

David M. Glener, MD

**Diplomate, American Board Of Anesthesiology
Diplomate, American Board of Pain Medicine
561 Lake Whitney Place
Suite 102
Port St. Lucie, FL 34986
Tel# (772) 337-3350
Fax# (772) 337-3395**

Dear Patient:

We thank you for choosing our office for your interventional pain management needs. Our goal is to provide you with the highest quality medical care. Enclosed is our new patient questionnaire. We ask that you fill this out in its entirety prior to your appointment. The accuracy of these forms is paramount to our providing you with the highest level of care.

Please arrive 15-20mins early and have the following information with you for your appointment:

- **Completed questionnaire**
- **Photo ID and Insurance Card(s)**
- **Medical records including of MRI/CT reports (if not previously faxed to us by your physician)**
- **Referral or Authorization form (if required by your insurance and not previously faxed to us by your primary care doctor)**

As a reminder, your first visit is for a consultation only. This evaluation is to set up the course of treatment that is comfortable for both you and the doctor. It is the doctor's discretion as to whether any prescriptions are provided on the initial visit. You may also be asked to provide a urine sample upon arrival to the office.

Payment, including deductibles, copayments, co-insurance and non-covered expenses are due at the time of your appointment. For your convenience, we accept cash, check, Visa, MasterCard, American Express & Discover.

If you have any questions, please contact our office at (772) 337-3350

Thank you,

The Staff of David M. Glener, M.D.

I have received and read the above: _____ Date: _____
Patient's Signature

PAPERWORK IS 2-SIDED!

TREASURE COAST ANESTHESIOLOGY, P.A., DAVID M. GLENER, M.D.
PATIENT REGISTRATION FORM

(Please Print)					
Today's date:		Primary Physician:		Referring Physician:	
PATIENT INFORMATION					
Last name:		First:	MI	Birth date:	<input type="checkbox"/> M <input type="checkbox"/> F Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no. ()		Work phone no. ()		Cell phone no. ()	
Street address:		Social Security no.		Email:	
City:		State:		ZIP Code:	
Occupation:		Employer:		Employer phone no. ()	
Have you ever seen another pain management physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who?					
Reason for leaving their practice:					
Have you ever filed a malpractice suit? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this visit related to an Automobile Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
WORKERS COMPENSATION INFORMATION					
Is this visit related to a Workers Comp Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you involved in pending litigation? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, attorney's name and telephone number:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		Birth date:	Address (if different):		Home phone no.:
		/ /			()
Occupation:	Employer:	Employer address:			Employer phone no.:
					()
Are you covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Freedom <input type="checkbox"/> Coventry/Summit <input type="checkbox"/> Humana HMO <input type="checkbox"/> Humana PPO					
<input type="checkbox"/> Florida Blue <input type="checkbox"/> United Healthcare <input type="checkbox"/> Cigna <input type="checkbox"/> Medicare Advantage Plan <input type="checkbox"/> Other:					
Subscriber's name:		Subscriber's S.S. no.:		Birth date:	Group no.:
				/ /	
Policy no.:		Co-payment:			
				\$	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
IN CASE OF EMERGENCY					
Name of local friend or relative		Relationship to patient:		Home phone no.:	Work phone no.:
				()	()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TREASURE COAST ANESTHESIOLOGY, P.A., DAVID M. GLENER, M.D. or insurance company to release any information required to process my claims. I understand that co-pays/co-insurance/deductibles are payable at the time services rendered. I also understand and acknowledge that the office is very busy and that a 24hr notice is required for cancellations. If I miss an appointment a "No-Show" fee (\$75 for an office visit & \$200 for procedures/diagnostic testing), will be imposed.</p>					
<div style="border-bottom: 1px solid black; width: 100%;"></div> <i>Patient/Guardian signature</i>				<div style="border-bottom: 1px solid black; width: 100%;"></div> <i>Date</i>	

ASSIGNMENT OF BENEFITS

I hereby authorize and transfer all insurance benefits due to me for services related to my visit, and authorize direct payment to Treasure Coast Anesthesiology, P.A., dba David M. Glener, M.D. I authorize the release of all medical information necessary to process insurance claims associated with my visit. A photo static copy of this assignment shall be considered effective and valid as the original.

FINANCIAL RESPONSIBILITY

I understand that, as a courtesy, Dr. Glener will file my insurance in accordance with the above assignment. After 60 days from the date of service, the total balance will become my responsibility and will be considered due and payable. Should the account be referred to an attorney or collection agency, I agree to pay reasonable attorney fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. I understand that some insurance companies use "usual and customary" fee schedule that often do not reflect the standard charges in our area. I understand that I am responsible for any difference remaining following payment by my insurance company, I certify that I am the patient or am duly authorized by the patient to serve as the patient's agent to execute this document and accept it's terms.

Patient's Signature_____Date_____

Witness_____

PLEASE ASK TO READ "THE NOTICE OF PRIVACY PRACTICES FOR TREASURE COAST ANESTHESIOLOGY, P.A." (AVAILABLE AT THE OFFICE)

After Reading:

Signature below is acknowledging that I have read and reviewed "Notice of Privacy Practices for Treasure Coast Anesthesiology, P.A." I understand that I may request a copy of this document at any time.

Print Name_____Date_____

Patient's signature_____

Patient Name:			Today's Date:		
			<div style="border: 1px solid red; padding: 2px; display: inline-block;"> This column too! </div>		
MEDICAL HISTORY					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack		<input type="checkbox"/> Yes <input type="checkbox"/> No	GERD	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Angina		<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Transient Ischemic Attack		<input type="checkbox"/> Yes <input type="checkbox"/> No	Irritable Bowel Syndrome	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker/AICD		<input type="checkbox"/> Yes <input type="checkbox"/> No	Enlarged Prostate	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Atrial Fibrillation		<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Stones	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension (High Blood Pressure)		<input type="checkbox"/> Yes <input type="checkbox"/> No	Polycystic Kidney	
<input type="checkbox"/> Yes <input type="checkbox"/> No	COPD		<input type="checkbox"/> Yes <input type="checkbox"/> No	Ovarian Cysts	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma		<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis		<input type="checkbox"/> Yes <input type="checkbox"/> No	Cataracts	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Pneumonia		<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Sinusitis	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke		<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures		<input type="checkbox"/> Yes <input type="checkbox"/> No	Hard of Hearing	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease		<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis		<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety Disorder	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Bipolar Disease	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Myasthenia Gravis		<input type="checkbox"/> Yes <input type="checkbox"/> No	Schizophrenia	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio		<input type="checkbox"/> Yes <input type="checkbox"/> No	Dementia	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis		<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV +	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (circle one) A B C		<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes (circle one) NIDDM IDDM		<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreatitis		<input type="checkbox"/> Yes <input type="checkbox"/> No	Scleroderma	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Inflammatory Bowel Disease				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have or have you ever had cancer? If yes, what type?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you now or have you ever used recreational drugs?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been treated for substance abuse? <i>If yes, Circle one: Drugs alcohol</i>				
	What is your height? _____ What is your weight? _____				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have ANY medical problems not mentioned above? <i>If yes, list below:</i>				
1.					
2.					
SOCIAL HISTORY					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever smoked?				
	If yes, how many packs per day?		_____ Packs per day		
	How many years?		_____ # of years	Quit _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcohol? If yes,				
<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	What type?		How much?	
	_____ times a week	Beer Wine Hard liquor		_____ glasses/cans at a time	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do any blood relatives have a history of substance abuse?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you employed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Retired?	
	Current or former occupation:				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently receiving disability?		Reason:		
	Educational level:				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(circle one)</i> some high school, high school diploma, some college, college diploma, graduate school				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have children?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you live alone?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Legal problems or ever been arrested?				
	If yes, please indicate the nature of the problem/arrest:				
FAMILY HISTORY					
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Current age _____	Age at death _____	Cause of death:	
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Current age _____	Age at death _____	Cause of death:	
Siblings	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Current age _____	Age at death _____	Cause of death:	
Any diseases "run in the family"? If yes, what disease and who?					

Patient Name:		Today's Date:	
REVIEW OF SYSTEMS			
	Constitutional		Musculoskeletal
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Changes? Loss or Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint swelling
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	joint stiffness
<input type="checkbox"/> Yes <input type="checkbox"/> No	Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle pains or cramps
	Eyes, Ears, Nose, Mouth & Throat		Integumentary / Skin / Breast
<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash or itching
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred or double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in hair or nails
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss or ringing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast lump
	Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast discharge
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pains		Neurological
<input type="checkbox"/> Yes <input type="checkbox"/> No	Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent or recurring headaches
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath while walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures
	Respiratory	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness or tingling sensation
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tremors
<input type="checkbox"/> Yes <input type="checkbox"/> No	Spitting up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head injury
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty speaking or swallowing
<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing		Psychiatric
	Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety
<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in bowel habits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insomnia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicidal thoughts
<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation		Endocrine
<input type="checkbox"/> Yes <input type="checkbox"/> No	Rectal bleeding or blood in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive thirst or urination
<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain or heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heat or cold intolerance
	Genitourinary	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hair loss or gain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination		Hematologic / Lymphatic
<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning or painful urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding or bruising tendency
<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia
<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Past transfusion
<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney stones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen glands
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual difficulty		Allergic / Immunologic
<input type="checkbox"/> Yes <input type="checkbox"/> No	Male - testicle pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug allergies
<input type="checkbox"/> Yes <input type="checkbox"/> No	Female - pain with periods	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives
<input type="checkbox"/> Yes <input type="checkbox"/> No	Female - irregular periods		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Female - vaginal discharge		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Female - Are you pregnant or		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a chance you are pregnant?		

DIAGNOSTIC STUDIES FOR PAIN			
Type of Imaging or Study		Body Part	What Facility and When?
<input type="checkbox"/> Yes <input type="checkbox"/> No	MRI		
<input type="checkbox"/> Yes <input type="checkbox"/> No	X-Rays		
<input type="checkbox"/> Yes <input type="checkbox"/> No	CT Scan		
<input type="checkbox"/> Yes <input type="checkbox"/> No	EMG/Nerve Conduction Studies		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone Scan		

SURGERY HISTORY		
Type of surgery:	Month & Year Surgery Done:	Doctor who did the surgery:

MEDICATION LIST		
Name of Medication:	Dosage & How often medication taken:	Who prescribed:

PAIN HISTORY

When did your pain begin? _____

What is the quality of your pain? *Circle one:* Aching Burning Stabbing Tingling

☐ Yes ☐ No, Is your pain constant?

What makes your pain worse?

What makes your pain better?

☐ Yes ☐ No, does your pain interfere with sleep?

☐ Yes ☐ No, have you decreased your daily activities because of pain?

☐ Yes ☐ No, do you have sexual difficulties because of pain?

☐ Yes ☐ No, any bowel or bladder incontinence associated with your pain?

☐ Yes ☐ No, do you have weakness or numbness associated with your pain? If so, where? _____

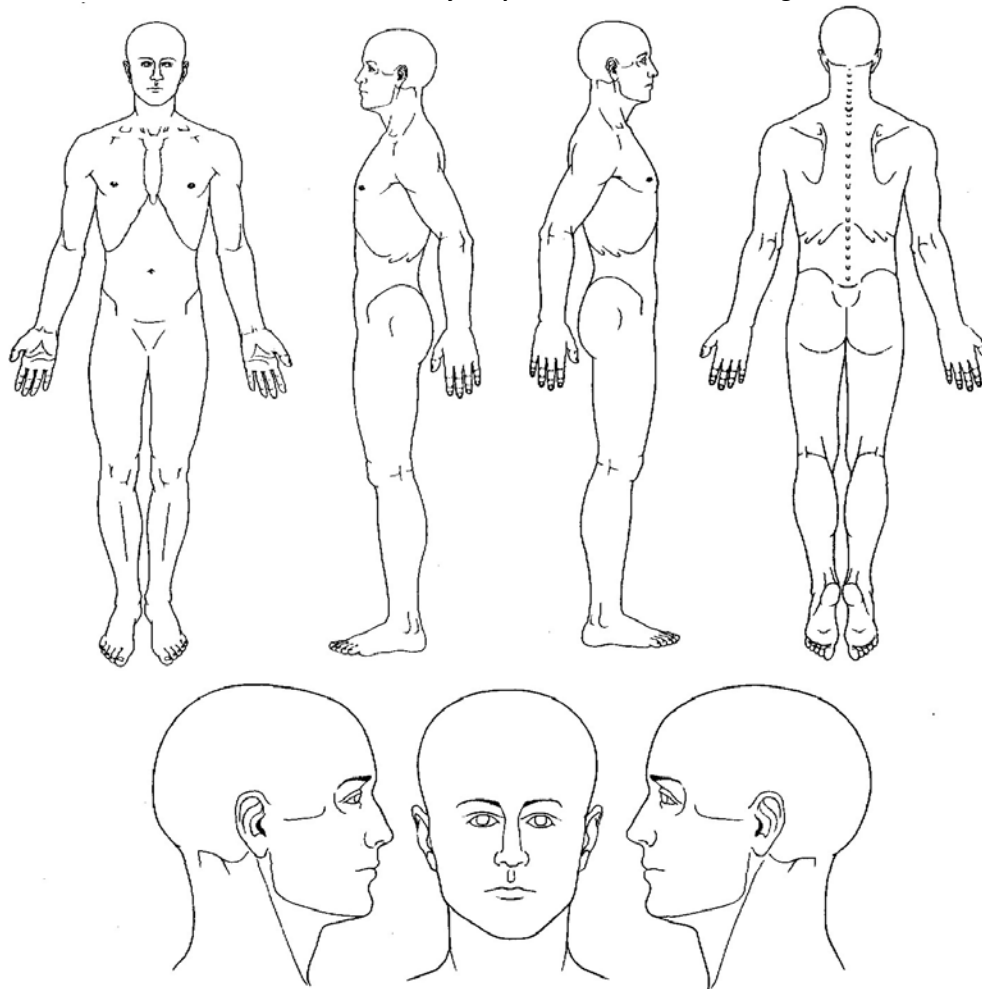
☐ Yes ☐ No, have you had a surgical consultation regarding your pain?

Please check the treatments have you tried in the past to alleviate your pain.

<input type="checkbox"/> Medications	<input type="checkbox"/> Trial of neurostimulation
<input type="checkbox"/> Epidural steroid injection	<input type="checkbox"/> TENS unit
<input type="checkbox"/> Facet joint injections	<input type="checkbox"/> Chiropractic manipulation
<input type="checkbox"/> Sacroiliac joint injections	<input type="checkbox"/> Physical therapy
<input type="checkbox"/> Trigger point injections	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Peripheral nerve block	<input type="checkbox"/> Herbal remedies or supplements

SHOW US WHERE YOUR PAIN IS

Please indicate with an "X" where your pain is located on the diagrams below.



I have read and understood the medical history questionnaire and certify that the answers given by myself or my representative are correct to the best of my knowledge.

PRINT NAME

SIGNATURE

DATE

Medication Management Agreement

This Agreement between _____, ("Patient") and David M. Glener, M.D. is for the purpose of establishing agreement between Dr. Glener and Patient on clear conditions for prescription and use of pain controlling medications prescribed by Dr. Glener for the Patient. Dr. Glener and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by Dr. Glener for the Patient:

01. I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
02. I realize that all of the medications have potential side effects, which have been explained to me, and I will have the recommended laboratory studies required to keep the regimen as safe as possible.
03. I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.
04. I will not use any illegal controlled substances.
05. I will not share, sell or trade my medication for money, goods, or services.
06. I will not attempt to get pain medication from any other health care provider without first obtaining permission from Dr. Glener. Dr. Glener is to be the only physician to prescribe such medication for Patient.
07. I will discontinue all previously used pain medications unless told to continue them by Dr. Glener.
08. I will safeguard my medications from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time. I understand that Dr. Glener will not replace medications.
09. I agree to waive any applicable privilege or right of privacy or confidentiality with the respect to the prescribing of my pain medication and I authorize Dr. Glener and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize Dr. Glener to provide a copy of the Agreement to my pharmacy.
10. I agree that I will submit to a blood or urine test if requested by Dr. Glener to determine compliance with this agreement and my regimen of pain control medication.
11. I agree that I will use my medication at a rate no greater than the prescribed rate, unless given approval by Dr. Glener, and that use of my medication at a greater rate will result in my being without medication for a period of time, and could possibly cause my death.
12. Dr. Glener and Patient agree that this Agreement is essential to Dr. Glener's ability to treat Patient's pain effectively and that failure of Patient to abide by the terms of the Agreement may result in the withdrawal of all prescribed medication by Dr. Glener and the immediate dismissal from Dr. Glener's practice.

This Agreement is entered into on this _____ day of _____.

Physician's Signature

Patient's Signature



David M. Glover, M.D.
543 SW Lake Whitney Place
Suite 102
Port St. Lucie, FL 34986

NW Lake Whitney Pl

NW Peacock Blvd

NW Peacock Blvd

Walmart Supercenter

Bealls Shopping Center

Panera Bread

Starbucks

NW Courtney Cir

Superplay USA

Carmike Cinemas

Outback Steakhouse

Chili's Grill & Bar

Chipotle Mexican Grill

Mountainview Blvd

Lake Charles Blvd

SW California Blvd

SW St. Lucie W Blvd

SW St. Lucie W Blvd

SW Blvd

Google