# 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 Insurance Information**
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): _____

Other Physicians seen for this problem: _____

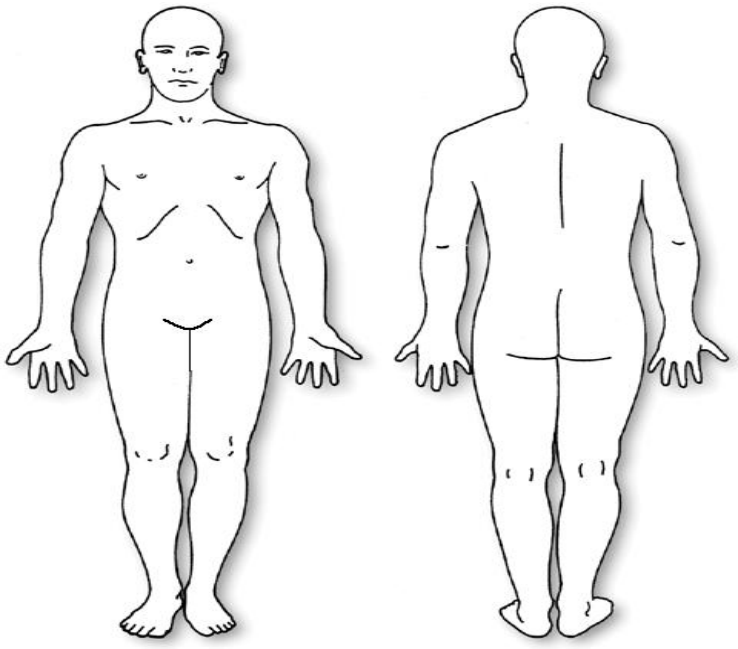
Allergies or adverse reactions to MEDICATIONS (pill or injection): _____

_____

Other Allergies: _____

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 |

1. Is your pain the result of an

| | YES | NO | IF YES, explain and give dates. |
|---|---|---|---|
| Illness | ☐ | ☐ | _____ |
| Accident | ☐ | ☐ | _____ |

2. Are you presently involved in litigation or a law suit resulting from this accident?
☐ YES ☐ NO
If yes, what is the name of your attorney? _____

3. Please indicate if the following increases, decreases or causes no change in your pain.

| | INCREASES PAIN | DECREASES PAIN | NO CHANGE |
|---|---|---|---|
| LIQUOR | ☐ | ☐ | ☐ |
| STIMULANTS (coffee, etc.) | ☐ | ☐ | ☐ |
| EATING | ☐ | ☐ | ☐ |
| HEAT | ☐ | ☐ | ☐ |
| COLD | ☐ | ☐ | ☐ |
| DAMP | ☐ | ☐ | ☐ |
| WEATHER CHANGES | ☐ | ☐ | ☐ |
| PHYSICAL ACTIVITY | ☐ | ☐ | ☐ |
| MASSAGE | ☐ | ☐ | ☐ |
| PRESSURE | ☐ | ☐ | ☐ |
| MOVEMENT | ☐ | ☐ | ☐ |
| SLEEP, REST | ☐ | ☐ | ☐ |
| LYING DOWN | ☐ | ☐ | ☐ |
| SITTING | ☐ | ☐ | ☐ |
| SEXUAL INTERCOURSE | ☐ | ☐ | ☐ |
| STANDING | ☐ | ☐ | ☐ |
| DISTRACTION (TV, etc.) | ☐ | ☐ | ☐ |
| URINATION | ☐ | ☐ | ☐ |
| BOWEL MOVEMENT | ☐ | ☐ | ☐ |
| TENSION | ☐ | ☐ | ☐ |
| BRIGHT LIGHTS | ☐ | ☐ | ☐ |
| LOUD NOISES | ☐ | ☐ | ☐ |
| FATIGUE | ☐ | ☐ | ☐ |
| SNEEZING, COUGHING | ☐ | ☐ | ☐ |

4. How many hours do you sleep at night? _____

5. Do you smoke? NO ☐ YES- ☐
☐ Current Smoker ☐ Former Smoker ☐ Chewing Tobacco

6. Do you drink caffeinated beverages? Circle one: coffee, tea, cola, energy drinks. How much do you drink daily?
_____

7. How much beer or alcoholic beverages do you drink daily? Please check one of the following choices:
Never Drink ☐ Rarely Drink ☐ Occasional drinker ☐ Social Drinker ☐ Former Drinker ☐ Everyday Drinker

8. Do you drive a car with automatic transmission manual transmission

9. Do you sleep on water bed traditional mattress

10. What is your usual occupation?___ _____

11. Are you presently working? YES NO ☐ RETIRED ☐ DISABLED

12. Please indicate which diagnostic procedures (test) you have had, and the approximate date and location where the test was performed.

| | YES | DATE | LOCATION |
|---|---|---|---|
| X-RAY | ☐ | _____ | _____ |
| EMG | ☐ | _____ | _____ |
| CT SCAN | ☐ | _____ | _____ |
| MYELOGRAM | ☐ | _____ | _____ |
| DISCOGRAM | ☐ | _____ | _____ |
| NMR, 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 | ☐ | ☐ | _____ |
| Local anesthetic (given by a doctor or dentist) | ☐ | ☐ | _____ |

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. 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.**

PAIN CARE SPECIALISTS OF FLORIDA
LUIS A. ESCOBAR, M.D.
DABPM. DAAPM, ABA

Pain Care Specialists of Florida

## AUTHORIZATION FOR RELEASE OF INFORMATION

**I, _____, Date of Birth ____ / ____ / ____**

**Authorize release of my medical information to:** ,

LUIS A. ESCOBAR, MD
**Name of Hospital, Physician or Facility**

4350 SHERIDAN STREET, suite 102
**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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