PATIENT CONTACT INFORMATION

Patient Name: _____ Date: _____

Address: _____ City: _____ Zip:_____

DOB: _____ SS#: _____

Home Phone: ( ) _____-_____ Cell Phone : ( ) _____-_____

Emergency Contact-1: Name_____ ( ) _____-_____

Emergency Contact-2: Name_____ ( ) _____-_____

Primary Insurance:

Insurance Name: _____ Phone: ( ) _____-_____

ID/CLAIM#: _____

Secondary Insurance:

Insurance Name: _____ Phone: ( ) _____-_____

ID/CLAIM#: _____

Please hand the front desk your current insurance card.

THANK YOU FOR YOUR TIME

CHRONIC PAIN INITIAL INFORMATION

PLEASE COMPLETE THIS FORM AS CAREFULLY AS POSSIBLE.

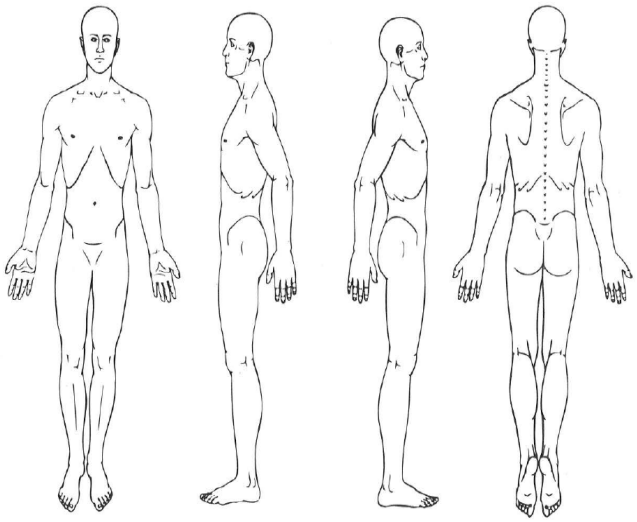
PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____

REGARDING THE LOCATION OF YOUR PAIN:

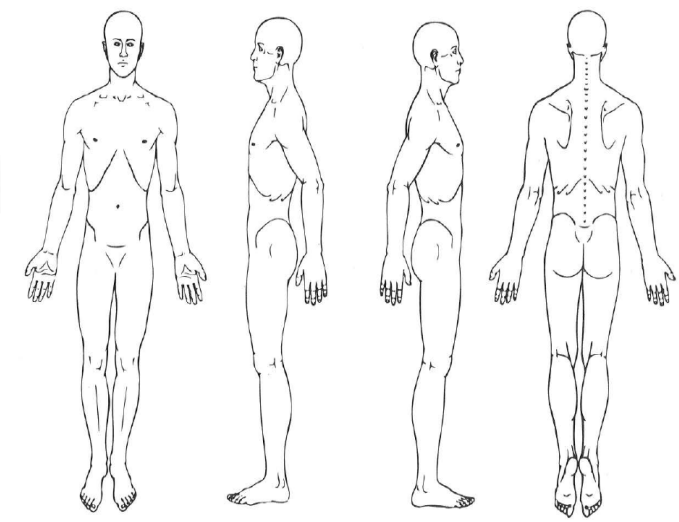
Mark the areas of your pain

R L L R L R

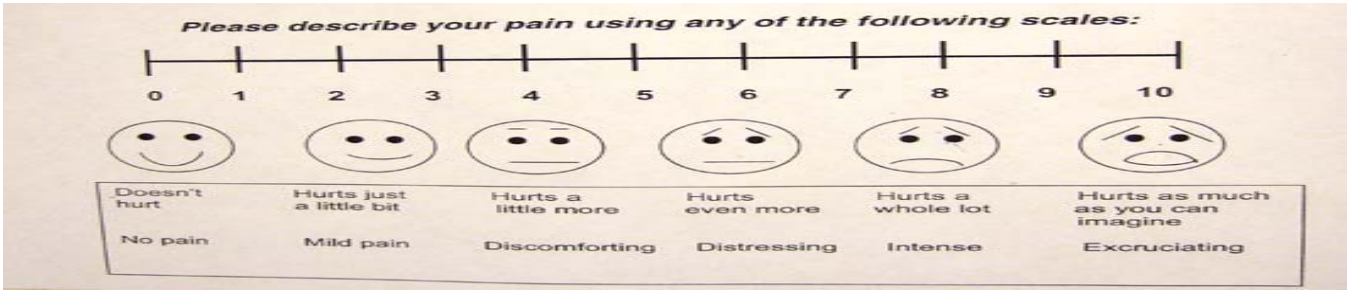


Mark the areas of your numbness or shooting pain

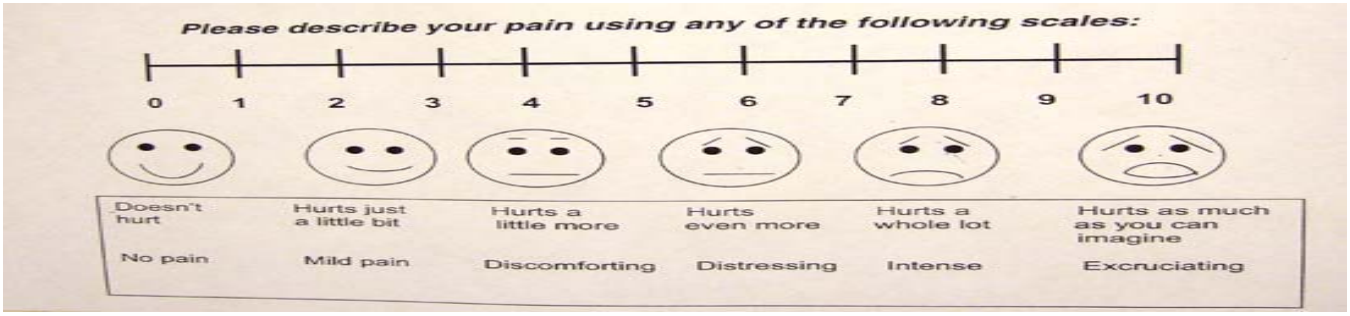
R L L R L R



- On the following scale, circle the range of intensity of your pain **MOST** of the time:



- On the following scale circle the range of intensity of your pain when it's **WORST:**



Please list your approximate height and weight:

Height _____ Weight _____

- Circle the word or words which **BEST** describe your pain when it is at its **WORST**

CONSTANT	INTERMITTENT	SHARP	ACHY
DULL	BURNING	THROBBING	DEEP
TINGLING	STABBING	NUMBESS	OTHER _____

- Do you have any radiating/shooting pain, numbness, or tingling sensations? YES NO

  If SO where do you feel this? SHOULDER / ARM / HAND / BUTTOCKS / LEG / FOOT

- Do you have any weakness? YES NO

  If YES, where? ARMS R/L LEGS R/L HANDS R/L KNEES R/L

- What makes your pain WORSE? _____

- What makes your pain BETTER? _____

- How long can you sit? _____

- How far or long can you walk before having to stop due to pain? _____
  - If walking does not affect your pain.

- Do you need a cane, walker, or wheelchair to assist you in your movement? YES NO

  If YES, which do you use? CANE / WALKER / WHEELCHAIR

- Does your pain interfere with your sleep or your normal lifestyle? YES NO

- Have you undergone any psychological counseling for CHRONIC PAIN or DEPRESSION, if present? YES NO

- Do you feel depressed at times? YES NO

- Have you undergone physical therapy? YES NO
  If so how much relief? _____

- Have you undergone chiropractic manipulation? YES NO
  If so how much relief? _____

- Have you undergone acupuncture? YES NO
  If so how much relief? _____

ALLERGIES:
Please list ALL allergies that you are aware of (including drug allergies, food allergies, and environmental allergies)

Allergy	Reaction to the substance
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

OTHER MEDICAL HISTORY
Please check any conditions that you have had in the past or currently have now.

___ High Blood Pressure
___ Heart Trouble
- ___ Angina
- ___ Palpitations
- ___ Congestive Heart Failure

___ Stroke
___ Arthritis
- ___ Osteoarthritis
- ___ Rheum aid Arthritis
- ___ Gout

___ Diabetes
- ___ Diet Controlled
- ___ Use Hypoglycemia Pills
- ___ Use Insulin

___ Lung Disease
- ___ Asthma
- ___ Emphysema
- ___ Bronchitis

___ Hemophilia
___ Bleeding Trouble
___ Peptic Ulcer Disease
___ Hostel Hernia
___ Gastritis

___ Cancer
- ___ Breast
- ___ Pancreatitis
- ___ Acute
- ___ Chronic

___ Liver Trouble
___ Hepatitis
___ Chronic Liver Failure
___ Gall Stones
- ___ Acute
- ___ Chronic

___ Thyroid Trouble
- ___ Hyperthyroid
- ___ Hypothyroid

___ Kidney Trouble
___ Frequency of kidney infections

___ Kidney Stones
___ Renal Failure
___ Cholesterol
- ___ High

___ Bleeding trouble

- Have you been on blood thinners? YES NO
  If YES how many times _____, how long _____

- Previous surgeries: Date:

_____	_____
_____	_____
_____	_____
_____	_____

- Previous injuries: Date:

_____	_____
_____	_____
_____	_____
_____	_____

Any work related? _____

Smoke: □ Yes □ No □ Quit If yes explain: _____

Drink: □ Yes □ No □Quit If yes explain: _____

Social Status: □ Married □ Single □ Other: _____

Children □ Yes □ No If yes how many: _____

Any family history with significant problems? YES NO

_____

_____

Please list any additional comments: _____

_____

_____

MEDICATIONS:

Please list ALL medications taken for medical conditions OTHER than the medication you listed for pain previously

PLEASE BRING A LIST OF ALL CURRENT MEDICATION TO EACH VISIT.

Medication	Prescribing Phys.	Dose	Amount per day average
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List any medications that you have already used (to the best of your knowledge) that have **NOT** helped your pain.

DRUG	Adverse reaction if applicable
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

CURRENT COMPLAINTS

What are your current medical complaints? (Please be specific and describe when **pain began** and the **intensity**, **frequency** of pain or **swelling** on each body part below:

HEAD: _____
_____
_____
_____
_____

NECK: _____
_____
_____
_____
_____

UPPER BACK: _____
_____
_____
_____
_____
_____

MID BACK: _____
_____
_____
_____
_____

LOW BACK: _____
_____
_____
_____
_____

OTHER: _____
_____
_____
_____
_____
_____

REASON FOR VISIT: _____

_____

_____

Please describe what caused your pain below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

INTEGRATED HEALTH SERVICES,
INCORPORATED
Eduardo Anguizola, M.D. 2050 N. Tustin Ave.
*Anesthesiologist/Pain Management** Santa Ana, CA 92705

Phone Number: (714) 543-2554
Facsimile Number: (714) 543-2212

Authorization For Release of Patients Records

I hereby authorize (name and address of organization)_____

_____to release requested records

obtained in the course of treatment of_____
(Name of Patient including AKA's, Maiden etc.)

_____/_____at this facility.
(Date of Birth) (Social Security Number)

Please forward records promptly to:

Integrated Health Services
2050 N. Tustin Ave.
Santa Ana, Ca. 92705

Such disclosure shall be limited to the following specific information from_____ to present.

- ☐ Narrative Reports
- ☐ Exam/Progress Notes
- ☐ Evaluation
- ☐ Operative Report
- ☐ Lab/Diagnostic Studies Results
- ☐ Diagnostic Films- MRI, CT, X-Rays
- ☐ Complete Records
- ☐ Other _____

Dated _____ _____
(Signature of Patient)

_____
(Print Name)

Dated _____ _____
(Signature of Parent or Guardian

Integrated Health Services
MEDICAL CORPORATION

2050 N Tustin Ave
Santa Ana, Ca 92705
Phone: (714) 543-2554
Fax: (714) 835-1383

NARCOTICS AGREEMENT

We are committed to doing all we can to treat your chronic pain condition. In some case, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws for proper and controlled substance use. The words "we" and "our" refer to the facility and the words "I","you","me" or "my" refer to you the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescription for controlled substances from any other physicians, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
2. I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.
3. I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This mean I may have any or all of the following symptoms: runny nose, yawning, large pupils, goose bumps, abdominal pain/cramping, diarrhea, irritability, aches throughout my body and a flu like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.
4. You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed.

5. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
6. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in section 1 above. I will not use, purchase or to otherwise obtain illegal drugs, including marijuana, cocaine, etc. I understand that driving while underneath influence of any substance, including q a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs), which impairs my driving ability, may result in DUI charges.
7. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
8. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
9. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.
10. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies; our office must be informed.
    The pharmacy that you have selected is:

    _____ Phone: _____
11. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.
12. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

_____
Patient's full name

_____ _____
Patient's signature Date

_____
Physician's full name

_____ _____
Physician's signature Date

_____
Witness

_____
Date

Assignment of Benefits Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits In consideration of services provided by Dr. Eduardo E Anguizola, I hereby assign and transfer to Dr. Eduardo E. Anguizola any and all rights which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Dr. Eduardo E. Anguizola to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay Dr. Eduardo E. Anguizola in accordance with the regular rates and terms. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Dr. Eduardo E. Anguizola.

If my account is placed with a collection agency, an additional 25% will be added to my balance.

Authorization to Release Information
I hereby authorize Dr. Eduardo E. Anguizola to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Eduardo E. Anguizola on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Print patient name Patient Signature & Date