PAIN CARE SPECIALISTS OF FLORIDA
Luis A. Escobar, M.D.

☐ **HOLLYWOOD**
4350 Sheridan Street, Suite 102 Hollywood, FL 33021
P) 954-322-8586 F) 954-322-8581

☐ **PEMBROKE PINES**
SW 129th Ave, Suite 401
Pembroke Pines, FL 33027
954-447-4790

☐ **AVENTURA**
2925 Aventura Blvd., Suite 102 Aventura, FL 33180
305-932-8177

PATIENT REGISTRATION FORM

Today's Date: ________________

Patient Name ____
Date of Birth _________/________/__________
Address ____
City ____________________ State ______________ Zip ______________
Home Phone ( ) _______/_______/___________
Cell Phone ( ) _______/_______/___________
Work Phone ( ) _______/_______/___________
Emergency Contact # _______________________________________
Name/ Relationship ____
Email address: ____
Marital Status S☐ M☐ D☐ W☐ Sex M☐ F☐
Race ____________________ Ethnicity ________________
Preferred Language ☐ English ☐ Spanish ☐ Other__________
Social Security Number _______/________/________

Referred By ____
Name of **Primary Care Physician**_____________________________
Telephone number ( ) ________ /_______/_______

Type of Injury Auto ☐ Work ☐ Other ☐ Date of Occurrence _____/_____/______

Patient Occupation ______________________ Retired ☐ Disabled ☐
Patient Employer ____
Address ____
City_____________________________ State_________Zip __________

Primary Insurance Company
Carrier Name _____________________________
Member Name _____________________________
Member's ID _____________________________
Group # _________________________________
Patient Relation Ship to Subscriber ____________

Secondary Insurance Company
Carrier Name _____________________________
Member Name _____________________________
Member's ID _____________________________
Group # _________________________________
Patient Relation Ship to Subscriber ____________

Auto/Workers Comp/Slip & Fall Insurance
Name of Ins Company_________________________
Policy # __________________________________
Claim # ___ _______________________________
Adjuster Name ______________________________
Telephone Number ( ) ______/_____/_____
Date of Accident _______/________/__________

Attorney Information (mark yes or no)
Any pending litigations related to your injury
Yes☐ No☐
Attorney Name ______________________________
Telephone Number ( ) ______/_____/_____

Preferred Pharmacy (ex. Walgreens, CVS)
Name ______________________________________
Address ____________________________________
City_____________ State _________Zip _________
Telephone Number ( ) _____/_____/______

A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGMENT OF MEDICAL BENEFITS
I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related claim.
I permit a copy for this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Furthermore, I request that payment under the medical insurance benefits either to myself or to the party who accepts assignment below. Furthermore, I request that payment under the medical insurance program be made to me or to LUIS A. ESCOBAR, MD LLC / ORTHO FLORIDA I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical information about me to release it to Social Security Administration or its intermediaries or carries any information needed for this related Medicare claim I understand that this is a lifetime signature authorization.

I request that the payment of authorized MEDIGAP benefits be made on my behalf to LUIS A. ESCOBAR, MD LLC / ORTHO FLORIDA . For any services furnished me by (physician/supplier). I authorize any holder of medical information to release to LUIS A. ESCOBAR, MD LLC / ORTHO FLORIDA . Any information needed to determine these benefits or the benefits payable for related services.

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION INITIAL HERE ____________
I authorize LUIS A. ESCOBAR, MD LLC / ORTHO FLORIDA to release to your company or its representatives any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Medical or Surgical treatment or service by reason of such treatment or service.

C. FINANCIAL RESPONSIBILITY INITIAL HERE ____________
I understand that I am financially responsible for charges not covered by this authorization and for guarantees stated above. Also, I understand that it is my responsibility as the insured to pay all copayments coinsurance and deductibles at the time of visit.

D. APPOINTMENT POLICY INITIAL HERE ____________
I understand that I will be charged a fee for appointments not canceled within 24 hours. This included canceled appointments, reschedule appointments, and missed appointments (NO SHOW). Appointments may be canceled via telephone 954-322-8586.The fee is $100.00 for procedures and $25.00 for office visits, but is subject to change at the discretion of LUIS A. ESCOBAR, MD LLC / ORTHO FLORIDA

E. REFERRALS AND AUTHORIZATIONS INITIAL HERE ____________

I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. LUIS A. ESCOBAR, MD LLC / ORTHO FLORIDA an authorization is not obtained by the time of the visit; the visit will be rescheduled and considered a same day cancellation, resulting in a fee. (SEE ABOVE)

I THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYCIAN AND PRACTICE TO REALEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OF LUIS A. ESCOBAR, MD LLC / ORTHO FLORIDA

PATIENT SIGNATURE ____ **DATE** ____________________________

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INITIAL QUESTIONNAIRE

DATE: ________________________

Please read these sheets carefully and answer all the questions to the best of your ability. They will assist us in better treating your pain. Thank you for your time and cooperation.

NAME: ____
LAST FIRST MIDDLE INITIAL

AGE: _____________ HEIGHT: _____________ WEIGHT: _____________

Referring Physician(s): ________________________________

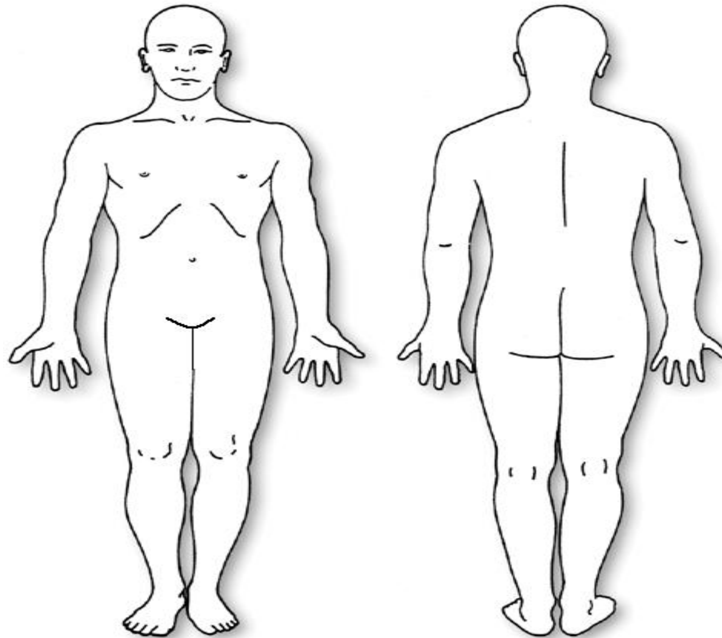
Allergies or adverse reactions to **MEDICATIONS** (pill or injection):__________________________

Is you pain the result of an: Illness YES___ NO__ Accident: YES____ NO__

Are you presently involve in litigation or a law suit resulting from this accident?

HOW LONG HAVE YOU HAD THIS PAIN? __________

Please shade in the areas on the diagrams where your pain is located.



RIGHT LEFT LEFT RIGHT

Please circle the appropriate words that best describe your pain.

ACHING	SHOOTING	DULL	CONSTANT	STINGING	SORENESS
BURNING	TINGLING	TIGHT	RADIATING	BRIEF	UNBEARABLE
CRAMPING	HOTNESS	HEAVY	ANNOYING	STABBING	SHARP
NUMBING	COLDNESS	INTENSE	EXCRUCIATING	TRANSIENT	SEVERE

	YES	DATE	LOCATION
X-RAY	☐	________	________
EMG	☐	________	________
CT SCAN	☐	________	________
DISCOGRAM	☐	________	________
MRI SCAN	☐	________	________

13. Please check any of the following treatments you have had for this pain problem. Include the dates and results.

TREATMENT	YES	PAIN RELIEF YES	PAIN RELIEF NO	DATE DONE
NERVE BLOCKS, EPIDURAL STEROIDS	☐	☐	☐	________
TENS UNIT	☐	☐	☐	________
PHYSICAL THERAPY	☐	☐	☐	________
TRACTION	☐	☐	☐	________
ACUPUNCTURE	☐	☐	☐	________
CHIROPRACTOR	☐	☐	☐	________
PAIN CLINIC	☐	☐	☐	________
PSYCHIATRIST, PSYCHOLOGIST	☐	☐	☐	________
HYPNOSIS, BIOFEEDBACK	☐	☐	☐	________
OTHER	☐	☐	☐	________

14. **Please list all medications** (prescriptions and non-prescription) you are currently taking.
Please indicate the doctor who prescribed them.

MEDICATION	REASON TAKEN	HOW OFTEN	DOCTOR
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________

15. Have you ever taken or been given

	YES	NO	WHEN? ANY PROBLEMS?
Anticoagulants (blood thinners --- Coumadin, Heparin)	☐	☐	________
Cortisone or Steroids	☐	☐	________

16. **Please list all surgeries** you have had, approximate dates and surgeon's name.

SURGERY	DATE	SURGEON

17. Please list any serious illnesses or hospitalizations you have had in the past. ______________________________

____

____

18. Please check the appropriate space if you have had or presently have any of the following health problems.

- ☐ DIABETES TYPE I ☐ TYPE II ☐
- ☐ HYPERTENSION
- ☐ HEART DISEASE
- ☐ VASCULAR PROBLEMS
- ☐ KIDNEY PROBLEMS
- ☐ AIDS
- ☐ HEPATITIS A ☐ B ☐ C ☐
- ☐ ASTHMA
- ☐ EMPHYSEMA
- ☐ EPILEPSY
- ☐ CVA (STROKE)
- ☐ HERPES ZOSTER (SHINGLES)
- ☐ TUBERCULOSIS
- ☐ HIGH CHOLESTOEROL
- ☐ OTHER ______________________________
- ☐ OTHER ______________________________

19. Do you smoke? YES ___ NO ___

20. ADDITIONAL COMMENTS: Please add any comments which you feel would help us in treating your pain.

SIGNATURE OF PATIENT: ______________________________

Thank you very much for taking the time to complete this form

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CHRONIC NARCOTIC THERAPY AGREEMENT

This agreement between the Pain Center and you the patient, ____ is intended to clarify the way chronic narcotics will be used to manage your chronic pain. Chronic narcotic therapy in patients who do not suffer from cancer is a controversial issue. The physicians at Pain Center have decided that you are an appropriate candidate for this form of therapy. As with all medications, there are risks such as allergy. Other side effects include sedation, itching, urinary hesitancy, nausea and vomiting. There are some special concerns when it comes to the use of narcotics, such as addiction, tolerance and drug dependency.

Tolerance
Over time, you will develop a certain amount of tolerance to the narcotic. The amount of tolerance is not known. Therefore, the initial dose of medication may become less effective over time. However, we may not increase your dosage in response to this. Obviously, we could not increase the dosage indefinitely. The final dosage will be decided between you and your doctor.

Physical Dependence
You will develop physical dependence on the drug. Therefore, you cannot stop this drug abruptly or you will experience symptoms such as nausea and vomiting, sweating and general malaise. If we do decide to stop the treatment, we will taper them slowly.

Addiction
There are some concerns about addiction. Most experts feel that the risk of addiction is very, very low when using these medications. If you have any questions about these various issues, i.e. tolerance, dependency or addiction, please talk with your doctor. The Pain Center will prescribe narcotics for you only if you follow the rules below:

1. Obtain narcotic prescriptions only from doctors at Pain Center except in following situations: If a new acute problem develops, such as trauma or surgery, then the doctor taking care of you for that acute problem may give you narcotics for a short time to cover your increase in pain that one can expect.

2. You need to be present for the follow-up examinations as indicated by your physicians. These are usually at monthly intervals in the beginning and which are decreased in frequency to 3 to 6 month intervals as time goes on.

3. You agree to be referred for psychological testing at our physician's request. Failure to do so will be grounds for discontinuation of therapy. Based on psychological evaluation it may be decided that you are not a candidate for continued chronic opoid/narcotic therapy.

4. You agree to submit to urine drug screening at your physician's request.

5. Renewal of medication will only be done following a scheduled visit to the Pain Center. Always have an idea of how many pills you have remaining. If you are running low on medications or anticipate an extended leave, contact the Pain Center. Frequent phone calls after hours or weekends requesting narcotics are an indication of inappropriate narcotic usage and may be grounds for discontinuation of therapy.

6. Any narcotic medication lost or misplaced WILL NOT be renewed under any circumstances.

_______________________________________ _______________________________________

Patient's Name (Printed) **Patient's Signature**

____

Date

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NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see a copy that record. We will not disclose you record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting The Office Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

May we leave a message on your home recorder? YES_____ NO______

May we leave a message with people at your house? YES_____ NO______

May we discuss your test results with members of your family? YES_____ NO______

Please list family members with whom we may discuss test results.

Name____ Relationship_________________________________

Name____ Relationship_________________________________

By my signature below I acknowledge acceptance of the Notice of Privacy Practices.

____ ______________________

Patient or Legally Authorized Individual Signature Date

Relationship to Patient

Parent ☐ Legal Guardian ☐ Personal Representative ☐

____ ______________________

Print Name if Signed on behalf of the Patient Date

This form will be retained in your medical record.

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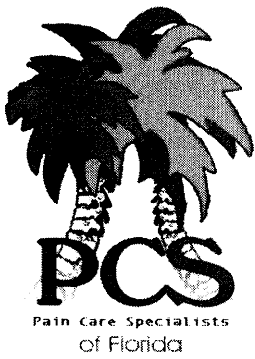
LUIS A. ESCOBAR, M.D.
DABPM. DAAPM, ABA



AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______________________________, Date of Birth ___ / ___ / ___ ,

Authorize release of my medical information to:

Name of Hospital, Physician or Facility

____
Street Address

HOLLYWOOD FL. 33021
City State Zip Code

(954)322-8586 (954)322-8581
Phone # Fax #

Any medical information concerning my treatment, including psychological, psychiatric, drug abuse, alcoholism, AIDS, Aids testing and care of hospitalization which may be in your care.

______________ ______________________________
Date Patient Signature

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www.painconsults.com