



7200 West Camino Real, Suite #104, Boca Raton, FL 33433
Telephone: (561) 404-7667 • Fax: (561) 405-3144

PATIENT DEMOGRAPHICS

TODAY'S DATE _____

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

SEX MALE FEMALE

RACE CAUCASIAN AFRICAN AMERICAN ASIAN/PACIFIC ISLANDER HISPANIC/LATINO

PHARMACY NAME _____ PHONE NUMBER _____

SPOUSE NAME _____ DATE OF BIRTH _____

EMERGENCY CONTACT NAME _____ PHONE NUMBER _____

Were you a previous patient at Anesco Interventional Pain Institute? NO YES

PRIMARY CARE PHYSICIAN _____ PHONE # _____

REFERRAL SOURCE Google Facebook Other: _____

Physician: _____ PHONE # _____

PRIMARY INSURANCE _____ ID# _____

SECONDARY INSURANCE _____ ID# _____

RESPONSIBLE PARTY _____ DATE OF BIRTH _____

RELATIONSHIP TO RESPONSIBLE PARTY _____



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CONSENT FOR TREATMENT

I, the undersigned, whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the my physician.

SIGNATURE x _____ DATE _____

ASSIGNMENT OF BENEFITS

I authorize any information about me to release to my insurance company or its intermediaries any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefit, otherwise payable to me, to Kamerlink Pain Institute. I understand that I am financially responsible for those charges not paid by my insurance.

SIGNATURE x _____ DATE _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize Kamerlink Pain Institute to disclose and/or receive my health information.

I authorize Kamerlink Pain Institute to receive my **ALL** of my health information.

I understand that if the person(s) or entity (ies) that received the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Kamerlink Pain Institute, its employees, and my physicians from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will not expire from the date signed below. I understand that I may revoke this authorization by notifying, in writing, Kamerlink Pain Institute, knowing that previously disclosed information would not be subject to my revoke request.

SIGNATURE x _____ DATE _____

WITNESS SIGNATURE x _____ DATE _____



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PAST MEDICAL HISTORY (PLEASE CIRCLE ALL MEDICAL PROBLEMS)

HEART HIGH BLOOD PRESSURE HIGH CHOLESTEROL HEART ATTACK IRREGULAR HEART BEAT

LUNG ASTHMA COPD SLEEP APNEA OTHER _____

BRAIN SEIZURE STROKE OTHER _____

ENDOCRINE DIABETES THYROID (HYPER / HYPO) OTHER _____

KIDNEY KIDNEY FAILURE DIALYSIS OTHER _____

LIVER LIVER FAILURE HEPATITIS A B C OTHER _____

BLOOD HIV BLEEDING DISORDERS OTHER _____

CANCER TYPE _____

PSYCHOLOGICAL DEPRESSION ANXIETY BIPOLAR SCHIZOPHRENIA

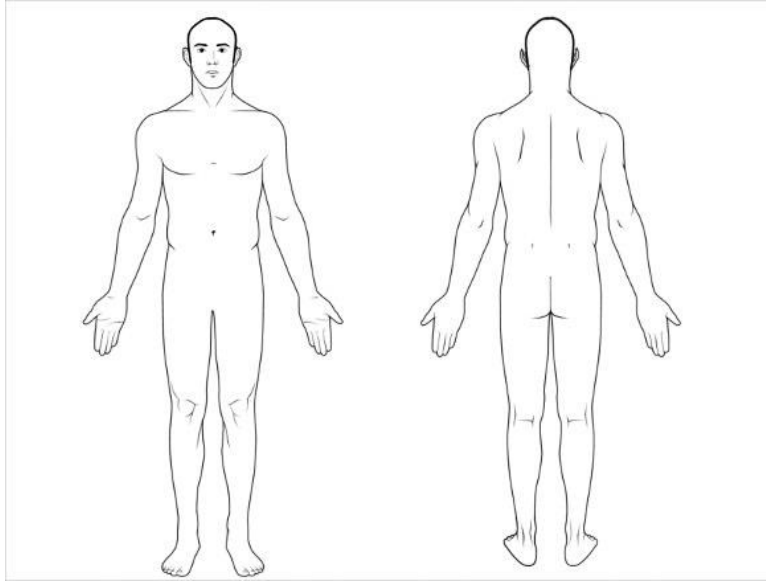
PAST SURGICAL HISTORY (LIST ALL SURGERIES YOU HAD IN THE PAST)

1. _____
2. _____
3. _____
4. _____

MEDICATIONS - PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

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

WHERE IS YOUR PAIN LOCATED? (PLEASE "X" ALL LOCATIONS)



HAVE YOU TRIED ANY MEDICATION(S) FOR YOUR PAIN SYMPTOMS?

- | | | |
|-----------------------------|--|---------------------------|
| ANTI-INFLAMMATORY | <input type="checkbox"/> NO <input type="checkbox"/> YES | WHAT NAME AND DOSE _____ |
| GABAPENTIN/NEURONTIN/LYRICA | <input type="checkbox"/> NO <input type="checkbox"/> YES | WHAT NAME AND DOSE? _____ |
| OPIOIDS | <input type="checkbox"/> NO <input type="checkbox"/> YES | WHAT NAME AND DOSE? _____ |
| OTHERS | <input type="checkbox"/> NO <input type="checkbox"/> YES | WHAT NAME AND DOSE? _____ |

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

IF YES, HOW MANY SESSIONS HAVE YOU COMPLETED? _____

HAVE YOU HAD ANY INJECTIONS FOR YOUR PAIN? NO YES

- | | | |
|---------------|--|-------------|
| EPIDURAL | <input type="checkbox"/> NO <input type="checkbox"/> YES | DATES _____ |
| FACET BLOCKS | <input type="checkbox"/> NO <input type="checkbox"/> YES | DATES _____ |
| TRIGGER POINT | <input type="checkbox"/> NO <input type="checkbox"/> YES | DATES _____ |

HAVE YOU HAD SURGERY FOR YOUR PAIN? NO YES

IF YES, PLEASE LIST YOUR SURGERY DATES _____

HAVE YOU TRIED A SPINAL CORD STIMULATOR? NO YES