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.

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

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Mt. Dora, FL 32757
www.FloridaPainManagementCenter.com

We would like to thank you for your inquiry about the services we provide here at The Florida Pain Management Center.
Please complete the enclosed forms, (including signing in the box at the bottom of this page) and mail or fax them back to us as soon as possible, or you can drop them off here at the office. If you have medical records concerning your pain condition from other doctors or health care providers, please send us copies of those records (do not send us the 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 them to us. It is important for Dr. Berckes to see copies of any X-Ray Reports, MRI Reports and other reports regarding your condition.
Once all of your paperwork is received here in the office, 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 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-Thursday: 9:00 A.M. to 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 given 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	**Date**

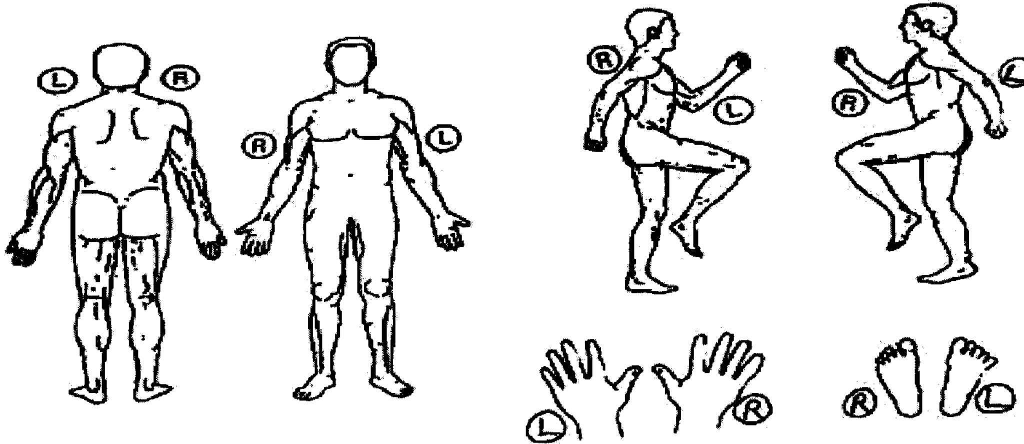
Rev 12/2014
06/2018

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?



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? Weight bearing ____ Prolonged standing / walking _____Bending___ Lifting____ Getting up and down from sitting / bed_______ Other: __________________________

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_____ Chiropractor_____ Accupucture____ Modified Activities ____ Injections:______ Please specify when you had above treatment for the pain you are being seen for today: ____________________________

Did you receive any pain relief from the above treatments? Yes ___ No ____

10. Rate your pain by circling the number thatbest describes your pain ats worse 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
radiating	cramping	hot	heavy	brief	tight
intense	severe	sore	stinging	tingling	excruciating
transient	unbearable	cold	burning	numbing	stabbing

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

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

Others:____

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***. Iclude any over the counter, herbal, vitamins. Please include dose and # taken a day. Please also include who prescribed:

Medication	Strength/dose	How often	Reason taking	Prescribed by:
____________________	__________	____________	________________	_______________
____________________	__________	____________	________________	_______________
____________________	__________	____________	________________	_______________
____________________	__________	____________	________________	_______________
____________________	__________	____________	________________	_______________
____________________	__________	____________	________________	_______________
____________________	__________	____________	________________	_______________

17. Do you take Aspirin? No ___ Yes ___, how many?_________Strength: 81 325 ____mg

Do you take a blood thinner? No ____ Yes ___, Plavix, Eliquis Xarelto Coumadin Warfarin Jantoven Heparin Pradaxa . How much per day? ____

Do you use marijuana? No ___ Yes ____ Do you use CBD oil or product? No ____ Yes _____

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

Medication and strength/dose	How often	Prescribed by:
___________________________ _	______________________	________________________
_____________________________	______________________	________________________
_____________________________	______________________	________________________
_____________________________	______________________	________________________
_____________________________	______________________	________________________

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

Medication and strength/dose	How often	Reason Stopped	Prescribed by:
_____________________________	__________	__________________	_________________
_____________________________	__________	__________________	_________________
_____________________________	__________	___________________	_________________
_____________________________	__________	__________________	_________________
_____________________________	__________	__________________	_________________

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

21. Marital status? Married ____ Divorced ____ Widowed ____ Single_____ Separated _____

22. Do you live alone? No ____ Yes _____ Do you have children or relatives near by? No ___ Yes ___

23. Do you drive? No ___ Yes___ , automatic transmission manual transmission

24.Present work status: Full time ____ Part time ___ Not working ___ On disability ___ Retired ____
What is or was your usual occupation? ____

25. Do you use tobacco? No ____, Former smoker? No ___ Yes ___, year quit:_______ Yes _____, how much? _______ daily for how long _________

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

27. Has any family member or relative had a chronic pain problem? No ____ Yes ____ If yes, please specify whom and the type of pain problem:____________________________________ Is this person living or deceased?

28. Please check or circle any ot the following that you are current 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
Sorethroat	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 you bladder (incontinence)? No ____ Yes____

30. Do you have any problems controlling your bowel (incontinence)? No ____ Yes ____

31. Do you have an tingling or numbness in your hands? No ___ Yes ___, Right Left Both
32. In your feet? No ___ Yes ___, Right Left Both

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

34. 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:

Xray of ____________________________ Date: _______________ Location: _________________

EMG/Nerve Conduction Study : Date: _______________ Location: __________________

CT Scan or MRI of ___________________ Date: ________________ Location: __________________

Signature of Patient: ____ Date: _______________

Signature if other than the patient: __________________________________ Date:________________

Print name and relation of the person signing if not the patient: _________________________________

rev 7/2019

AUTHORIZATION TO OBTAIN I 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):

❿HIV/AIDS Information ❑ Sexually Transmitted Disease Information

❿Mental Health Information ❑If Patient is under the age of eighteen (18), Pregnancy Information

❿Substance 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.

Signature of Patient or authorized Please Print Name

Date: ____________________ D05:_______/_____/_____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

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 Workers 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:____

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 __________ Home (_____) __________

Cell: (____) __________ Work: (_____) __________ Best one to contact you: __________

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 ☐

Do you have an Advanced Directive on file with your primary care physician? Yes ☐ No ☐

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

Signature __________ Date: __________