PATIENT CONTACT INFORMATION

Patient Name: ___________________________________ Date: ____________

Address: _______________________________ City: ____________ Zip: __________

DOB: _______________________ SS#: ________-_________-___________

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

Emergency Contact-1: Name__________________________ ( ) _____-______

Emergency Contact-2: Name__________________________ ( ) _____-______

<u>Current Attorney</u>: (Workers Comp / Personal Injury Patients Only)

Attorneys Name: ______________________________ Phone: ( ) _____-______

Address: _______________________________ City: ____________ Zip: __________

<u>Current Insurance:</u>

Insurance Name: _____________________________ Phone: ( ) _____-______

ID/CLAIM#: ________________________________

Please hand the front desk your ID card.

THANK YOU FOR YOUR TIME

INTEGRATED HEALTH SERVICES, INC.
EDUARDO ANGUIZOLA M.D.
2050 N. TUSTIN AVE
SANTA ANA, CA 92705
(714) 543-2554 · Voice
(714) 835-1383 · Fax

To:

Patient's Name:
Date of Injury:

Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full medical report of his examination, diagnosis, treatment, prognosis, of myself in regards to the accident in which I was involved, dated above.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me both by reason of this accident and to withhold such sums from any settlement, judgement, or verdict as may be adequately necessary to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney or myself as the result of the injuries for
which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

A photocopy of this lien will be considered as valid as the original.

Patient's Signature____***Date***______________________

Patient's Address:

ATTORNEY(S), please sign, date, retain one copy for your files, return one copy to our office. Our medical report, and billing will not be forwarded until properly signed liens have been returned to this office. You may fax your lien to (714) 835-1383.

The undersigned being attorney(s) of record for the above patient does hereby agree to observe all of the terms and conditions of the above lien and agree(s) to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect the said doctor named above.

Attorney(s) Signature ____***Date***_______________________

Allied Surgery Center
13132 Newport Avenue, Ste 210
Tustin, CA 92780
Phone: 323-932-9352 Fax: 310-907-5199

Notice of Medical Lien

Patient/ Client: ______________________________

Re: ______________________________ DOI: ______________

I do hereby authorize Allied Surgery Center to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said facility such sums as may be due and owing said facility for medical service rendered to me both by reason of this accident and by reason of any other bills that are due to the facility and to withhold such sums from any settlement , judgment, or verdict as may be necessary to fully compensate said facility. I hereby further give a lien on my case to said facility against any and all proceeds of my settlement, judgment, or verdict which may be paid to you , my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said facility for all medical bills submitted by said facility for service rendered me and that this agreement is made solely for said facility's additional protection and in consideration of the doctor awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said facility of any change or addition of attorney(s) used by me in connection with this accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the facility. I have been advised that if my attorney does not wish to cooperate in protecting the facilities interest, the doctor will not await payment but may declare the entire balance due and payable.

Date: ____________ Signature of Patient/ Client/Claimant______________________ Name: ______________

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said facility above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Date: __________ Signature of Claimant Attorney: ______________________ Name and Title: ______________

CHRONIC PAIN INITIAL INFORMATION

PLEASE COMPLETE THIS FORM AS CAREFULLY AS POSSIBLE.

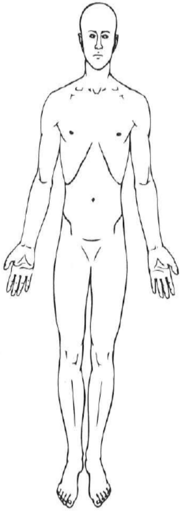
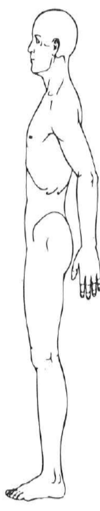
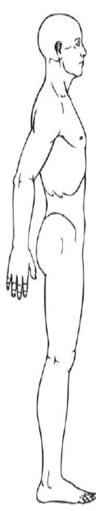
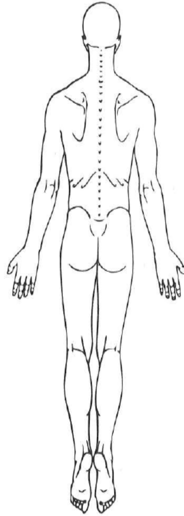
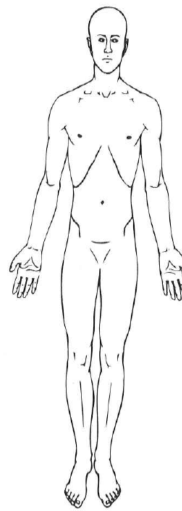
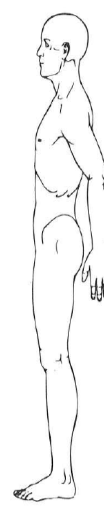
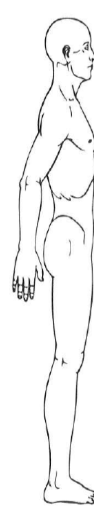
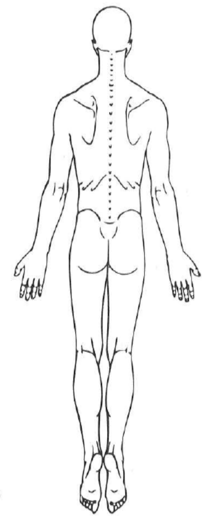
PATIENT NAME: ______________________________ DATE: ____________

DATE OF BIRTH: ____________

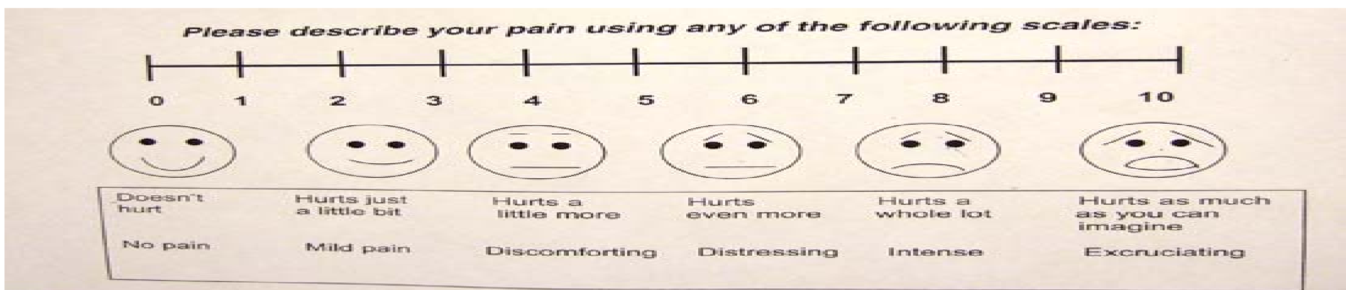
REGARDING THE LOCATION OF YOUR PAIN:

Mark the areas of your pain **Mark the areas of your numbness or shooting pain**

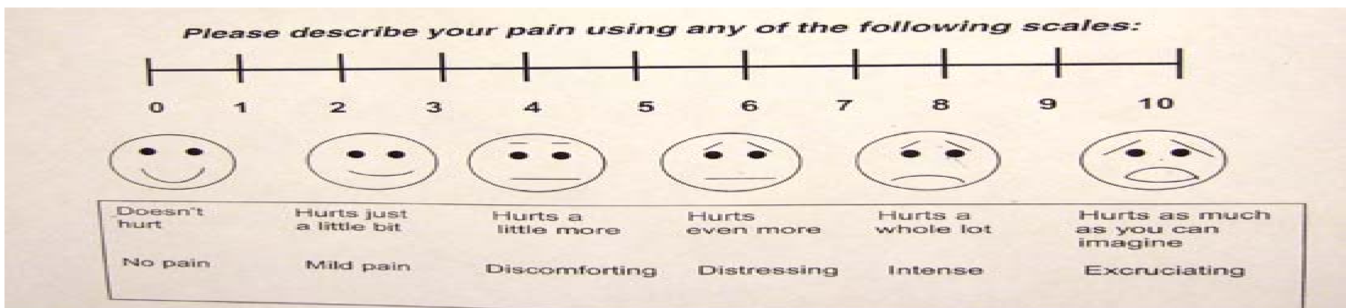
R L L R L R R L L R L R

- 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

Accident Report

DATE OF INJURY: ___________________________

Please Circle injured body part:

HEAD NECK UPPER BACK MID BACK LOW BACK HERNIA

LEGS-R/L WRIST-R/L KNEES-R/L SHOULUDER-R/L PSYCHE INTERNAL

OTHER: ____

Please describe how the accident happened.

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

Dated __________________________ ____
(Signature of Patient)

____
(Print Name)

Dated __________________________ ____
(Signature of Parent or Guardian

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