



Stacy John Berckes, M.D.
Diplomate, American Board of Anesthesiology
Board Certified in Pain Management
Board Certified in Pain Medicine

Phone (352) 735-3313
Fax (352) 735-3711

11 Waterman Avenue
Mt. Dora, Florida 32757

Our office would like to take this opportunity to welcome you. Enclosed, you will find a personal/medical questionnaire. Please fill this out as completely as possible and return at your scheduled appointment. This will allow Dr. Berckes to fully understand your medical history and begin to establish a protocol for your condition.

Patient Financial Responsibility

If you have Medicare as a Primary insurance, we will gladly file this for you. However, we **do not** file supplement policies. The only exception will be if Medicare automatically crosses over to your supplement. Not all plans do this, but we will call to verify with your plan before your appointment. Please come prepared to pay your 20% and/or deductibles if not met, at the time of visit. We will also file all primary insurance plans that the office participate with. It will be your responsibility to pay any co-pays, deductibles or percentages at the time of visit. This will also be verified before your appointment.

Pharmacy / Rx Request

If a patient needs a refill or written Rx, please allow ample time for the nurse/doctor to provide this. Generally, the request can be performed within the same business day. It is our office policy not to provide Rx on weekends. Otherwise, make sure the present Rx will last at least for two days. Please take into consideration, there are some Rx that cannot be called in and a written script is necessary. There will also be times when Dr. Berckes will require an office visit before a refill is given.

Office Staff

Florida Pain Management Center, Inc., has a very courteous and knowledgeable staff. If at any time you have a problem or question, please feel free to contact our office. Expect your concern to be handled in a timely fashion.

Office Hours

Monday.....9:00 A.M. to 5:30 P.M.
Tuesday.....9:00 A.M. to 5:30 P.M.
Wednesday.....9:00 A.M. to 5:30 P.M.
Thursday.....9:00 A.M. to 5:30 P.M.
Friday.....9:00 A.M. to 12:00 P.M.
Saturday/Sunday.....Closed

ACKNOWLEDGEMENT

I, the undersigned, understand that submission of this information to Florida Pain Management Center and Dr. Berckes in no way guarantees that I will be given an appointment for evaluation and/or treatment.

Date: _____

THE FLORIDA PAIN MANAGEMENT CENTER - STACY JOHN BERCKES, M.D.
PATIENT REGISTRATION FORM

Date _____ SS# _____ Drivers License # and State _____

First Name _____ Last Name: _____ Sex F M

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

DOB ___/___/___ Age _____ Marital Status: M S D W Spouse's name: _____

Email: _____ May we contact you via email? Yes No

OTHER HOME ADDRESS IF NOT FULL TIME FLORIDA RESIDENT AND DIFFERENT FROM ABOVE:

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

NEAREST RELATIVE NOT LIVING WITH YOU : Name: _____ Relationship _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

PRIMARY /FAMILY PHYSICIAN: Name: _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

REFERRING PHYSICIAN : Physician's Name _____

Address: _____

City _____ State _____ Zip _____ Phone (_____) _____

EMPLOYER'S INFORMATION: Retired Yes No If no, Employer's Name: _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

If this injury regarding Auto Accident, Personal Injury or Worker's Compensation, please complete additional information on back of this page.

PRIMARY INSURANCE INFORMATION: Insurance Name: _____

Address: _____

City _____ State _____ Zip _____ Phone (_____) _____

Insured's Name _____ Sex F M DOB _____ Insured's relation to patient: _____

Policy # _____ Group Name/# _____ Group ID# _____

SECONDARY INSURANCE INFORMATION: Insurance Name: _____

Address: _____

City _____ State _____ Zip _____ Phone (_____) _____

Insured's Name _____ Sex F M DOB _____ Insured's relation to patient: _____

Policy # _____ Group Name/# _____ Group ID# _____

Medigap or Employer Supplemental

Signature _____ Date: _____

Please complete and return to The Florida Pain Management Center

Only complete this section if your injury is due to Auto, Personal Injury or Worker's Compensation accident:

WORKER'S COMPENSATION:

Claim/ID# _____ Date of Injury _____

Name of Employer through which this claim was filed _____

Insurance Company:

Name: _____ Telephone (_____) _____

Address _____ City _____ State _____ Zip _____

Dr. of Record _____ Tel (_____) _____

Case Worker's Name _____ Tel (_____) _____

AUTO ACCIDENT / PERSONAL INJURY

Date of Injury _____ State where accident occurred _____ Adjustor's name: _____

Insurance Co _____ Tel (_____) _____

Address: _____

Insured's Name _____ Policy/ID# _____

Attorney: _____ Telephone: (_____) _____

Complete
address: _____

**AUTHORIZATION TO OBTAIN / RELEASE OR USE INFORMATION FOR TREATMENT,
PAYMENT, OR HEALTH CARE OPERATIONS**

I hereby authorize the release or use of my individually identifiable health information (“protected health information”) and medical record information by Florida Pain Management Center in order to carry out treatment, payment, or healthcare operations. **I also hereby authorize FPMC to request all medical “Protected Health Information” in order to carry out medical treatment.** I have been informed of the “Notice of Privacy Practices” for a more complete description of the potential release and use of such information. I have also been informed I have the right to review such Notice prior to signing this Consent Form.

FPMC reserves the right to change the terms of its Notice of Privacy Practices at any time. If changes to the terms of its Notice of Privacy Practices are made, I may obtain a copy of the revised Notice. I retain the right to request FPMC to further restrict how my protected health information is released or used to carry out treatment, payment or health care operations. FPMC is not required to agree to such requested restrictions; however, if they do agree to my requested restrictions(s), such restrictions are then binding on FPMC. **I acknowledge and agree that the FPMC may disclose my protected health information and medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:**

Name of individuals authorized to received my health protected information:

I agree that Florida Pain Management Center may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

- | | |
|--|--|
| <input type="checkbox"/> HIV/AIDS Information | <input type="checkbox"/> Sexually Transmitted Disease Information |
| <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> If Patient is under the age of eighteen (18), Pregnancy Information |
| <input type="checkbox"/> Substance Abuse Information | |

Florida Pain Management Center may refuse to treat if I (or any authorized representative) do not sign this Consent Form. If I (or authorized representative) sign this Consent and then revoke it, FPMC has the right to refuse to provide further treatment to me as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent, (if requested) and I am the patient (or the authorized party to act on the behalf of the patient to sign this document) verifying consent to the above terms.

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Signature of Patient or authorized representative	<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> Please Print Name
Date: _____	DOB: ____/____/____ SS# _____

*Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the patient:

--

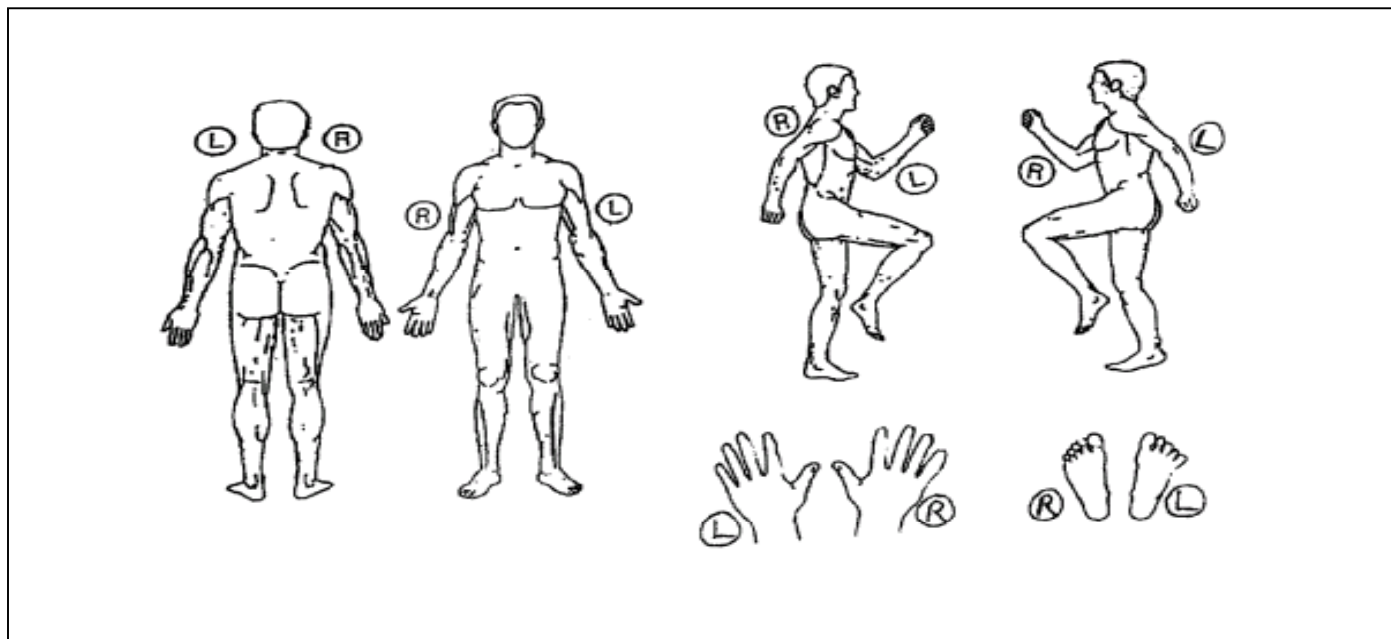
Please complete, sign and return to The Florida Pain Management Center

The Florida Pain Management Center
MEDICAL QUESTIONNAIRE

Name: _____ Date: _____ Date of birth: _____

Who is your primary physician? _____ Who referred you to this office? _____

1. What is your age? _____ 2. Where is your pain located? On the diagrams below, please shade in the areas where your pain is located. Is your pain Left Right both sided? _____



2. How long have you had this pain? _____

3. Do you know what caused your pain? Please explain: _____

5. What makes your pain better? Rest Medication Others: _____

6. What makes your pain worse? Activity Weight Bearing Others: _____

7. What time of day is your pain the worst? Morning Afternoon Evening Nighttime

8. Has your pain changed your ability to do activities of daily living, your work, or your sleep patterns?

Please explain: _____

9. Please check any treatments you have had in the past for this pain.

Physical Therapy Massage Chiropractor Injections _____

Others: _____

Did you receive any pain relief from the above treatment? Yes No

10. Rate your pain by circling the number that best describes your pain at its worst in the last month.
 No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

11. Rate your pain by circling the number that best describes your pain at its least in the last month.
 No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

12. Rate your pain by circling the number that best describes your pain right now.
 No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

13. Please circle the appropriate words that best describe your pain.

- | | | | | | |
|------------------------------------|-------------------------------------|-------------------------------|-----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> aching | <input type="checkbox"/> shooting | <input type="checkbox"/> dull | <input type="checkbox"/> constant | <input type="checkbox"/> annoying | <input type="checkbox"/> sharp |
| <input type="checkbox"/> radiating | <input type="checkbox"/> cramping | <input type="checkbox"/> hot | <input type="checkbox"/> heavy | <input type="checkbox"/> brief | <input type="checkbox"/> tight |
| <input type="checkbox"/> intense | <input type="checkbox"/> severe | <input type="checkbox"/> sore | <input type="checkbox"/> stinging | <input type="checkbox"/> tingling | <input type="checkbox"/> excruciating |
| <input type="checkbox"/> transient | <input type="checkbox"/> unbearable | <input type="checkbox"/> cold | <input type="checkbox"/> burning | <input type="checkbox"/> numbing | <input type="checkbox"/> stabbing |

14. Please check any of the following health problems you have been diagnosed with:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cancer of _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Gastric Reflux Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Parkinson's | |
| <input type="checkbox"/> Other: _____ | | |

15. Please list all surgeries you have had, approximate dates, and surgeons name:

Surgery	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Please list all current medications you are taking for reasons other than pain. Include any over the counter, or herbal/natural

Medication	Reason Taking	How Often	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take Aspirin? No Yes. How many? _____ strength: _____

17. Are you currently taking a "blood thinner" Plavix Coumadin Ticlid, Heparin
 No Yes, How much per day? _____

18. Please list all current medications you take for pain:

Medication	How Often	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. Please list any medications you have taken for pain in the past, and reason you stopped taking them:

Medication	How often	Reason Stopped	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

20. Do you have any drug allergies? Yes No If yes, please give name of drug and type of reaction you experienced.

21. Marital status? Married Divorced Widowed Single separated

22. Do you live alone Yes No Do you have children Yes No Relatives near by Yes No

23. Do you drive? Yes No If yes Automatic transmission Manual transmission

24. Present work status: Full time Part time Not working on disability retired

25. What is or was your usual occupation? _____

26. Do you smoke tobacco? Yes No If yes, how much? _____ How long? _____
If no, have you ever smoked tobacco? Yes No How much? How long? _____ Year Quit: _____

27. Do you consume alcoholic beverages? Daily occasionally rarely never

28. Has any family member or relative had a chronic pain problem? Yes No

If yes, please specify whom and the type of pain problem: _____
_____. Is this person living or deceased? Living Deceased

29. Please check any of the following that you are currently experiencing:

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chest Pain/ Pressure | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Bleed Easily | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> General weakness |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Urinary Difficulty | <input type="checkbox"/> Too Hot | <input type="checkbox"/> Menstrual Difficulty |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Too Cold | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Swelling | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Black outs | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Always Thirsty | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Itching | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Infection | <input type="checkbox"/> Other: _____ | | |

30. Do you have any problems controlling your bladder? Yes No
Do you have any problems controlling your bowel? Yes No If yes, please explain: _____

31. Do you have any tingling or numbness in your hands? Yes No In your feet? Yes No

32. Do you need assistance such as a wheelchair, walker, or cane to get around? Yes No
If yes, which do you use? _____

33. Please indicate any diagnostic procedures (tests) you have had, and the approximate date and location where the test was performed:

- | | | | |
|------------------------|------------------------------|-------------|-----------------|
| X-ray | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| EMG | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| C T Scan | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| MRI or NMR Scan | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| Myelogram | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |
| Nerve Conduction Study | <input type="checkbox"/> Yes | Date: _____ | Location: _____ |

Signature of Patient _____ Date _____

Signature if other than patient _____ Relationship to patient _____