INTERVENTIONAL MEDICAL ASSOCIATES

Name: ______________________________________ Date: ___________________

Chief Complaint for Today's Visit:

____

____

Briefly Describe Accident or Development of Present Complaint:

____

____

Are Symptoms Related to a Work Related Accident? ☐ Yes ☐ No Date: _________

Are Symptoms Related to an Accident or Trauma? ☐ Yes ☐ No Date: _________

If related to motor vehicle accident:

Were you the driver? ☐ Yes ☐ No Were you wearing a seat belt? ☐ Yes ☐ No

Were you Stopped or Moving? _______ What speed were you travelling? ________________

Were you hit Head on, Driver's side, Passenger's side, rear of vehicle? ________________________

Did you have loss of consciousness? ☐ Yes ☐ No if yes, for how long? ____________________

Was airbag deployed? ☐ Yes ☐ No Did you go to the emergency room? ☐ Yes ☐ No

Complaint Characteristics:

When did symptoms start? (Date) _________

Are symptoms ☐ Continuous ☐ Intermittent (Off and On)

Are symptoms ☐ Mild ☐ Moderate ☐ Severe

Pain score worst: 0 1 2 3 4 5 6 7 8 9 10 greater than 10

Pain score usual: 0 1 2 3 4 5 6 7 8 9 10 greater than 10

Pain score least: 0 1 2 3 4 5 6 7 8 9 10 greater than 10

Pain characteristic: ☐ Dull ☐ Sharp ☐ Burning ☐ Tooth-ache like ☐ Stabbing ☐ Pressure like ☐ Throbbing ☐ Other: ____________________

Have you had similar pain before: ☐ Yes ☐ No When: ____________________________

What makes the symptoms worse? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Lifting ☐ Bending ☐ Twisting ☐ Coughing ☐ Driving ☐ Other: _______________

What makes symptoms better? ____

Associated Symptoms:

Do you have Numbness? ☐ Yes ☐ No Where? ______________________________

Do you have Tingling? ☐ Yes ☐ No Where? ______________________________

Do you have Weakness? ☐ Yes ☐ No Where? ______________________________

Do you have symptoms at night? ☐ Yes ☐ No Where? ______________________________

Do you have promblems urinating? ☐ Yes ☐ No Explain? ______________________________

Do you have Bowel Function problems? ☐ Yes ☐ No Explain? ______________________________

Do you have Sexual Dysfunction? ☐ Yes ☐ No Explain? ______________________________

Are symptoms: ☐ Increasing ☐ Decreasing ☐ Remain about the same

What treatments have you tried? ☐ Medications ☐ Physical Therapy ☐ Chiropractic Care ☐ Surgery ☐ Injections ☐ Electrical Stimulation ☐ Braces/Canes ☐ Acupuncture ☐ Other:___________

By whom (or where) have you been treated for this problem? ___________

Primary care physician: ___________ Attorney: ___________

Pharmacies used in the last two years (name and city): ___________

What tests have you had for this problem? ☐ Myelogram ☐ MRI ☐ CAT Scan ☐ Electrodiagnostic Studies ☐ Bone Scan ☐ Arthrogram ☐ X-Ray ☐ Other: ___________

Your Past Medical History:

☐ Diabetes
☐ Arthritis
☐ Heart Disease
☐ High Blood Pressure
☐ Pacemaker
☐ Vascular Disease
☐ Ulcers
☐ Liver Disease
☐ Glaucoma
☐ Tuberculosis
☐ Other: ___________

☐ Taking a blood thinner
☐ Kidney Disease
☐ HIV / AIDS
☐ Stroke
☐ Lung Disease
☐ Sleep Apnea
☐ Seizures
☐ Gastric band/bypass

☐ Thyroid Disease
☐ Cancer
☐ Depression
☐ Bipolar
☐ Schizophrenia
☐ Prior Suicide Attempt
☐ Polio

Do you have a history of substance abuse? ☐ Yes ☐ No ☐ N/A ☐ Quit When? ___________

If history of substance abuse, please explain:
When? ___________ What substance(s)? ___________
How long? ___________ Any Treatments? ___________

Have you ever been denied care or released by any healthcare providers because of violations to their drug policies? ☐ Yes ☐ No Where & When? ___________

Any history of arrests or convictions due to illegal substances or alcohol issues? ☐ Yes ☐ No

Have you ever seriously considered suicide? ☐ Yes ☐ No
Were you sexually abused as a child? ☐ Yes ☐ No

Habits: Do you smoke? ☐ Yes ☐ No ☐ Quit How much? ___________
Do you drink alcohol? ☐ Yes ☐ No ☐ Quit How much? ___________

List surgeries or operations:

____
____
____

Hobbies: ___________

Work history:
Occupation: ___________ Education level/Training: ___________
Describe your job: ___________
Place of work: ___________
Last worked: (Date) ___________ How many hours a week? ___________ Restrictions? ☐ Yes ☐ No

Medication	Dose	#	Frequency	Purpose	% of relief

Previous medication taken for pain:

Medication	Dose	#	Frequency	Purpose	% of relief

Patient Signature: ______________________________ Date: ______________

REVIEW OF SYSTEMS

Patient Name: ______________________________ **DOB:** ________________

Check any of the signs or symptoms below that have had.

General:

- [ ] Weight Loss
- [ ] Weight Gain
- [ ] Fever
- [ ] Chills
- [ ]
- [ ] Trouble Sleeping
- [ ] Fatigue
- [ ] Weakness

Skin:

- [ ] Rashes
- [ ] Itching
- [ ] Color Changes
- [ ] Lumps
- [ ] Dryness
- [ ] Hair changes
- [ ] Nail changes

Head:

- [ ] Headache
- [ ] Head Injury

Ears:

- [ ] Decreased Hearing
- [ ] Earache
- [ ]
- [ ] Ringing in the ears (tinnitus)
- [ ] Drainage

Eyes:

- [ ] Vision
- [ ] Blurry Vision
- [ ] Double Vision
- [ ] Cataracts
- [ ] Glasses
- [ ] Contacts
- [ ] Flashing Lights
- [ ] Pain
- [ ] Specks
- [ ] Redness
- [ ] Glaucoma

Nose:

- [ ] Stuffiness
- [ ] Itching
- [ ] Nosebleeds
- [ ] Discharge
- [ ] Hay Fever
- [ ] Sinus Pain

Mouth:

- [ ] Teeth
- [ ] Sore Tongue
- [ ] Thrush
- [ ] Gums
- [ ]
- [ ] Dry Mouth
- [ ] Non-healing sores
- [ ] Bleeding
- [ ] Dentures

Throat/Neck:

- [ ] Sore Throat
- [ ] Hoarseness
- [ ] Lumps
- [ ] Pain
- [ ] Swollen Glands
- [ ] Stiffness

Breasts:

- [ ] Lumps
- [ ] Pain
- [ ] Discharge
- [ ] Self-exams
- [ ] Breast-feeding

Respiratory:

- [ ] Dry Cough
- [ ] Wet Cough
- [ ] Productive Cough
- [ ] Coughing up Blood
- [ ] Wheezing
- [ ] Colored Sputum
- [ ] Shortness of Breath (dyspnea)
- [ ] Painful Breathing

Cardiovascular:

- ☐ Chest Pain
- ☐ Chest discomfort
- ☐ Difficulty Breathing
- ☐ Sudden awaking from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)
- ☐ Tightness
- ☐ Swelling (edema)
- ☐ Palpitations
- ☐ Calf Pain with Walking (Claudication)
- ☐ Leg Cramping
- ☐ Shortness of breath with activity (dyspnea)

Gastrointestinal:

- ☐ Swallowing difficulties
- ☐ Change in bowel habits
- ☐ Yellow eyes or skin (jaundice)
- ☐ Heartburn
- ☐ Rectal Bleeding
- ☐ Constipation
- ☐ Nausea
- ☐ Diarrhea

Urinary:

- ☐ Frequency
- ☐ Blood in urine (hematuria)
- ☐ Change in urinary strength
- ☐
- ☐ Urgency
- ☐ Burning or pain
- ☐ Incontinence

MALE

- ☐ Pain with sex
- ☐ Sores
- ☐ Hernia
- ☐ Masses
- ☐ Pain
- ☐ Erecticle Dysfunction

FEMALE

- ☐ Pain with sex
- ☐ Hot Flashes
- ☐ Itching
- ☐ Rash

Musculoskeletal:

- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Swelling of joints
- ☐ Stiffness
- ☐ Redness of Joints
- ☐ Trauma

Neurological:

- ☐ Dizziness
- ☐ Weakness
- ☐ Tremor
- ☐ Fainting
- ☐ Numbness
- ☐ Seizures
- ☐ Tingling

Hematological:

- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine:

- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Frequent Urination (polyuria)
- ☐ Increase in appetite
- ☐ Decrease in appetite
- ☐ Sweating
- ☐ Ease of bleeding
- ☐ Thirst (polydipsia)

Psychiatric:

- ☐ Nervousness
- ☐ Memory Loss
- ☐ Stress
- ☐ Depression

☐ **Check here if you have non of the above symptoms.**

Are you pregnant? Yes No

Do you have a problem with self-care or mobility issues? Yes No
If yes, Explain: ____

FAMILY HISTORY

Review the following below and list family conditions:

Chemotherapy, bleeding disorder, stroke, BPH, diabetes, arthritis, meningitis, CHF, high blood pressure, sickle cell, hyperthyroid, CAD, cancer, asthma, kidney stone, HIV, kidney disease, GERD, anxiety, COPD, chest pain, ulcer, heart murmur, pacemaker, rheumatic fever, liver disease, depression, hepatitis B, hepatitis C, hypothyroid, etc.

- ☐ Father (Alive/Deceased): ______________________________
- ☐ Mother (Alive/Deceased): ______________________________
- ☐ Siblings (Alive/Deceased): ______________________________
- ☐ Child (Alive/Deceased): ______________________________
- ☐ Paternal Grandfather (Alive/Decreased): ______________________________
- ☐ Paternal Grandmother (Alive/Deceased): ______________________________
- ☐ Maternal Grandfather (Alive/Deceased): ______________________________
- ☐ Maternal Grandmother (Alive/Deceased): ______________________________

ALLERGIES:

Please select which best describes

☐ I am not aware of any allergies that I might have

I am allergic to: ☐ IV Contrast Dye ☐ Shellfish ☐ Tape ☐ Latex ☐ Other: ___________

I am allergic to the following medications:

Medication	Reaction

MEDICATION:

Do you take medication for pain relief? ☐ Yes ☐ No

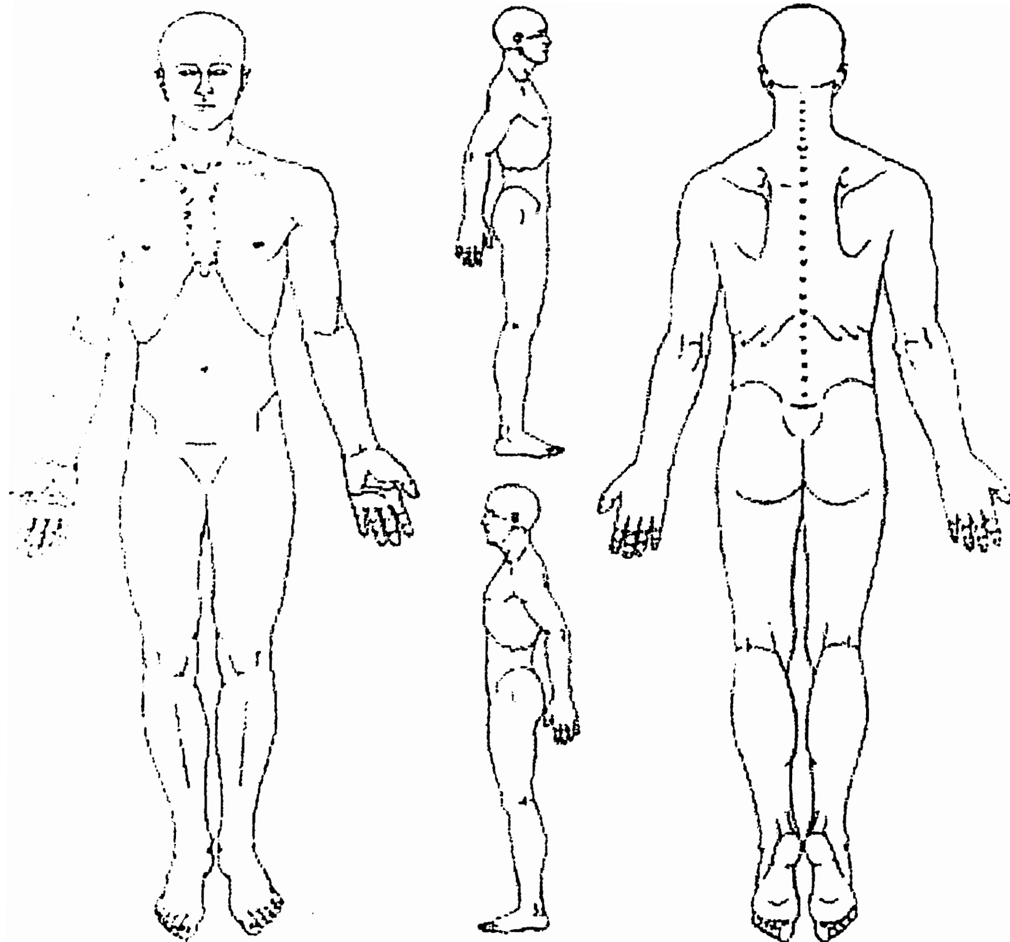
On the average, does the medication: ☐ always take the pain away ☐ always decrease the pain ☐ usually take the pain away ☐ usually decrease the pain ☐ provide little or no relief

Are you taking **Coumadin or Warfarin**? ☐ Yes ☐ No
Are you taking **Plavix/Clopldogrel, or Effient/Prasugrel**? ☐ Yes ☐ No
Are you taking **Ticlid or Ticlopidine**? ☐ Yes ☐ No
Are you taking **Aggrenox, Persantine or Dipyridamole**? ☐ Yes ☐ No
Are you taking **Lovenox, Clexane or Enoxaprin**? ☐ Yes ☐ No
Are you taking **Pradaxa or Dabigatran**? ☐ Yes ☐ No
Are you taking **Eliquis?** ☐ Yes ☐ No
Are you taking **Brilenta/ticagrelor or Xarelto**? ☐ Yes ☐ No
Are you taking **Aspirin or Aspirin products**? ☐ Yes ☐ No
Are you taking **Garlic Supplements?** ☐ Yes ☐ No
Are you taking **Ginkgo Supplements?** ☐ Yes ☐ No
Are you taking **Ginseng Supplements?** ☐ Yes ☐ No
Are you taking **Ginger Supplements?** ☐ Yes ☐ No
Are you taking **Fish Oil Supplements?** ☐ Yes ☐ No
Are you taking **Vitamin E Supplements?** ☐ Yes ☐ No

Current Medications (ALL medications you take; use a second sheet if needed. If you are not sure of spelling or dosage please bring ALL your medications with you to your first appointment):

Where is your pain located?

Use this diagram to show where you have your pain. Mark the area with the symbol that best describes your pain:



Aching Pain	********
Burning Pain	xxxxxxxx
Numbness	=======
Pins & Needles	ooooooo
Stabbing Pain	/ / / / / / /

PATIENT INFORMATION

Please Circle: Mr. / Mrs. / Ms. / Miss / Dr.

Last Name: ____________________ **First Name:** ____________________ **MI:** ________

Address: ______________________ **City:** ________________ **State:** ____ **Zip:** ______

Home Phone: _______________ **Cell Phone:** _______________ **Gender:** M or F

Date of Birth: ___________ **SS#:** ______________ **Married?** Yes No Other ___________

Email Address: _____________________ **Primary Care Physician:** __________________

Emergency Contact: _________________**Relation:**_________ **Phone:** _________________

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ American Indian ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

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Primary Insurance: ______________________________________ ID#: _____________

Responsible party if different from patient: _____________________________ DOB: _________

Secondary Insurance: ______________________________________ ID#: ____________

Responsible party if different from patient: _____________________________ DOB: _________

Auto Accident?: Yes / No DOA: ______ Name of insured: ____________________

Workers' Comp?: Yes / No DOI: ______ Employer at time of injury: ______________

Case Manager: ____________________________________ Phone: ____________________

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled, including Medicare private insurance, major medical benefits, auto benefits, workers' compensation and any other health plans to Interventional Medical Associates. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient Signature: ____ Date: __________________

FINANCIAL POLICY

ABOUT FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

As your physician, we are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time services are rendered.

We accept cash, checks, debit, and credit cards. Returned checks are subject to a service charge f $25.00 and you may lose your privilege to write checks in our office.

Cancelled Appointments

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a $25.00 to $50.00 fee. After a second occurrence you may be discharged from the practice.

Medicare

Your deductible and 20% of the allowable charges are due at the time of service. If we do not know the Medicare allowable charge for a specific service, we will bill you after Medicare pays. Please bring a copy of the Medicare Explanation of Benefits (EOB) showing you have met your yearly deductible.

Blue Cross Blue Shield

Coinsurance, deductible, and co-pays must be paid at the time of service. Because we are under contract with this insurance company, we will file your insurance.

Auto

Most auto policies cover 80% of your accident-related healthcare costs. The 20% balance must be paid at the time services are rendered unless prior arrangements have been made. Representation by an attorney does not mean that you are not responsible for your coinsurance.

Financial Agreement

We will gladly discuss your proposed treatment and do our best to answer any questions relative to your insurance. You must realize, however that: 1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. 2. Not all services are a covered benefit in all contracts. Some insurance companies may arbitrarily select certain services that they will not cover.

We must emphasize that, as your medical care provider, our relationship and concern is with you and your health, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility from the date the services are rendered**. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If it becomes necessary to collect any sum through an attorney r collections agency, then the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether a suit is filed or not.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature: ____ Date: ____________________

Interventional Medical Associates
Robert G. Valentine, MD & Prathima Reddy, MD
6821 NW 11th Place
Gainesville, Florida 32605
Phone: (352) 331-3353
Fax: (352) 333-9035

Name: ______________________ **Date of Birth:** ___ / ___ / ____

Release of Information

Please select one of the following:

[ ] I authorize the release of information including the diagnosis, records, appointments, insurance adjustments, examination rendered to me and claims information to the below listed person[s].

______________________________	________________
Name	Relation
______________________________	________________
Name	Relation
______________________________	________________
Name	Relation
______________________________	________________
Name	Relation

[ ] Information is not to be release to anyone other than myself.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: ____________________________ Date: ____ / ____ / ______

Witness: ____________________________ Date: ____ / ____ / ______

Interventional Medical Associates
Robert G. Valentine, MD & Prathima Reddy, MD
6821 NW 11th Place
Gainesville, Florida 32605
Phone: (352) 331-3353
Fax: (352) 333-9035

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ **DOB:** ______________ **SSN:** ________________

Address: ________________________________ **City:** _______________ **State:** _____ **Zip:** _______

Home Phone: ____________________________ **Work Phone:** __________________________

__

I herby authorize **Interventional Medical Associates** to release or obtain any information from my medical record to coordinate my healthcare.

The following items are needed:

- O Face Sheet (Patient information)
- O Insurance Information
- O Progress Notes
- O Radiology / Imaging Reports
- O Lab Results
- O Operative / Procedure Reports
- O Entire Record
- O Other: ____

I acknowledge and hereby consent to such that the released or obtained information may contain:

- ◊ Alcohol and drug abuse information
- ◊ Psychiatric information
- ◊ HIV testing, HIV results, and / or AIDS information

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that disclosure of this information to a party other than one directly involved with my healthcare is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information".

A photocopy of this "Authorization for Release of Medical Information" shall be considered as effective and valid as the original.

Patient Signature: ____ Date: ____________________

CONTROLLED PAIN MEDICATIONS

OUR PRACTICE IS PRIMARILY ON THE USE OF MINIMALLY INVASIVE PROCEDURAL TECHNIQUES TO ATTEMPT TO REDUCE OR CONTROL PAIN, OFTEN COMBINED WITH VARIOUS TYPES OF NON-CONTROLLED MEDICATIONS, PHYSICAL THERAPY OR OTHER FORMS OF TREATMENT.

**** <u>PLEASE NOTE</u> THAT NEITHER DR. REDDY NOR DR. VALENTINE IS ACCEPTING PATIENTS TO CONTINUE PRESCRIBING CONTROLLED MEDICATIONS WHICH HAVE BEEN PRESCRIBED BY ANOTHER PHYSICIAN.**

PLEASE NOTE THAT WE DO NOT, UNDER ANY CIRCUMSTANCES, PROVIDE CONTROLLED (OPIATE) PAIN MEDICATION(S) AT A PATIENT'S INITIAL VISIT.

IN THE EVENT WE FEEL CONTROLLED PAIN MEDICATION MAY BE INDICATED, ADDITIONAL EVALUATION WILL BE REQUIRED, THE DEGREE OF WHICH DEPENDS ON THE INDIVIDUAL CASE. THIS MAY INCLUDE A DRUG HOLIDAY, OR PERIOD OF TIME WITHOUT USING CONTROLLED MEDICATIONS, IN ORDER TO DETERMINE WHETHER IT/THEY IS/ARE ARE ACTUALLY EFFECTIVE.