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:	❑ M ❑ F Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no. ( ) Work phone no. ( )	Cell phone no. ( )
Street address:	Social Security no.
City: State:	ZIP Code:
Occupation: Employer:	Employer phone no. ( )

Have you ever seen another pain management physician? ❑ Yes ❑ No If yes, who?

Reason for leaving their practice:

Have you ever filed a malpractice suit? ❑ Yes ❑ No Is this visit related to an Automobile Accident? ❑ Yes ❑ No

WORKERS COMPENSATION INFORMATION

Is this visit related to a Workers Comp Injury? ❑ Yes ❑ No Are you involved in pending litigation? ❑ Yes ❑ 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? ❑ Yes ❑ No

Please indicate primary insurance ❑ Medicare ❑ Freedom ❑ Coventry/Summit ❑ Humana HMO ❑ Humana PPO

❑ Florida Blue ❑ United Healthcare ❑ Cigna ❑ Medicare Advantage Plan ❑ Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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.

Patient/Guardian signature *Date*

Patient Name:		**Today's Date:**	
MEDICAL HISTORY			
❑ Yes ❑ No	Heart Attack	❑ Yes ❑ No	GERD
❑ Yes ❑ No	Angina	❑ Yes ❑ No	Ulcers
❑ Yes ❑ No	Transient Ischemic Attack	❑ Yes ❑ No	Irritable Bowel Syndrome
❑ Yes ❑ No	Pacemaker/AICD	❑ Yes ❑ No	Enlarged Prostate
❑ Yes ❑ No	Atrial Fibrillation	❑ Yes ❑ No	Kidney Stones
❑ Yes ❑ No	Hypertension (High Blood Pressure)	❑ Yes ❑ No	Polycystic Kidney
❑ Yes ❑ No	COPD	❑ Yes ❑ No	Ovarian Cysts
❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Glaucoma
❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Cataracts
❑ Yes ❑ No	Recent Pneumonia	❑ Yes ❑ No	Chronic Sinusitis
❑ Yes ❑ No	Stroke	❑ Yes ❑ No	Sleep Apnea
❑ Yes ❑ No	Seizures	❑ Yes ❑ No	Hard of Hearing
❑ Yes ❑ No	Parkinson's Disease	❑ Yes ❑ No	Depression
❑ Yes ❑ No	Multiple Sclerosis	❑ Yes ❑ No	Anxiety Disorder
❑ Yes ❑ No	Muscular Dystrophy	❑ Yes ❑ No	Bipolar Disease
❑ Yes ❑ No	Myasthenia Gravis	❑ Yes ❑ No	Schizophrenia
❑ Yes ❑ No	Polio	❑ Yes ❑ No	Dementia
❑ Yes ❑ No	Meningitis	❑ Yes ❑ No	HIV +
❑ Yes ❑ No	Hepatitis (circle one) A B C	❑ Yes ❑ No	Rheumatoid Arthritis
❑ Yes ❑ No	Diabetes (circle one) NIDDM IDDM	❑ Yes ❑ No	Lupus
❑ Yes ❑ No	Pancreatitis	❑ Yes ❑ No	Scleroderma
❑ Yes ❑ No	Inflammatory Bowel Disease		
❑ Yes ❑ No	Do you have or have you ever had cancer? If yes, what type?		
❑ Yes ❑ No	Do you now or have you ever used recreational drugs?		
❑ Yes ❑ No	Have you ever been treated for substance abuse? *If yes, circle one:* Drugs alcohol		
	What is your height?_____ What is your weight?_____		
❑ Yes ❑ No	Do you have ANY medical problems not mentioned above? *If yes, list below:*		
1.			
2.			

SOCIAL HISTORY			
❑ Yes ❑ No	Do you smoke?		
❑ Yes ❑ No	Have you ever smoked?		
	If yes, how many packs per day?	_____Packs per day	
	How many years?	_____# of years	Quit_____
❑ Yes ❑ No	Do you drink alcohol? If yes,		
❑ Yes ❑ No	How often?	What type?	How much?
	___times a week	Beer Wine Hard liquor	___glasses/cans at a time
❑ Yes ❑ No	Do any blood relatives have a history of substance abuse?		
❑ Yes ❑ No	Are you employed?	❑ Yes ❑ No	Retired?
	Current or former occupation:		
❑ Yes ❑ No	Are you currently receiving disability?	Reason:	
	Educational level:		
❑ Yes ❑ No	*(circle one)* some high school, high school diploma, some college, college diploma, graduate school		
❑ Yes ❑ No	Do you have children? ❑ Yes ❑ No	Do you live alone?	
❑ Yes ❑ No	Legal problems or ever been arrested?		
	If yes, please indicate the nature of the problem/arrest:		

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

DIAGNOSTIC STUDIES FOR PAIN			
Type of Imaging or Study		**Body Part**	**What Facility and When?**
❑ Yes ❑ No	MRI		
❑ Yes ❑ No	X-Rays		
❑ Yes ❑ No	CT Scan		
❑ Yes ❑ No	EMG/Nerve Conduction Studies		
❑ Yes ❑ 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?_____

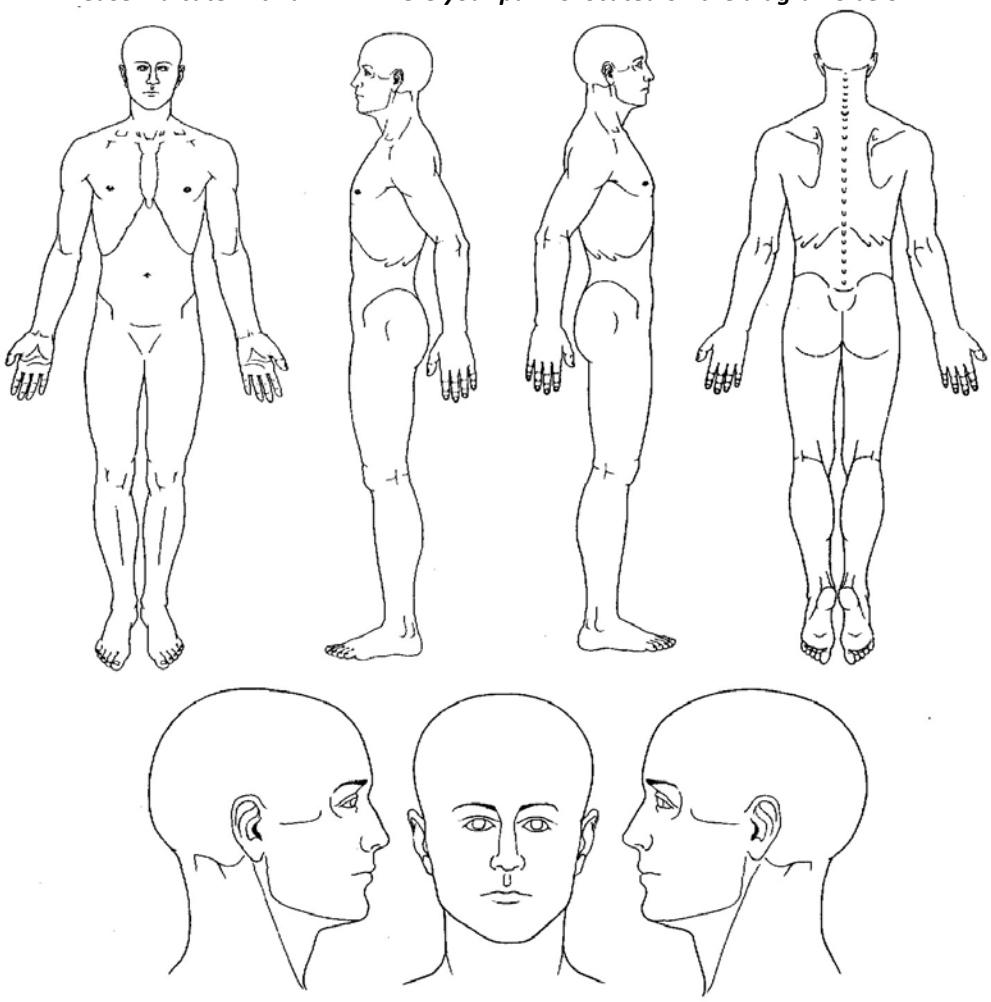
❑ Yes ❑ No, have you had a surgical consultation regarding your pain?

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

❑ Medications	❑ Trial of neurostimulation
❑ Epidural steroid injection	❑ TENS unit
❑ Facet joint injections	❑ Chiropractic manipulation
❑ Sacroiliac joint injections	❑ Physical therapy
❑ Trigger point injections	❑ Acupuncture
❑ Peripheral nerve block	❑ 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 my 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