ☐No ☐Yes: _____

_____

Full Name _____ Date of Birth _____ / ____ / ____

PAIN INVENTORY – Please check all of the following words that describe your pain:

☐ Numb/Dull ☐ Sharp ☐ Tender ☐ Shooting ☐ Cramping ☐ Firing/Exhausting
☐ Tingling ☐ Aching ☐ Heavy ☐ Stabbing ☐ Throbbing ☐ Hot/Burning

CHRONOLOGY

When did your pain start? _____

_____

Did anything happen that triggered it? _____

_____

What makes the pain better/worse? _____

_____

What is the duration of your pain?

☐ Constant ☐ Constant but variable in intensity ☐ Intermittent ☐ Episodic

PREVIOUS TREATMENT

☐ X-Ray ☐ CT Scan ☐ MRI Scan ☐ Myelogram ☐ EMG ☐ Bone Scan

What other treatments have you tried? Check all that apply:

☐ Surgery ☐ Physical Therapy ☐ Acupuncture ☐ Epidural/Steroidal Injections
☐ Non-Steroidal Anti-Inflammatory Medications ☐ Chiropractic ☐ Non-Prescription Drugs
☐ Other: _____

Which treatment(s) worked the best? _____

_____

How much better did you feel? _____%

Which treatment(s) were least effective? _____

_____

Are you taking any blood thinners? (Plavix, Coumadin, Pletal, Etc)

☐ No ☐ Yes: _____

Are you allergic to any medications?

☐ No ☐ Yes: _____

Do you take your medications as prescribed? ☐ Yes ☐ No

Do you feel impaired with your medication? ☐ Yes ☐ No

Do you drive while impaired? ☐ Yes ☐ No

Full Name _____ Date of Birth _____/_____/_____

MEDICATIONS – Please list ALL medications you are currently taking, including dosage and time taken:

	Name	Dose	Time		Name	Dose	Time
1]				5]			
2]				6]			
3]				7]			
4]				8]			

PAST MEDICAL HISTORY – Please select all that apply. Unchecked boxes indicated a negative.

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer/Tumor
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eye Problems
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Loss of Bladder Control
- ☐ Loss of Bowel Control
- ☐ Rheumatic Fever
- ☐ Seizure
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcer

Other _____

FAMILY MEDICAL HISTORY – Please select all that apply to Father, Mother, Brother, Sister, Son or Daughter. Unchecked boxes indicated a negative.

F M Br S Sn D				
☐☐ ☐☐ ☐☐ Anemia	☐☐ ☐☐ ☐☐ Depression	☐☐ ☐☐ ☐☐ High Blood Press	☐☐ ☐☐ ☐☐ Osteoporosis
☐☐ ☐☐ ☐☐ Anxiety	☐☐ ☐☐ ☐☐ Diabetes	☐☐ ☐☐ ☐☐ High Cholesterol	☐☐ ☐☐ ☐☐ Seizures
☐☐ ☐☐ ☐☐ Arthritis	☐☐ ☐☐ ☐☐ Emphysema	☐☐ ☐☐ ☐☐ HIV	☐☐ ☐☐ ☐☐ Spinal Disorder
☐☐ ☐☐ ☐☐ Asthma	☐☐ ☐☐ ☐☐ Glaucoma	☐☐ ☐☐ ☐☐ Kidney Problems	☐☐ ☐☐ ☐☐ Stroke
☐☐ ☐☐ ☐☐ Blood Clots	☐☐ ☐☐ ☐☐ Heart Disease	☐☐ ☐☐ ☐☐ Liver Problems	☐☐ ☐☐ ☐☐ Substance Abuse
☐☐ ☐☐ ☐☐ Cancer/Tumor	☐☐ ☐☐ ☐☐ Hepatitis	☐☐ ☐☐ ☐☐ Mental Illness	☐☐ ☐☐ ☐☐ Thyroid Prob
☐☐ ☐☐ ☐☐ Chronic Pain	Other: _____		☐☐ ☐☐ ☐☐ Ulcer

PAST SURGICAL HISTORY – Please be as specific as possible (ex. Right Knee ACL Repair) Include dates.

1] _____ 4] _____
2] _____ 5] _____
3] _____ 6] _____

Full Name _____ Date of Birth _____/_____/_____

SOCIAL HISTORY

What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: _____

Could you be pregnant?

☐ No ☐ Maybe ☐ Yes How many weeks? _____ Due: _____

How many children do you have?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+ How many? _____

What is your highest level of education completed?

☐ GED ☐ High School ☐ Trade School ☐ College 2 Yrs ☐ College 4 Yrs ☐ Masters
☐ Other: _____

Do you use tobacco?

☐ No ☐ Former ☐ 1/4 Pack/day ☐ 1/2 Pack/day ☐ 1 Pack/day ☐ 1+ Pack/day

Do you drink alcohol?

☐ No ☐ Former ☐ Current – Every Day - Amount:_____ ☐ Current – Some Days - Amount:_____

Are you currently using any of the following?

☐ None ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ PCP ☐ Other: _____

Have you used any of the following in the past?

☐ Never ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ PCP ☐ Other: _____

Are you currently working?

☐ Retired ☐ Short Term Disability ☐ Long Term Disability ☐ Unemployed
☐ Yes Occupation _____ Employer _____

Duties at work?

☐ Lifting ☐ Bending ☐ Standing ☐ Reaching ☐ Other _____

Full Name _____ Date of Birth _____/____/____

Please circle if you are experiencing any of the following symptoms:

CONSTITUTIONAL
Fever, Chill, Night Sweats, Weight Gain, Weight Loss, Fatigue, Lethargic

EYES
Dry Eyes, Eye Irritation, Vision Change

EMNT
Difficulty Hearing, Ear Pain, Frequent Nosebleeds, Nose/Sinus Problems, Sore Throat, Bleeding Gum, Snoring, Dry Mouth, Oral Abnormalities, Mouth Ulcers, Teeth Problems, Mouth Breathing

CARDIOVASULAR
Chest Pain on Exertion, Arm Pain on Exertion, Shortness of Breath When Walking, Shortness of Breath When Lying Down, Palpitations, Known Heart Murmur, Light-Headed When Standing

RESPIRATORY
Cough, Wheezing, Shortness of Breath, Coughing Up Blood, Sleep Apnea

GASTROINTESTINAL
Abdominal Pain, Vomiting, Appetite Change, Black or Tarry Stools, Frequent Diarrhea, Vomiting Blood, Fecal Incontinence

GENITOURINARY
Urinary Loss of Control, Difficulty Urinating, Increased Urinating Frequency, Blood in Urine, Incomplete Emptying

MUSCULOSKELETAL
Muscle Aches, Muscle Weakness, Arthralgia/Joint, Back Pain, Swelling in the Extremities

INTEGUMENTARY
Abnormal Mole, Jaundice, Rash, Itching, Dry Skin, Growths/Lesions

NERUOLOGIC
Loss of Consciousness, Weakness, Numbness, Seizures, Dizziness, Frequent or Severe Headaches, Migraines, Restless Legs

PSYCHIATRIC
Depression, Sleep Disturbance, Restless Sleep, Feeling Unsafe in Relationship, Alcohol Abuse, Suicidal Idealization, Anxiety

ENDOCRINE
Hair Loss, Cold Intolerance, Increases Hair Growth

HEMATOLOGIC/LYMPHATIC
Swollen Glands, Easy Bruising, Excessive Bleeding

ALLERGIC/IMMUNOLOGIC
Runny Nose, Sinus Pressure, Itching, Hives, Frequent Sneezing, Seasonal Allergies

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

*Patient Name:	*Birth Date:	Social Security Number:
*Provider (Who is releasing information):		
Address 1:		
Address 2:		
City:	State	Zip
Phone:	Fax Number:	

* Recipient's Name (Who is receiving information):		
Address 1:		
Address 2:		
City:	State	Zip
Phone:	Fax Number:	

* This authorization will expire upon the following: (Fill in the Date or Event, but not both)

(If no expiration is specified, this authorization will expire 90 days from the date signed)

* The following information may be disclosed (Choose one of the following):

*** All Medical Records covering dates _____ through _____
*** Entire Medical Record
*** Specific Medical Records _____
*** Other (Specify): _____

*** I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. _____ (initial) (Is not applicable, check here ☐)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see & obtain a copy of the information described in this form for a reasonable copy fee, if I ask for it.
6. I may retain a copy of this form after I sign it.

** Signature of Patient / Guardian / Legal Representative:	Date:
(If not signed by the patient) Print Name:	Relationship to Patient:

Legal paperwork is required if not signed by patient.

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PROTECTED HEALTH INFORMATION
USE AND DISCLOSURE AUTHORIZATION

I authorize ____**Seaside Spine & Pain Center**____ to use and disclose of the protected health information.

Purpose of the disclosure: _____

Entity or Person(s) to Receive Information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization is effective through (Check one);

☐ _____ / _____ / _____

☐ **NO EXPIRATION**, unless revoked or terminated by the patient or the patient's personal representative.

I understand that I have the right to terminate or revoke this authorization at any time. To do so, my request must be provided to your office in writing. Written requests can be sent to:

4863 Palm Coast Parkway NW Units 2 & 3
Palm Coast, FL 32137

I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that information that is disclosed under this authorization may be disclosed by the recipient, as such the privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to. I understand that my authorization is not required as a condition to receive treatment, payment, or enrollment or eligibility for benefits.

_____
Name of Patient or Personal Representative (Print)

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority