Kamerlink PAIN INSTITUTE
7200 West Camino Real, Suite #104, Boca Raton, FL 33433
Telephone: (561) 404-7667 • Fax: (561) 405-3144

PATIENT DEMOGRAPHICS

TODAY'S DATE _____

PATIENT NAME _____ **DATE OF BIRTH** _____

ADDRESS _____ **APT#** _____

CITY _____ **STATE** _____ **ZIP CODE**_____

HOME PHONE _____ **CELL PHONE** _____

EMAIL _____

SEX ❒ MALE ❒FEMALE

RACE ❒CAUCASIAN ❒AFRICAN AMERICAN ❒ ASIAN/PACIFIC ISLANDER ❒ HISPANIC/LATINO

PHARMACY NAME _____ **PHONE NUMBER** _____

SPOUSE NAME _____ **PHONE NUMBER** _____

EMERGENCY CONTACT NAME _____ **PHONE NUMBER** _____

PRIMARY CARE PHYSICIAN _____ **PHONE #** _____

RERFERRAL SOURCE Google Facebook Other: _____

Physician: _____ PHONE # _____

PRIMARY INSURANCE _____ **ID#** _____

SECONDARY INSURANCE _____ **ID#** _____

RESPONSIBLE PARTY _____ **DATE OF BIRTH** _____

RELATIONSHIP TO RESPONSIBLE PARTY_____

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CONSENT FOR TREATMENT

I, the undersigned, whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the my physician.

SIGNATURE x _____ DATE _____

ASSIGNMENT OF BENEFITS

I authorize any information about me to release to my insurance company or its intermediaries any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original. I further authorize payment of medical and/or surgical insurance benefit, otherwise payable to me, to Kamerlink Pain Institute. I understand that I am financially responsible for those charges not paid by my insurance.

SIGNATURE x _____ DATE _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize Kamerlink Pain Institute to disclose and/or receive my health information.

I authorize Kamerlink Pain Institute to receive my **ALL** of my health information.

I understand that if the person(s) or entity (ies) that received the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Kamerlink Pain Institute, its employees, and my physicians from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will not expire from the date signed below. I understand that I may revoke this authorization by notifying, in writing, Kamerlink Pain Institute, knowing that previously disclosed information would not be subject to my revoke request.

SIGNATURE x _____ DATE _____

WITNESS SIGNATURE x _____ DATE _____

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PAST MEDICAL HISTORY (PLEASE CIRCLE ALL MEDICAL PROBLEMS)

HEART	HIGH BLOOD PRESSURE HIGH CHOLESTEROL HEART ATTACK IRREGULAR HEART BEAT
LUNG	ASTHMA COPD SLEEP APNEA OTHER _____
BRAIN	SEIZURE STROKE OTHER _____
ENDOCRINE	DIABETES THYROID (HYPER / HYPO) OTHER _____
KIDNEY	KIDNEY FAILURE DIALYSIS OTHER _____
LIVER	LIVER FAILURE HEPATITIS A B C OTHER _____
BLOOD	HIV BLEEDING DISORDERS OTHER _____
CANCER	TYPE _____
PSYCHOLOGICAL	DEPRESSION ANXIETY BIPOLAR SCHIZOPHRENIA

PAST SURGICAL HISTORY (LIST ALL SURGERIES YOU HAD IN THE PAST)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

MEDICATIONS - PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

	NAME OF MEDICATION	DOSE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

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ARE YOU ALLERGIC TO ANY MEDICATIONS? ❒ NO ❒ YES (IF YES, PLEASE LIST BELOW)

	ALLERGY	REACTION
1.		
2.		
3.		
4.		

SYMPTOMS YOU HAVE ENCOUNTERED (PLEASE CIRCLE ALL THAT APPLY)

GENERAL	FEVER FATIGUES CHILLS WEIGHT CHANGES
EYES	REDNESS CORRECTIVE LENSES BLURRED VISION
ENT	NOSEBLEEDS RINGING IN THE EARS HOARSENSS
CV	CHEST PAIN PALPITATIONS FAINTING MURMUR LEG CRAMPS
RESPIRATORY	SHORTNESS OF BREATH WHEEZING COUGH HURTS TO BREATH
GI	HEARTBURN NAUSEA/VOMITING CONSITPATION DIARRHEA BLOOOD IN STOOL
GU	FREQUENT URINATION PAINFUL URINATING INCONTINENCE BLOOD IN URINE
MUSCULOSKELETAL	JOINT PAIN JOINT SWELLING JOINT STIFFNESS UNSTEADY GAIT
PSYCHOLOGICAL	NERVOUS ANXIETY DEPRESSION SUICIDAL THOUGHTS HALLUCINATIONS
ENDOCRINE	EXCESSIVE THIRST/URINATION HEAT/COLD INTOLERENCE
HEM/LYMPH	EASY BLEEDING EASY BRUISING ENLARGED LYMPH NODE

Do you take any blood thinning medications ❒ NO ❒ YES

Do you have a cardiac device (pacemaker or defibrillator) ❒ NO ❒ YES

Are you allergic to iodine or contrast ❒ NO ❒ YES

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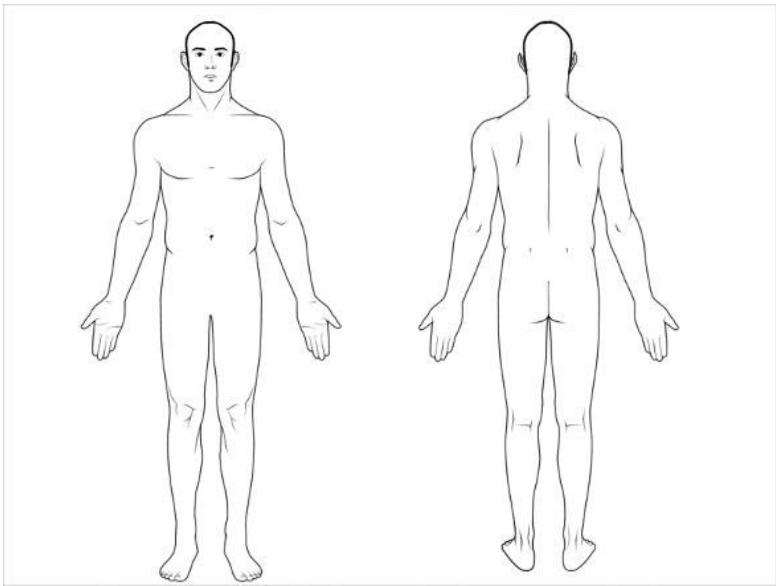
WHERE IS YOUR PAIN LOCATED? (PLEASE "X" ALL LOCATIONS)



HAVE YOU TRIED ANY MEDICATION(S) FOR YOUR PAIN SYMPTOMS?

ANTI-INFLAMMATORY ❒ NO ❒ YES WHAT NAME AND DOSE _____

GABAPENTIN/NEURONTIN/LYRICA ❒ NO ❒ YES WHAT NAME AND DOSE? _____

OPIOIDS ❒ NO ❒ YES WHAT NAME AND DOSE? _____

OTHERS ❒ NO ❒ YES WHAT NAME AND DOSE? _____

HAVE YOU HAD ANY PHYSICAL THERAPY FOR YOUR PAIN? ❒ NO ❒ YES

IF YES, HOW MANY SESSIONS HAVE YOU COMPLETED? _____

HAVE YOU HAD ANY INJECTIONS FOR YOUR PAIN? ❒ NO ❒ YES

EPIDURAL ❒ NO ❒ YES DATES _____

FACET BLOCKS ❒ NO ❒ YES DATES _____

TRIGGER POINT ❒ NO ❒ YES DATES _____

HAVE YOU HAD SURGERY FOR YOUR PAIN? ❒ NO ❒ YES

IF YES, PLEASE LIST YOUR SURGERY DATES _____

HAVE YOU TRIED A SPINAL CORD STIMULATOR? ❒ NO ❒ YES