Felix M. Ramirez D.O.
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Cooper City, FL 33024
954-751-5589 (O) 954-751-5589 (F)

Demographics

First Name:_____ Last Name:_____

Address:_____ City:_____ State: _____ Zip:_____

Email Address: _____ Telephone: _____

Social Security: _____ Date of Birth:_____ Ethnicity: _____

Race: _____ Language:_____

Emergency Contact

Name:_____ Relationship:_____

Address:_____ City:_____ State: _____ Zip:_____

Telephone: _____

Insurance

Primary Insurance Company: _____ Telephone: _____

Primary Insured Name:_____ Social Security: _____

Policy Number: _____ Group Number: _____ Date of Birth: _____

Secondary Insurance Company: _____ Telephone: _____

Secondary Insured Name:_____ Social Security: _____

Policy Number: _____ Group Number: _____ Date of Birth: _____

Primary Care Physician: _____ Telephone: _____

Address:_____ City:_____ State: _____ Zip:_____

Pharmacy Name: _____ **Phone #** _____

Address: _____

Medical History

Any Allergies to Medications:

_____

Current Medications:

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Patient Name: _____ Height: _____ Weight: _____

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non- Hispanic ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Other: _____

Pharmacy Name: _____ Pharmacy Telephone: _____

Pharmacy Address: _____

Primary Doctor: _____ Primary Telephone: _____

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Description of Symptoms- please state the body part for today's date of service:

_____

_____

_____

☐ Pain ☐ Numbness/Tingling; Where? _____

☐ Fracture ☐ Stiffness ☐ Other: _____

Pain radiates from/to (Ex: from low back to right leg):

_____

_____

_____

Is your problem the result of an injury or accident?

☐ No Injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery ☐ Slip and Fall

Onset Date: _____ when did the pain start? _____

Have you had a problem like this before? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Have you been seen in the ER or Urgent Care? ☐ Yes ☐ No Date: _____

If yes, what hospital? Please describe your visit:

_____

_____

_____

What is your pain scale from 1 through 10? _____

Do the symptoms wake you from your sleep? Do you have trouble performing everyday activities?

☐ Yes ☐ No

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Are you being represented by an attorney? ☐ Yes ☐ No

If yes, who is your attorney? _____

What is the timing of your symptoms? ☐ Constant ☐ Intermittent ☐ Brief ☐ Momentary ☐ Steady

Is your pain getting better or worse? ☐ Getting better ☐ Worse ☐ Unchanged

Please describe what makes your symptoms better or worse:

_____

_____

_____

Are there any associated symptoms?

_____

_____

What does your pain feel like?

☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling ☐ Throbbing ☐ Cramping ☐ Pulling ☐ Crushing ☐ Dull

☐ Pounding ☐ Aching ☐ Sore ☐ Hurting ☐ Heavy ☐ Tender ☐ Tiring ☐ Sickening ☐ Intense ☐ Tight

☐ Numb ☐ Squeezing ☐ Piercing ☐ None ☐ Other _____

Have you had any prior testing?

☐ None ☐ MRI ☐ CT Scan ☐ X- Ray ☐ Bone Scan ☐ Nerve Test (EMG) ☐ Ultrasound

Have you had any treatments for this pain? (Ex. Physical therapy, chiropractic treatments, cortisone/epidural injections, pain medication, anti-inflammatory medications, TENS therapy, etc.) Please include doctor and contact number.

_____

_____

_____

_____

_____

Do you have any metal in your body? ☐ Yes ☐ No

Are you taking blood thinners? ☐ Yes ☐ No

Do you have any past surgical history? Please include orthopedic and general surgery with dates.

_____

_____

_____

_____

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Please mark an "**X**" to indicate where your pain begins and mark a **LINE** to indicate where the pain ends:

Please list any family medical history or conditions: (Mother, Father, Siblings)

_____

_____

_____

_____

Do you or have you ever used tobacco? ☐ Yes ☐ No

Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Have you ever been diagnosed with or treated for a drug or alcohol abuse? ☐ Yes ☐ No

If yes, please describe:

_____

_____

Marital Status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled

What is/was your occupation? _____

Do you have any allergies? ☐ Yes ☐ No

If yes, please list below:

_____

_____

_____

Latex allergy? ☐ Yes ☐ No

Please list all current medications with the dosage:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take Aspirin? ☐ Yes ☐ No

Do you take anti-inflammatory medication? ☐ Yes ☐ No If yes, which one? _____

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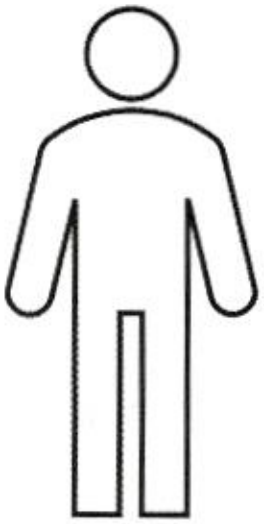

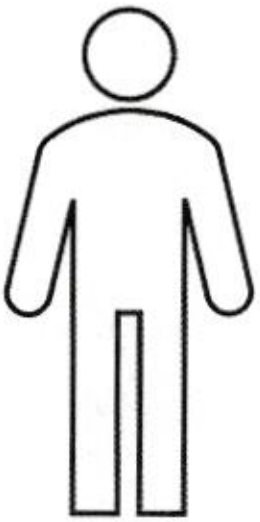

FRONT **BACK**

Do you have any personal history of any of the following?

- ☐ Aneurysm; Where? _____
- ☐ Angina (Chest Pain)
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Bone or Joint Infections
- ☐ Cancer; Type? _____
- ☐ Chemotherapy/Radiation
- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Diabetes; Type? _____
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Hepatitis; Type? _____
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease/Cirrhosis
- ☐ Migraines or Chronic Headaches
- ☐ MRSA Infection
- ☐ Neuropathy
- ☐ Pacemaker
- ☐ Phlebitis (Blood Clots)
- ☐ Pulmonary Embolism
- ☐ Reaction to Anesthesia; Type? _____
- ☐ Sickle Cell Disease
- ☐ Seizures
- ☐ Stomach Ulcers
- ☐ Stroke/TIA
- ☐ Tuberculosis

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Have you had a pneumonia vaccination? ☐ Yes ☐ No If yes, when? _____

Have you had a Flu Vaccination? ☐ Yes ☐ No If yes, when? _____

Do you little interest in or pleasure in doing things? ☐ Yes ☐ No

Are you feeling down, depressed or hopeless? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

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Office Policies

Due to the increasing number of patients no shows and same day cancellations of appointment, we are instituting a new policy, effective immediately. They are as follows:

1. Cancelled appointments within 24 hours of appointment time - $25.00 fee
2. No show appointments time - $50.00 fee
3. Cancellation of procedure five days prior to procedure time - $750.00 fee
4. Any forms, letters, or disability paperwork -$35.00 and up.

By signing this document, you have read and acknowledged it's content. Our staff appreciates your understanding, if you have any questions please let us know.

Patient Name: _____ Date: _____

Patient Signature: _____

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Opioid Treatment Agreement

This is an agreement between patient _____ and Premier Pain and Wellness LLC and it's affiliates. The purpose of this agreement is to outline the responsibilities of the patient regarding the safe use of opioid analgesics for the treatment of chronic pain.

1. I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand that the goals of treatment are not to eliminate pain, but to partially relieve my pain to improve my ability to function. Chronic opioid therapy is only ONE part of my pain management plain.
2. I understand that my provider and I will continually evaluate the effect of my pain medications on achieving the treatment goals and make changes as needed. I agree to take medication at the dose of opioids on my own and understand that doing so may lead to treatment discontinuation.
3. I understand that the common adverse effects of opioid therapy include constipation, nausea, sweating, and itching. Drowsiness may occur when occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating machinery until such drowsiness disappears completely.
4. I will not seek opioid medications from another physician for the treatment of my chronic pain. Regular follow-up care is required and only my provider will prescribe these medications from my chronic pain at scheduled appointments.
5. I will attend all appointments, treatments, and consultations as requested by my providers. I may be required to bring in all unused pain medicine to an appointment.
6. I will not give or sell my medication to anyone else, including my family members; nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication always.
7. I understand that if my prescription runs out early for any reason, for example, if I lose the medication or take more than prescribed, my provider may not proscribe extra medication for me.
8. I understand that using other medications can cause adverse effects or interfere with the opioid therapy. Therefore, I agree to nifty my provider of the use of all substances, including marijuana, sleeping pills, medications not prescribed for me, and all illicit drugs. I agree to not consume any alcohol while on opioid medications.
9. I agree that I will submit to a periodic unscheduled drug screen if requested by my doctor to determine my adherence to my treatment plan. I further agree to pay for the drug screen whenever it is not covered by my insurance. IF I refuse to undergo the drug screen for any reason, my provider will not prescribe medication for me.
10. I understand that I may become physically dependent on opioid medications, which may lead to addiction in a few patients. I agree that if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.
11. I understand that my failure to meet these requirements may result in my provider choosing to stop writing opioid prescriptions for me. Withdrawal from these medications will be coordinated by the provider. Abd may require specialist referrals.
12. I hereby agree that I will sign an appropriate release so that my provider has the authority to discuss my pain management with other healthcare professionals and select family members when it is deemed medically necessary in the providers judgment.
13. My providers may obtain information from state databases of controlled substances and from other prescription monitoring programs. In addition, I agree to use only one pharmacy to fill my prescriptions.
14. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given for my records.

Patient Name: _____ Date: _____

Patient Signature: _____

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Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Daytime Phone: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of medical records or a summary or narrative of my protected health information, to the person(s) or entity below.

HIV/ AIDS: I DO____ DO NOT_____ consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agents of AIDS with the results of my medical records.

Initials: _____ Date: _____

Limitations on the information you may release subject to the release form are as follows:

_____

_____

Release my protected health information to the following person(s):

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

I do____ DO NOT_____ give permission for these records to be faxed to the above entity.

Patient Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005