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PAIN MANAGEMENT CENTER.

DATE: _____

LAST NAME: _____ **ADDRESS:** _____

FIRST NAME: _____ **CITY:** _____

MIDDLE INITIAL: _____ **STATE:** _____

SS#: _____ **ZIP CODE:** _____

BIRTHDATE: _____ **HOME PHONE:** _____

EMPLOYER: _____ **WORK PHONE:** _____

MARITAL STATUS: _____ **SEX:** _____ **AGE:** _____

REFERRED BY: _____ **PRIMARY DOCTOR:** _____

E-MAIL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **SECOND INSURANCE:** _____

POLICY: _____ **POLICY:** _____

GROUP: _____ **GROUP:** _____

PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to rendering of care, including treatment, administration of anesthetic and performance of diagnostic and /or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is responsibility of the staff to carry out the instruction of such physician. (s)

ASSIGNMENT BENEFICITS: I hereby assign payment directly to the physician (s) accepting this assignment of medical benefits responsible for the charges no covered by this assignment or for any and all charges, which the insurance carrier declines to pay. It is further agreed that any credit balance, resulting from payment of insurance or other services may be applied to any other accounts owed to said physician (s) by the insured or his/her family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is may be liable under a contract to the physician (s) or to the patient or to a family member or employer of the patient for all part of the physician(s) charges, including but not limited to , insurance companies, workers compensation carries, welfare funds or the patient's employer.

MEDICARE.

MEDICARE CERTIFICATION-PAYMENT CLASSIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT AND REQUEST. I certify that the information given by applying got payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to the Social Security Administration or its intermediary carries any information needed for this related Medicare, Medicaid or other party claim. I request that payment of responsible for my health insurance deductible and co-insurance.

SIGNATURE OF PATIENT/INSURED PARTY: _____

DATE: _____

| | | | |
|---------------------------|--------------|-----|----|
| Do you have pain when you | Lie down | YES | NO |
| | Sitting down | YES | NO |

| | | | |
|--------------------------------|-----------------|----|----|
| <i>Tiene dolor cuando esta</i> | <i>Acostado</i> | SI | NO |
| | <i>Sentado</i> | SI | NO |

How do you get relief? _____

Como obtiene alivio de su dolor? _____

| | | |
|-----------------------------|-----|----|
| Are you depressed? | YES | NO |
| <i>Esta usted deprimido</i> | SI | NO |

| | | |
|-----------------------|---------------------|----|
| Do you feel Weakness? | YES | NO |
| | <i>Where?</i> _____ | |

| | | |
|--------------------------------|---------------------|----|
| <i>Siente usted debilidad?</i> | SI | NO |
| | <i>Donde?</i> _____ | |

| | | |
|-----------------------|---------------------|----|
| Do you fell numbness? | YES | NO |
| | <i>Where?</i> _____ | |

| | | |
|-------------------------------------|---------------------|----|
| <u>Siente usted Adormecimiento?</u> | SI | NO |
| | <i>Donde?</i> _____ | |

| | | |
|--------------------------|-----|----|
| Recent urinary problems? | YES | NO |
|--------------------------|-----|----|

| | | |
|-------------------------------|----|----|
| Problemas urinarios reciente? | SI | NO |
|-------------------------------|----|----|

| | | |
|----------------|-----|----|
| Constipation? | YES | NO |
| Estrenimiento? | SI | NO |

Do you currently have or have you ever had one of the following health problems?

Padece usted ahora o ha padecido de algunos de estos problemas de salud?

| | | |
|----------------------------------|-----|----|
| Epilepsy, Seizures | YES | NO |
| Epilepsia Convulsiones | SI | NO |
| Bronchitis, other lung disease | YES | NO |
| Problemas con los pulmones | SI | NO |
| Thyroid Disease | YES | NO |
| Enfermedad de las Tiroides | SI | NO |
| Liver disease, Hepatitis | YES | NO |
| Enfermedad del Hgado | SI | NO |
| Psychiatric Disorder | YES | NO |
| Enfermedad de los Nervios | SI | NO |
| Tuberculosis | YES | NO |
| Tuberculosis | SI | NO |
| Heart Disease | YES | NO |
| Enfermedad del Corazon | SI | NO |
| High blood pressure | YES | NO |
| Presion Alta | SI | NO |
| Kidney Disease | YES | NO |
| Enfermedad del rinon | SI | NO |
| Bladder Problems | YES | NO |
| Enfermedad de la vejiga urinaria | SI | NO |

| | | |
|---|------------|----------|
| Discharge from urethra, penis Flujo de la uretra o pene | YES SI | NO NO |
| Bowel Problems Problemas Intestinales | YES SI | NO NO |
| Hearing Problems Problemas visuals | YES SI | NO NO |
| Stroke Embolia Cerebral | YES SI | NO NO |
| Diabetes Diabetes | YES YES | NO NO |
| Ulcers, other stomach problems Ulceras o otros problemas de estomago | YES SI | NO NO |
| Joint Disease, Arthritis Problemas de Artritis | YES SI | NO NO |
| Drug Allergies Alergias a Medicinas | YES SI | NO NO |

List of medicines that you are taking that are **NO FOR PAIN.**

Lista de las medicinas que no son para el dolor. **NO PARA EL DOLOR**

List of Surgeries.

Mencione las Cirugias que ha tenido.

Do you smoke?

YES

NO

Usted fuma?

SI

NO

Do you drink Alcohol?

YES

NO

Usted toma Alcohol?

SI

NO

If you drink alcohol, do you drink to relieve pain?

YES

NO

Usted toma alcohol para aliviar su dolor?

SI

NO