PATIENT INFORMATION FORM

PATIENT CHART # _____ DOCTOR _____

PRIMARY CARE DOCTOR _____ PRIMARY CARE DOC. PH# _____ FAX# _____

NAME _____ SEX ☐ M ☐ F

SOCIAL SECURITY # _____ BIRTHDATE _____ MARITAL STATUS ☐ S ☐ M ☐ W ☐ D

CULTURAL CONCERNS _____ AGE _____ HOME PH. # ( ) _____ CELL PH. # ( ) _____

STREET ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

DRIVER'S LICENSE # _____ DRIVER'S LICENSE STATE _____

EMPLOYER/SCHOOL _____ TITLE _____ PHONE # ( ) _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE _____ AGE _____ BIRTHDATE _____

SPOUSE EMPLOYER _____ TITLE _____ PHONE # ( ) _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

TRANSLATOR NEEDED ☐ YES ☐ NO PRIMARY LANGUAGE SPOKEN _____ REFERRED BY: _____

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME _____ PHONE ( ) _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME _____ MOTHER'S NAME _____

EMPLOYED BY _____ EMPLOYED BY _____

POSITION _____ POSITION _____

PHONE _____ PHONE _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE # _____

I.D. # _____

GROUP NAME OR # _____

INSURED'S FULL NAME _____

IS THIS AN EMPLOYER PLAN? _____

INSURED'S SOCIAL SEC. # _____

INSURED'S D.O.B _____

RELATIONSHIP TO INSURED _____

(Self— Husband— Wife— Child— Other)

SECONDARY INSURANCE INFORMATION

INSURANCE CO. _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE # _____

I.D. # _____

GROUP NAME OR # _____

INSURED'S FULL NAME _____

IS THIS AN EMPLOYER PLAN? _____

INSURED'S SOCIAL SEC. # _____

INSURED'S D.O.B _____

RELATIONSHIP TO INSURED _____

(Self— Husband— Wife— Child— Other)

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature _____ Date _____

(Patient's parent, if minor)

Authorization to Discuss Protected Health Information*

I, _____ , authorize _____

_____

to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons**:

1. _____ 3. _____

2. _____ 4. _____

- *PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.
- **YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

Please list phone numbers where you would like us to contact you for:

- Results - lab, X-ray, Ultrasounds, etc.
- Reminder notices
- Changes on scheduled appointments

1. _____

2. _____

Patient's name: _____

DOB: _____

SS#: _____

Date: _____

Patient's Signature: _____

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ADVANCE DIRECTIVE

DO YOU HAVE AN ADVANCE DIRECTIVE/LIVING WILL? _____ IF YES, PLEASE PROVIDE US WITH A COPY FOR OUR RECORDS.

IF NO, PLEASE LET US KNOW IF YOU REQUIRE INFORMATION.

Edward J. Frankoski, D.O.
Interventional Rehabilitation of South Florida, Inc.

PLEASE PRINT

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ RACE: _____ SEX: _____

MARITAL STATUS: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Other

NAME OF DOCTOR THAT REFERRED YOU TO OUR PRACTICE? _____

OCCUPATION: What do you do? What does your work involve? _____

_____

_____

How many hours per week do you work? _____

How much work, if any, have you missed in the last month due to your pain? _____

Is this a work related injury? _____

ONSET OF SYMPTOMS: How long have you had this problem? _____

Was there an accident or fall? Date? _____

DESCRIBE what your pain is like: (circle all that apply)

QUALITY of the pain is: Throbbing Burning Aching Sharp Tingling Other _____

Pain is INCREASED by: Sitting Standing/Walking Bending Lying Down Cold Heat

Weather Changes Time of Day (am pm) Other Activity: _____

Pain is DECREASED by: Sitting Standing/Walking Bending Lying Down Cold Heat

Weather Changes Time of Day (am pm) Other Activity: _____

PREVIOUS TREATMENTS FOR PAIN

			HELPFUL?		
	Yes	No	Yes	No	COMMENTS
Tens Unit?	❑	❑	❑	❑	
Physical/Occupational Therapy?	❑	❑	❑	❑	
Biofeedback?	❑	❑	❑	❑	
Psychological Evaluations?	❑	❑	❑	❑	
Acupuncture?	❑	❑	❑	❑	
Chiropractic Treatment?	❑	❑	❑	❑	
Epidural Steroid Injections/ Nerve Blocks?	❑	❑	❑	❑	
Pain Meds?	❑	❑	❑	❑	

*** PLEASE PRINT ***

MEDICAL HISTORY

Height_____ Weight_____

In the past 6 months to a year, which of the following tests have you had to evaluate your pain?

TEST	DATE	PLACE	RESULTS
❑ X-Ray			
❑ C-T Scan			
❑ MRI			
❑ Laboratory			
❑ EMG			
❑ Myelogram			

Which of the following conditions have you had, or do you presently have? Please note when diagnosed.

CONDITION	WHEN DIAGNOSED	CONDITION	WHEN DIAGNOSED
❑ High Blood Pressure		❑ Arthritis	
❑ Allergies		❑ Ulcer(s)	
❑ Diabetes		❑ Heart Problems	
❑ Asthma		❑ Kidney Problems	
❑ Cancer		❑ Bleeding Problems	
❑ Emphysema		❑ Liver Disease	
❑ Thyroid Disease		❑ Infectious Disease	

List any surgeries you have had:

SURGERY	WHERE	WHEN

*** PLEASE PRINT ***

Do you smoke? ❑ No ❑ Yes If so, how many packs per day?_____ppd

Do you drink alcoholic beverages? ❑ No ❑ Yes If so, how much per week? _____

* FEMALE ONLY *

Are you pregnant? ❑ Yes ❑ No

Are you planning to become pregnant? ❑ Yes ❑ No

MEDICATIONS

Are you allergic to any medications or Iodine? ❑ No ❑ Yes If yes, please list: _____

Are you taking any anticoagulants (blood thinners)? ❑ No ❑ Yes If yes, please specify:_____

CURRENT MEDICATIONS: What, if any, medications are you *currently* taking? Please list all current medications below (prescription and over-the-counter):

MEDICATION	WHY PRESCRIBED	DOSAGE	EFFECTIVENESS

Litigation: If your pain is due to an accident, is litigation (legal suit) or an insurance settlement pending? ❑ No ❑ Yes
If yes, please explain the current state of litigation or settlement:

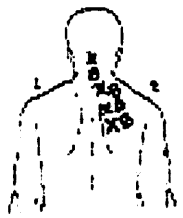
Do you have plans to pursue a legal or insurance settlement in the future? ❑ No ❑ Yes If yes, please explain:

***** PLEASE PRINT *****

Please use the following symbols to indicate on the drawings below the type and location of your pain:

TYPE OF PAIN	SYMBOL
Sharp	X
Shooting	→
Burning	B
Aching	A
Spasming	S
Tingling	T
Numbness	N

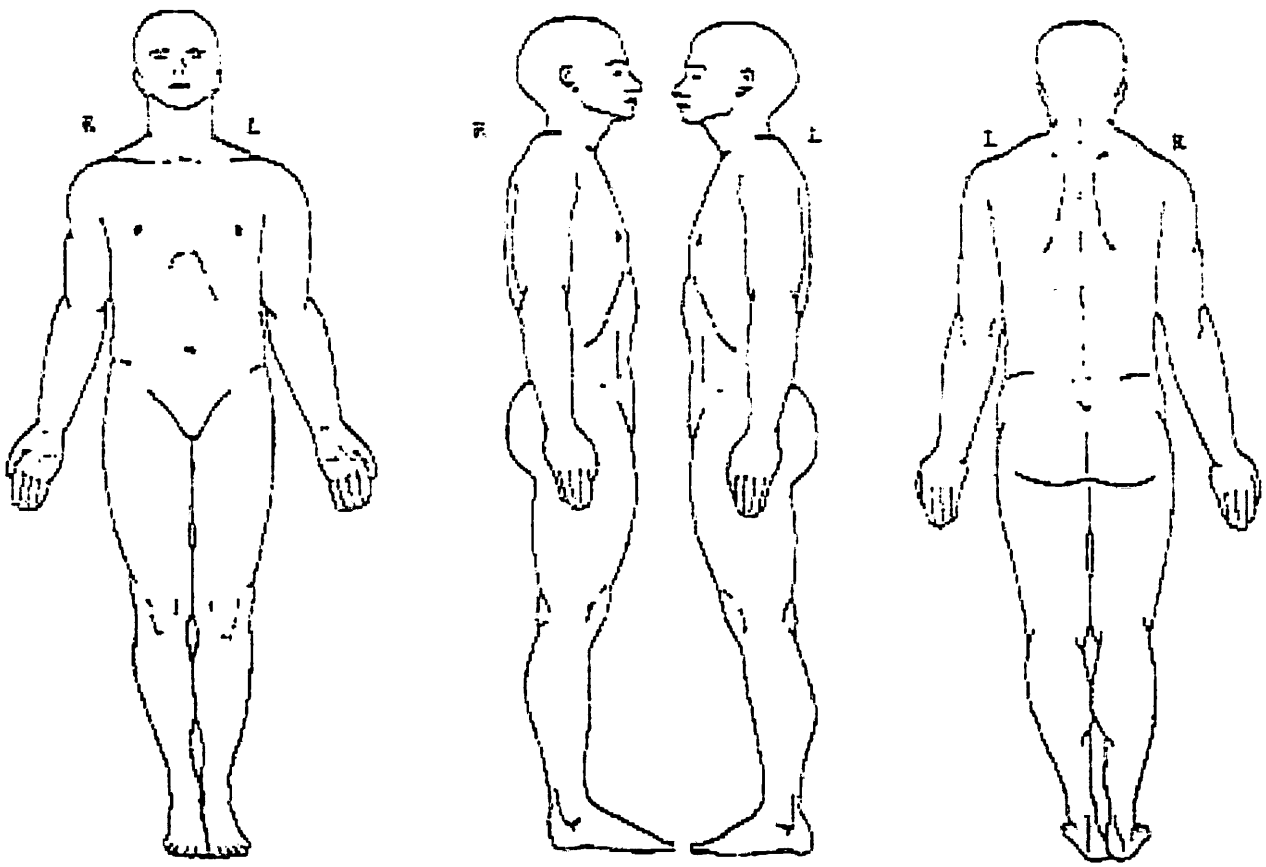
EXAMPLE *Type of pain:* Sharp and Burning
Location of pain: back of neck down to right shoulder blade



PAIN INTENSITY

On a scale of 0 to 10, with 0 representing no pain and 10 representing severe pain, what is your pain like today?

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10



Patient's Signature _____

Edward J. Frankoski, D.O., D.A.B.P.M.
Aventura Medical Arts Building
21097 NE 27th Court, Suite 340
Aventura, FL 33180
Tel305-932-1660 Fax 305-932-1649

MEDICATION RECORD

Name: ________________________________ Allergies:________________________________

Medication and dosage	Frequency and Route	Date	Date	Date	Date	Date	Date

Edward J. Frankoski, D.O.,D.A.B.P.M
Aventura Medical Arts Building
21097 NE 27th Court, Suite 340
Aventura, FL 33180
Tel 305-932-1660 Fax 305-932-1649

Patient Name: _____

INFORMED CONSENT FOR CONTROLLED SUBSTANCE THERAPY

Dr. Edward J. Frankoski may initiate treatment with controlled substance (including narcotics, sleeping pills, and nerve pills) to increase your comfort and improve your functioning; this is an important decision since this treatment approach does have risks, the most common of which are listed below:

RISKS:

1. Constipation and/or urinary problems.
2. Nausea and/or decreased appetite
3. Breathing too slowly: overdose can lead to respiratory arrest and death
4. Confusion or other alteration in thinking and alertness
5. Coordination/balance problems that may make it unsafe to operate dangerous equipment or motor vehicles
6. Increased sleepiness or drowsiness
7. Sexual difficulties including impotence or diminish sex drive
8. Physical dependence: if you stop the medication abruptly, you may experience a withdrawal syndrome characterized by one or more of the following, runny nose, anxiety, diarrhea, abdominal cramping or goose flesh
9. Psychological dependence: the medication may cause you to miss or crave the medication.
10. Tolerance: you may require higher doses of the medication to achieve the same results
11. Children born to mothers taking controlled substances are likely to be born with physical dependence on the controlled substances.
12. Other less common risks and side effects are possible.

We are willing to initiate controlled substance therapy under the following conditions to which you must attest:

1. I do not have problems with substance abuse/dependence
2. I have never been involved in the sale, illegal possession, diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills).
3. I certify that I am not pregnant now and will notify Dr. Edward J. Frankoski if I am planning a pregnancy or become pregnant.

4. I will have my prescriptions prescribe by Dr. Edward J. Frankokski filled by only one pharmacy and will supply the name address and phone number of this pharmacy to Dr. Frankoski
5. I will receive prescriptions for all pain medications from only Dr. Edward J. Frankoski
6. I will attend all scheduled appointments with Dr. Edward J. Frankoski. I understand that prescriptions will be dispensed only after a schedule office visit. I understand that a 24 hour advance notice is required if I cannot meet a scheduled appointment.
7. I will notify Dr. Frankoski of an emergent need to see another physician (e.g. dental procedures, surgery) that may require or have required a change in my controlled substance dose.
8. I will allow Dr. Edward Frankoski to communicate with my referring physician, primary care physician, and/or pharmacist regarding my treatment plan, controlled substance medication and results of testing.
9. I will follow the schedule of medication as prescribed. I understand that there will be no early refills prior to my next scheduled appointment.
10. I will not share medications with other individuals
11. **I understand there is no medication refills after business hours or on weekends.**
12. **Prescriptions which are lost, stolen or accidentally disposed of will not be refilled until the next scheduled appointment.**
13. I will abstain from using any illicit substances while under treatment with Dr. Edward Frankoski (marijuana, cocaine, etc.) If I test positive for such substances. I will be discharged.
14. I will submit to a urine/blood screen at the request of Dr. Frankoski to assess my compliance with the treatment plan and to ensure that no illicit substances are been used.
15. I agree that if my physician is concerned regarding my physical/psychological dependence on the controlled substance medication, then I may be:

(A) referred for an inpatient pain admission, or
(B) Referred to a specialist in substance abuse/dependence.

16. I will follow the advised of Dr, Frankoski regarding the operation of motor vehicles and other equipment while under treatment with controlled substance medications.
17. I understand that if I do not demonstrate an increase in function i.e., daily activities, etc., my medications may be discontinued.
18. Any violation of the conditions established in this consent may result in my pain medication (s) being discontinued over an appropriate period of time, in a change in my treatment plan and/or in my being discharged from Dr Edward J. Frankoski

I have read this document, including the above stated risks, understand it, and have had all my questions answered satisfactorily. I will use controlled substances to manage my pain and I understand that my treatment with controlled substances will be in accordance with the conditions stated above.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____