# VICTORY PAIN CENTER

HOWARD W. POPP M.D., M.S., M.B.A.
VIVIAN HERNANDEZ-POPP M.D.
8740 NORTH KENDALL DRIVE
SUITE 114
MIAMI FLORIDA 33176
PH: 305.275.9990
FAX: 305.275.9433
VPCDESK@VICTORYPAINCENTER.COM

## PATIENT INFORMATION

INFORMACION DEL PACIENTE

| | | |
|---|---|---|
| **LAST NAME:** (APELLIDO): | **FIRST NAME:** (NOMBRE): | |
| **ADDRESS:** (DIRECCION): | | |
| **CITY:** (CIUDAD): | **STATE:** (ESTADO): | **ZIP CODE:** |
| **DATE OF BIRTH:** (FECHA DE NACIMIENTO): / / | **SS #:** | |
| **HOME PHONE:** (TEL. DE LA CASA): | **WORK PHONE:** (TEL DEL TRABAJO): | |
| **CELL:** (TEL. CELULAR): | **SEX:** □ M □ F □ Other (SEXO): | |
| **REFERRAL Dr:** (REFERIDO POR EL Dr): | **PHONE:** **FAX:** | |
| **EMAIL:** | | |

| |
|---|
| **RELATION TO INSURED:** □ SELF □ SPOUSE □ PARENT □ OTHER: (RELACION DEL ASEGURADO): □ EL MISMO □ ESPOSO (A) □ PADRE/MADRE □ OTRO: |
| **INS COMP. / W/C:** |
| **BILLING ADDRESS:** |
| **PHONE:** **FAX:** |
| **MEMBER ID:** **GROUP:** |
| **CASE MANAGER:** |
| **PHONE:** **FAX:** |
| **C/M EMAIL:** |
| **ADJUSTER:** |
| **PHONE:** **FAX:** |
| **ADJ EMAIL:** |
| **DATE OF ACCIDENTE:** / / **CLAIM #:** |
| **NAME OF ATTORNEY:** |
| **PHONE:** **FAX:** |

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## REGISTRATION

Patient Name and Last Name: _____

Responsible Party (If a Minor): _____ Phone:_____

Address: _____

Sex: □ M □ F Age: _____ Birthdate: _____ □ Single □ Married □ Widowed □ Separated □ Divorced

Patient Employed By: _____

Business Address: _____

Occupation:_____ Business Phone: _____

SPOUSE (OR RESPONSIBLE PARTY) EMPLOYED BY: _____

Business Address: _____

Occupation:_____ Business Phone: _____

Purpose of Visit: _____

Who is responsible for this account? _____ Relationship to Patient:_____

Social Security #:_____

Do you have Medical Insurance? □ No □ Yes If Yes,

Name of Primary Insurer: _____ ID: _____ GROUP: _____

Name of Secondary Insurer: _____ ID: _____ GROUP:_____

I prefer to:

□ Pay my balance in full at time of service. □ Pay my balance in full upon receipt to first statement. □ Make payment arrangements prior to services being rendered.

In case of emergency, who should be notified? _____ Phone: _____

Your Drugstore Name: _____ Phone: _____

How did you learn of our practice? _____

### ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ nereby authorized _____
(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

to pay and hereby assign directly to **Howard W. Popp M.D., M.S., M.B.A** all benefits, if any, otherwise payable to me for his/her services as descrited on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and pay **Howard W. Popp M.D., M.S., M.B.A** will be credited to my account, in accordance with the above assignment.

_____ _____
(AUTHORIZED SIGNATURE ) (DATE)

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## HEALTH HISTORY

**NAME:**_____ **DOB:**_____ **Today's Date:**_____

What is your reason for visit?

**SYMPTOMS:** CHECK □ SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

### GENERAL

□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Loss of sleep
□ Loss of weight
□ Nervousness
□ Numbness
□ Sweats

### CARDIOVASCULAR

□ Chest Pain
□ High blood pressure
□ Irregular heart beat
□ Low blood pressure
□ Poor circulation
□ Rapid heart beat
□ Sewlling of ankles
□ Varicose veins
□ Heart attack

### MUSCLE/JOINT/BONE PAIN, WEAKNESS, MUMBNESS IN:

□ Arm □ R □ L
□ Back □ U □ L
□ Hand □ R □ L
□ Hip □ R □ L
□ Leg □ R □ L
□ Neck □ R □ L
□ Shoulder □ R □ L
□ Feet □ R □ L

### SKIN

□ Bruise easily
□ Hives
□ Itching
□ Rash
□ Sore that won't heal

### WOMEN ONLY

□ Abnormal Pap Smear
□ Bleeding between periods
□ Breast lump
□ Extreme menstrual pain
□ Hot flashes
□ Nipple discharge
□ Painful intercourse
□ Vaginal discharge
□ Other

□ Date of last menstrual period
_____

□ Have you had a mammogram?_____

□ Are you pregnant?_____

□ Number of children _____

### GASTROINTESTINAL

□ Acid reflux
□ Appetite poor
□ Bowel changes type_____
□ Constipation
□ Diarrhea
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Heart burn
□ Indigestion
□ Nausea
□ Rectal bleeding
□ Stomach pain
□ Vomiting
□ Vomiting blood

### GENITO-URINARY

□ Blood in urine
□ Frequent urination
□ Lack of bladder control
□ Painful urination

### EYE,EAR, NOSE, THROAT

□ Bleeding gums
□ Blurred vision
□ Difficulty swallowing
□ Double vision
□ Earache
□ Ear discharge
□ Hay fever
□ Hoarseness
□ Loss of hearing
□ Nosebleeds
□ Persistent cough
□ Ringing ears
□ Sinus problems
□ Vision - Flashes
□ Vision – Halos

### MEN ONLY

□ Breast lump
□ Erection difficulties
□ Lump in testicles
□ Penis discharge
□ Sore in penis
□ Other _____

**CONDITIONS:** CHECK □ CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

□ AIDS
□ Alcoholism
□ Anemia
□ Anorexia
□ Appendicitis
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Breast lump
□ Bronchitis
□ Bulimia
□ Cancer Type _____
□ Cataracts
□ Chemical Dependency
□ Chicken Pox
□ Diabetes □ Insulin Dependent □ Non Insulin
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Goiter
□ Gonorrhea
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herpes
□ High Cholesterol
□ HIV Positive
□ Kidney Disease
□ Liver Disease
□ Measles
□ Migraine Headaches
□ Miscarriage
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Pacemaker
□ Pneumonia
□ Polio
□ Prostate Problem
□ Psychiatric Care
□ Rheumatic Fever
□ Scarlet Fever
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Typhoid Fever
□ Ulcers
□ Vaginal Infections
□ Vaginal Disease

**ALLERGIES:** TO MEDICATIONS, SUBSTANCE OR FOOD

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## FAMILY HISTORY

| RELATION | AGE | STATE OF HEALTH | AGE AT DEATH | CAUSE OF DEATH |
|---|---|---|---|---|
| **Father** | | | | |
| **Mother** | | | | |
| **Brothers** | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Sisters** | | | | |
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## HOSPITALIZATIONS

| YEAR | HOSPITAL | REASON FOR HOSPITALIZATION AND OUTCOME |
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Have you ever had a blood transfusion? □ YES □ NO If yes, please give approximate date _____

| SERIOUS ILLNESS / INJURIES | DATE | OUTCOME |
|---|---|---|
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## OCCUPATIONAL CONCERNS

**CHECK □ IF YOUR WORK EXPOSES YOU TO THE FOLLOWING:**

□ Stress
□ Hazardous Substances
□ Heavy Lifting
□ Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this forms.

_____ _____

**Patient Signature** **Date**

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## PERSONAL MEDICATION LIST

**Lista Personal de Medicinas**

Patient Name and Last Name: _____ D.O.B: _____

| **Prescription Medications**<br>**Medicinas Recetadas** | **Dose**<br>**Dosis** | **Time (s) of the day** |
|---|---|---|
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| **Over The Counter Medications** | **Dose** | **Time (s) of the Day** |
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**Your Pharmacy Name, Address and Phone #:**_____

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## ACKNOWLEDGMENT OF RECEIPT

## OF

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices (pages 1-4) and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

**Patient Name (please print)** **Date**

_____

**Parent or Authorized Representative (If applicable)**

_____

**Signature**

---

Internal Use Only;

If the patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented

to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

Privacy Officer's acknowledgement: _____

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# OPIOID RISK TOOL (ORT)

**Name:** _____ **Date:** _____

| Mark each box that applies | | Female | Male |
|---|---|---|---|
| 1.- **Family History** of substance abuse | * Alcohol<br>* Illegal Drugs<br>* Prescription drugs | ( )<br>( )<br>( ) | ( )<br>( )<br>( ) |
| 2.- **Personal History** of substance abuse | * Alcohol<br>* Illegal Drugs<br>* Prescription drugs | ( )<br>( )<br>( ) | ( )<br>( )<br>( ) |
| 3.- Age (mark box if 16-45 years) | | ( ) | ( ) |
| 4.- History of preadolescent sexual abuse | | ( ) | ( ) |
| 5.- Psychological disease | Attention-deficit/hyperactivity disorder,<br>Obsessive-compulsive disorder,<br>Bipolar disorder,<br>Schizophrenia,<br>Depression | ( )<br>( )<br>( )<br>( )<br>( ) | ( )<br>( )<br>( )<br>( )<br>( ) |

Signature of Patient

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## CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by **Victory Pain Center, Howard W. Popp. M.D., P.A.** (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient:

_____

_____

_____

**Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records if Patient has NOT initialed the appropriate categories listed below:**

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Substance Abuse Information

_____ Sexually Transmitted Disease Information

_____ If Patient is under the age of eighteen (18), Pregnancy Information

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please initial the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is: _____

_____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ The Patient may contact the Practice and provides the appropriate information (including the Patient's name, date of birth and/or social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

**I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I IIAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT T0 THE ABOVE STATED TERMS.**

**Date:_____ Time_____ AM/PM.**

_____

**Signature of Patient (or Authorized Representative*)**

_____

**Please Print Name**

***Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:**_____
_____
_____
_____
_____
_____

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## BRIEF PAIN INVENTORY

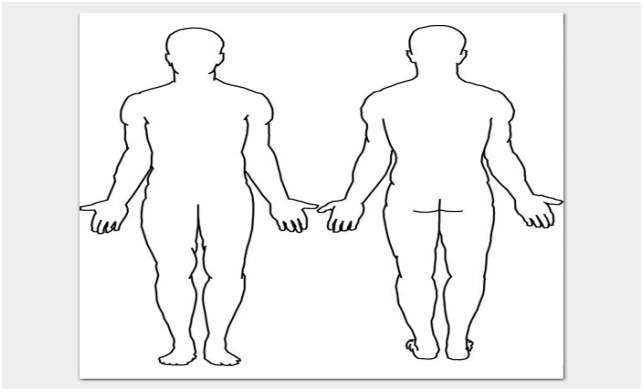
**Name:** _____ **Date:** _____

**1.-**Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. **Yes** 2. **No**

**2.-** On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

**Right Front Left** **Left Back Right**



3.- Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

**No Pain** **Pain as bad as you can imagine**

**4.-** Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

**No Pain** **Pain as bad as you can imagine**

**5.-** Please rate you pain by circling the one number that best describes your pain on the average.

0 1 2 3 4 5 6 7 8 9 10

**No Pain** **Pain as bad as you can imagine**

**6.-** Please rate your pain by circling the one number that tells how much pain you have right now.

0 1 2 3 4 5 6 7 8 9 10

**No pain** **Pain as bad as you can imagine**

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**7.-** What treatment or medications are you receiving for your pain?

_____

_____

**8.-** In the last 24 hours. How much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**No Relief** **Complete Relief**

**9.-** Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

**(A) General Activity**

0 1 2 3 4 5 6 7 8 9 10

**Does not Interfere** **Completely Interferes**

**(B) Mood**

0 1 2 3 4 5 6 7 8 9 10

**Does not Interfere** **Completely Interferes**

**(C) Walking Ability**

0 1 2 3 4 5 6 7 8 9 10

**Does not Interfere** **Completely Interferes**

**(D) Normal Work (includes both work outside the home and housework)**

0 1 2 3 4 5 6 7 8 9 10

**Does not Interfere** **Completely Interferes**

**(E) Relations with other people**

0 1 2 3 4 5 6 7 8 9 10

**Does not Interfere** **Completely Interferes**

**(F) Sleep**

0 1 2 3 4 5 6 7 8 9 10

**Does not Interfere** **Completely Interferes**

**(G) Enjoyment of life**

0 1 2 3 4 5 6 7 8 9 10

**Does not Interfere** **Completely Interferes**

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## STRATFORD DISABILITY PAIN SCALE

**PATIENT NAME:** **DATE: / /**

| | ACTIVITIES | EXTREME DIFFICULTY OR UNABLE TO PERFORM ACTIVITY | QUITE A BIT OF DIFFICULTY | MODERATE DIFFICULTY | A LITTLE BIT OF DIFFICULTY | NO DIFFICULTY |
|---|---|---|---|---|---|---|
| A. | ANY OF YOUR USUAL WORK, HOMEWORK OR SCHOOL ACTIVITIES | 0 | 1 | 2 | 3 | 4 |
| B. | YOUR USUAL HOBBIES, RECREATIONAL OR SPORTING ACTIVITIES | 0 | 1 | 2 | 3 | 4 |
| C. | GETTING INTO OR OUT OF THE BATH | 0 | 1 | 2 | 3 | 4 |
| D. | WALKING BETWEEN ROOMS | 0 | 1 | 2 | 3 | 4 |
| E. | PUTTING ON YOUR SHOES OR SOCKS | 0 | 1 | 2 | 3 | 4 |
| F. | SQUATTING | 0 | 1 | 2 | 3 | 4 |
| G. | LIFTING AN OBJECT, LIKE BAG OF GROCERIES FROM THE FLOOR | 0 | 1 | 2 | 3 | 4 |
| H. | PERFORMING LIGHT ACTIVITIES AROUND YOUR HOME | 0 | 1 | 2 | 3 | 4 |
| I. | PERFORMING HEAVING ACTIVITIES AROUND YOUR HOME | 0 | 1 | 2 | 3 | 4 |
| J. | GETTING INTO OR OUT OF A CAR | 0 | 1 | 2 | 3 | 4 |
| K. | WALKING 2 BLOCKS | 0 | 1 | 2 | 3 | 4 |
| L. | WALKING A MILE | 0 | 1 | 2 | 3 | 4 |
| M. | GOING UP OR DOWN 10 STAIRS (ABOUT 1 FLIGHT OF STAIRS) | 0 | 1 | 2 | 3 | 4 |
| N. | STANDING FOR 1 HOUR | 0 | 1 | 2 | 3 | 4 |
| O. | SITTING FOR 1 HOUR | 0 | 1 | 2 | 3 | 4 |
| P. | RUNNING ON EVEN GROUND | 0 | 1 | 2 | 3 | 4 |
| Q. | RUNNING ON UNEVEN GROUND | 0 | 1 | 2 | 3 | 4 |
| R. | MAKING SHARP TURNS WHILE RUNNING FAST | 0 | 1 | 2 | 3 | 4 |
| S. | HOPPING | 0 | 1 | 2 | 3 | 4 |
| T. | ROLLING OVER IN BED | 0 | 1 | 2 | 3 | 4 |
| | COLUMN TOTALS: | | | | | |

**SCORE _____ /80**