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.
Mt. Dora, FL 32757
www.FloridaPainManagementCenter.com

Office Phone: 352.735.3313
Fax: 352.735.3711

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**

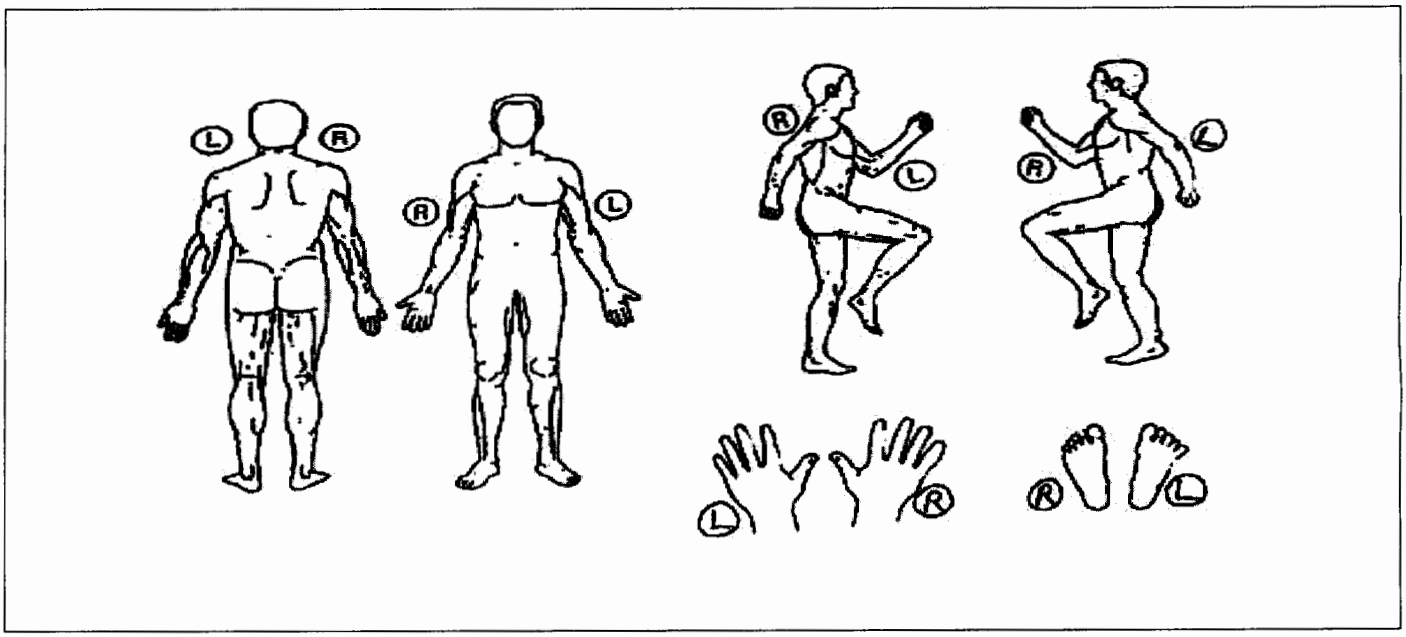
Rev 12/2014
06/2018

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 ___ Water Therapy ___ Medication ___ Certain Positions ___Others:_____
6. What makes your pain worse? ___ Bending ___ Weight Bearing ___ Lifting_____Prolonged sitting____Prolonged standing_____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 _ Acupuncture _ Ice _ Heat ___ Modified Activities
_____Injections. Please specified ***when*** you had above treatment 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 be 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 check or 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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?

29. 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
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:_____

_____

30. 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:

_____

31. Do you have any tingling or numbness in your hands? ___Yes ___No In 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 of _____ : Date: _____Location:_____

EMG /Nerve Conduction Study: Date:_____Location: _____

C T Scan ___Yes Date:_____ Location: _____

MRI or NMR Scan of :_____ Date:_____Location: _____

Signature of Patient_____ Date_____

Signature if other than patient _____Relationship to the patient _____

Print name of person signing if not the patient: _____

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

Do you take Aspirin? __ No __ Yes, how many? _____ strength:_____

17. Are you currently taking a "blood thinner" __ Plavix __ Eliquis ___Xarelto __ Coumadin _Heparin___Jantoven
__ No __ Yes, How much per day? _____

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

Medication and strength/dose	How Often	Physician

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

Medication – Strength/dose	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

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: _____

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):

- ☐ HIV/AIDS Information
- ☐ Mental Health Information
- ☐ Substance Abuse Information
- ☐ Sexually Transmitted Disease Information
- ☐ If Patient is under the age of eighteen (18), Pregnancy 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 representative 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