ONLY SEND COPIES OF YOUR RECORDS. MEDICAL RECORDS SUBMITTED FOR REVIEW WILL BE DESTROYED IN THE EVENT WE ARE UNABLE TO PROVIDE YOU CARE. RECORDS WILL NOT BE RETURNED TO YOU.

Florida Pain Management Center, Inc.
"Improving your quality of life"

STACY JOHN BERCKES, M.D.
Diplomate, American Board of Anesthesiology
Board Certified in Pain Management
Board Certified in Pain Medicine.

111 Waterman Ave.
Mount Dora, FL 32757
www.FloridaPainManagementCenter.com

Office Phone: 352-735-3313
Fax: 352-735-3711

We would like to than you for your inquiry about the services we provider here at The Florida Pain Management Center.

Please complete the enclosed forms, (including signing the box at the bottom of this page) and mail, fax or drop them off at our office. It is important for Dr. Berckes to see copies of X-Ray reports, CT reports, MRI reports and other reports from doctors or health care providers that have treated you in the past for your pain condition. Please include copies of these records with your Questionnaire **(do not send originals as they will not be returned)**. If you do not have copies of your medical records, please contact the physician who treated you and ask them to send records to us.

Once all of your paperwork has been received, Dr. Berckes will review it and determine if the treatments he has to offer would potentially be of benefit to you. If so, we will contact you with an appointment time.

Patient Financial Responsibility: If you have Medicare as 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 the visit. We will also file all primary insurance plans that the office participates 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 on a prescription, please allow ample time for the nurse/doctor to provide this. Generally, the request can be performed within two business days. **It is our office policy not to provide prescriptions and refills on weekends.** Please make sure your current Rx will last for at least 3 days. Please take into consideration, there are some prescriptions that cannot be called in. There will also be times when Dr. Berckes will require an office visit before a refill is given.

Office Staff: The Florida Pain Management Center has a very courteous and knowledgeable staff. If at any time you have a problem or question, please do not hesitate to contact our office. Your concern will be handled in a timely fashion.

Office Hours
Monday – Thursday: 9:00 A.M – 5:00 P.M.

I, the undersigned, understand that submission of this information to The Florida Pain Management Center and Dr. Berckes does not guarantee that I will be provided an appointment for evaluation and/or treatment. *I authorize Dr. Berckes to check the Florida Prescription Drug Monitoring Program with my name, address and birthdate.*

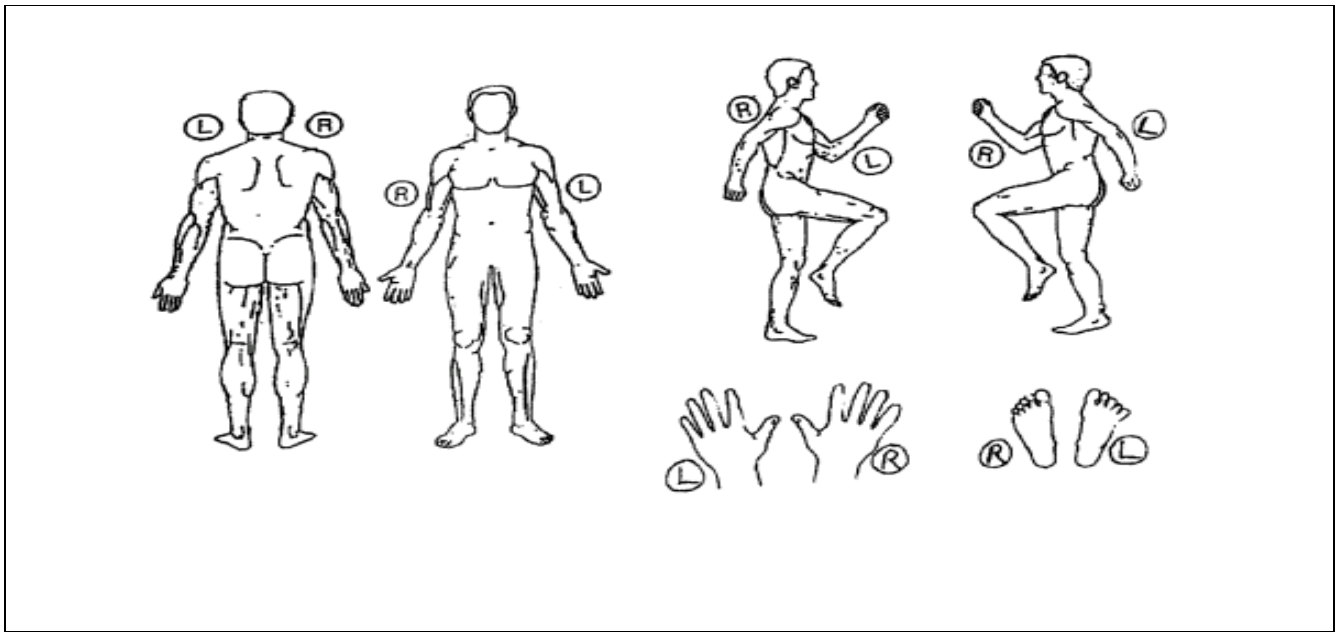
Name Signature Date

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 circle/shade in the areas where your pain is located. Is your pain Left Right both sides



3. How long have you had this pain?_____

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

_____

5. What makes your pain better? Rest Massage Heat Ice Meditation Distraction Medication Home Exercise/stretching Other: _____

6. What makes your pain worse? Prolonged Standing Walking Bending Lifting Weight Bearing Getting up and down from sitting/bed Prolonged Sitting Laying flat Other: _____

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

8. How has your pain changed your ability to do activities of daily living (eating, bathing, getting dressed, sitting, toileting, getting in and out of bed/chairs etc.), your work, or your sleep patterns
Please explain: _____

9. Please circle any treatments you have had in the past for ***this*** pain ***(very important, please detail)***.
Physical Therapy Massage Chiropractor Modified Activities Acupuncture Injections
Please **specify *when*** and for **how long** you had above treatments for the pain you are being seen for today:

_____

_____

_____

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.

aching	shooting	dull	constant	annoying	sharp
cramping	hot	heavy	brief	tight	stabbing
intense	severe	sore	stinging	tingling	excruciating
transient	unbearable	cold	burning	numbness	radiating

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

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

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 . Please include dose (example __mg) ,

Medication	Strength/Dose	How often	Reason taking	Prescribed by
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you take Aspirin?_____, how many? _____, Strength: 81mg 325mg

Do you use any form of marijuana? _____ Do you use any CBD oil or product? _____

17. Are you currently taking a "blood thinner"? Plavix Eliquis Xarelto Coumadin
Warfarin Heparin Jantoven Pradaxa

How much per day? _____

18. Please list **all current medications you take for pain (over the counter and prescribed). Include NSAIDS and Tylenol if you are taking them.**

Medication	Strength/dose	How Often	Prescribed by	For How Long
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

Medication	Strength/dose	How often	For how long?	Reason Stopped
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 or Manual transmission

Present work status: Full time Part time Not working On disability Retired

What is or was your usual occupation? _____

25. Tobacco Status: Current use Former use Never used

Length of use _____ How much daily_____ Year quit_____

26.Do you consume alcoholic beverages? Daily Occasionally Rarely Never

27. 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? _____

28. Please check or circle any of the following that you are currently experiencing:

Weight Changes	Loss of Appetite	Fever	Skin rashes	Non healing lesions
Joint pain	History of Fracture	Headaches	Dizziness	Change in vision/double
Decreased hearing	Ringing in ears	Sinus pain	Nasal discharge	Bleeding gums
Sore throat	Neck pain	Enlarged glands	Breast lump	Cough
Shortness of Breath	Leg/ankle swelling	Chest discomfort	Palpitations	Difficulty swallowing
Nausea	Vomiting	Constipation	Diarrhea	Heartburn
Pain on urination	Urinary frequency	Excess Bleeding	Memory loss	Anxiety/Moodiness

Other:_____

_____

29. Do you have any problems controlling your bladder (incontinence)? Yes No
Do you have any problems controlling your bowel? (incontinence)? Yes No If yes, please explain:

_____

30. Do you have any tingling or numbness in your hands? Yes No Right Left Both
In your feet? Yes No Right Left Both

31. Does your pain radiates to your arms? Yes No Right Left Both
To your feet? Yes No Right Left Both

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, relating to your current pain, and the approximate date and location where the test was performed: (X-Ray, CT, MRI)

Type of test	Body Part Studied	Date	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMG /Nerve Conduction Study: Date _____ Location _____ _____

_____ _____
Signature of Patient Date

_____ _____
Signature of personal representative Name (if not patient)

_____
Relationship to patient

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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 Florida Pain Management Center 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.

Florida Pain Management Center 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 Florida Pain Management Center to further restrict how my protected health information is released or used to carry out treatment, payment or health care operations. Florida Pain Management Center is not required to agree to such requested restrictions; however, if they do agree to my requested restriction(s), such restrictions are then binding on Florida Pain Management Center.

I acknowledge and agree that Florida Pain Management Center may disclose my protected health information and medical record to the following individuals who are my family members, legal representatives, guardians, healthcare surrogates or have power of attorney on my behalf:

Name of individuals authorized to received my protected health 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):

_____ HIV/AIDS Information _____ Sexually Transmitted Disease Information

_____ Mental Health Information _____ Substance Abuse Information

_____ Pregnancy Information - If Patient is under the age of eighteen (18)

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, Florida Pain Management Center 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.

_____ _____
Patient Name Signature of Patient or Authorized Representative

_____ _____
Patient Date of Birth Date Signed

_____
If not patient, state name and relationship to patient or authority to sign

The Florida Pain Management Center – Stacy John Berckes, M.D.
Patient Registration Form

Date: _____ SS# _____ Drivers License #/State _____

First Name _____ Last Name _____ Sex F ___ M ___

Home Address:_____

City _____ State _____ Zip _____

Mailing Address:_____

Phones: (C) _____ (H) _____ (W) _____ Best to contact_____

DOB ____/_____/_____ Age _____ Marital Status: M S W D 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: _____

NEAREST RELATIVE NOT LIVING WITH YOU: Name _____ Relationship _____

Address: _____

City _____ State_____ Zip _____ Phone _____

PRIMARY / FAMILY PHYSICIAN: Name _____ Phone _____

Address: _____

REFERRING PHYSICIAN: Name _____ Phone_____

Address: _____

EMPLOYERS INFORMATION: Name _____ Phone_____

Address: _____

PRIMARY INSURANCE INFORMATION: Insurance Name _____

Address _____

City_____ State _____ Zip _____ Phone _____

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

ID # _____ Group Name _____ Group ID # _____

SECONDARY INSURANCE INFORMATION: Insurance Name _____

Address _____

City_____ State _____ Zip _____ Phone _____

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

ID # _____ Group Name _____ Group ID # _____

Medigap or Employer Supplemental
(If this injury is regarding Auto Accident, Personal Injury or Worker's Compensation, please complete additional information on next page.)

Do you have an Advanced Directive on file with your Primary Care Physician? Yes or No

How did you hear about Dr. Berckes and The Florida Pain Management Center? _____

Signature _____ **Date**_____

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

WORKERS COMPENSATION:

Claim/ID # Date of Injury

Name of Employer through which this claim was filed

Insurance Company: Telephone

Address

City State Zip

Doctor of Record Telephone

Case Worker's Name Telephone

AUTO ACCIDENT / PERSONAL INJURY

Date of Injury State where accident occurred Adjuster's Name

Insurance Company Telephone

Address

City State Zip

Insured's Name Policy/ID #

Attorney Telephone

Address

City State Zip