LAKE MARY MEDICAL SERVICES
PATIENT INTAKE FORM

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Contact Phone: _____ Email: _____

Address: _____

_____

Work History (circle IF applicable): EMPLOYED RETIRED DISABLED

Emergency Contact: _____ Emergency Phone: _____

How did you hear about us? _____

When did your pain or problem begin? _____

_____

Where are you having pain? _____

_____

Character of pain (circle all that apply): SHARP DULL ACHING
BURNING STABBING THROBBING OTHER

Do you have any numbness or tingling? NO YES _____

Does the pain radiate to another part of your body? NO YES _____

What makes your pain better? _____

What makes your pain worse? _____

Any previous treatment for this injury? ☐ No ☐ Yes (please describe): _____

_____

Current Medications including vitamins and supplements: _____

_____

Surgical history: _____

_____

MELANIE CROSS, MD • 956 International Parkway, Suite 1580 • Lake Mary, FL 32746
Ph (407) 721-2127 •Fax (407) 936-0316 •

LAKE MARY MEDICAL SERVICES
PATIENT INTAKE FORM

Medical History/Review of Systems (please check all that apply):

- ☐ Allergy to Latex, Food, or Medication (specify):
- ☐ Angina/Chest Pain
- ☐ Anxiety and/or Depression
- ☐ Arthritis
- ☐ Asthma or Breathing Difficulties
- ☐ Blood Pressure (specify): High Low
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Circulatory Disorder or Peripheral Vascular Disease
- ☐ Defibrillator or Pacemaker
- ☐ Diabetes
- ☐ Fainting/Dizziness/Vertigo
- ☐ Fever or Night Sweats
- ☐ Fibromyalgia
- ☐ Headaches or Migraines
- ☐ Heart Arrhythmia
- ☐ Heart Disease and/or Heart Attack
- ☐ Hepatitis
- ☐ Hernia(s) or Hernia Repair
- ☐ HIV
- ☐ Joint Pain, Swelling, or Stiffness
- ☐ Joint Replacement and/or Metal Implants
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Osteopenia or Osteoporosis
- ☐ Pregnant and/or Breastfeeding (currently)
- ☐ Parkinson 's Disease
- ☐ Scoliosis
- ☐ Seizure(s)
- ☐ Shortness of Breath
- ☐ Smoker (current)
- ☐ Stroke or TIA
- ☐ Spinal Disk Herniation
- ☐ Spinal Fusion
- ☐ Thyroid Disorder

Reproductive Health History (IF applicable):
Date of last menstrual period (or indicate if post-menopause): _____

I acknowledge that the health history information provided above is accurate to the best of my knowledge.

Signature: _____ Date: _____

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LAKE MARY MEDICAL SERVICES

▪ AUTHORIZATION FOR TREATMENT ▪
▪ ASSIGNMENT OF BENEFITS ▪
▪ RELEASE OF RECORDS ▪

AUTHORIZATION FOR TREATMENT:
I, the undersigned, a patient of Lake Mary Medical Services hereby authorize Lake Mary Medical Services to administer treatment for the purpose of pain management, medication management for anxiety or sleep disturbance as needed. I have been informed of the nature and purpose of treatment, common side effects thereof, alternative treatment modalities, approximate length of care, and that consent can be revoked orally or in writing prior to or during the treatment period. I have read and fully understand this authorization for treatment. No guarantee or assurance has been made to me as to the results that may be obtained.

ASSIGNMENT OF BENEFITS:
This is an assignment of my rights and benefits. I authorize the insurance company to issue payment directly to Lake Mary Medical Services. I also authorize the insurance company to release any information about my policy and claim directly to Lake Mary Medical Services.

In exchange for medical services, I hereby assign and transfer all insurance policy rights, benefits, and causes of action to Lake Mary Medical Services for services rendered by Lake Mary Medical Services (date) _____.

RELEASE OF RECORDS:
I hereby authorize Lake Mary Medical Services to release to any attorney, physician, or insurance company, involved in my case, any medical records or other information necessary to process my claim, which will be utilized for the ultimate recovery of benefits related to my injury/illness.

My signature below indicates I have read the above statements regarding authorization for treatment, assignment of benefits, release of records, and attorney representation and agree to abide by them.

Print Name: _____ **Date:** _____

Signature: _____

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LAKE MARY MEDICAL SERVICES
RECEIPT OF PRIVACY NOTICE

My signature, below, certifies I have received or reviewed a copy of the NOTICE OF PRIVACY PRACTICES.

Printed Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

Comments: _____

_____

LAKE MARY MEDICAL SERVICES

Below are the telephone numbers that must be posted by each licensed FQA facility to comply with CORE 408.801(5)(a)1. And 2. See statute below.

The complaint number is our agency toll free # 1-888-419-4356

The abuse line is 1-800-96-ABUSE (962-2873)

_____

408.810(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "to report a complaint regarding the services you receive, please call toll free 1-888-4119-3456"

2. Abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "to report abuse, neglect or exploitation, please call toll free 1-888-96-ABUSE (962-2873)." The agency shall publish a minimum.

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LAKE MARY MEDICAL SERVICES
PAIN MANAGEMENT PATIENT AGREEMENT

____I understand that there is a risk of psychological and/or physical dependence and addiction associated with the chronic use of controlled substances.

____I understand that this Agreement is important to the trust and confidence needed in a doctor/patient relationship and that my doctor agrees to treat me based on this Agreement.

____I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines. They will taper off my medicine over a period of a few days to avoid withdrawal symptoms and refer me to a drug-dependence treatment program.

____I will be agreeable to seeking mental health (psychiatric or psychological) treatment if my doctor thinks it necessary.

____I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relive the pain.

____I will not use illegal controlled substances including Cocaine, MDMA, and amphetamines. Nor will I misuse or self-prescribe legal controlled substances. The use of alcohol is to be AVOIDED, especially when driving/operating machinery.

____I will not share my medication with anyone. I will keep my medications safe from loss, theft, or unintentional use by others. LOST OR STOLEN MEDICATIONS WILL NOT BE REPLACED!

____I will not try to get any controlled medications, including opioid pain medications, or any anti-anxiety medications from any other provider and understand that refills of my prescriptions for pain medications will be made ONLY at the time of an office visit.

____I authorize my doctor and pharmacy to cooperate fully with any law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my pain medication.

____I agree that I will do a blood or urine test when requested by my doctor, without delay or evasion, to check on my compliance with my pain management program.

____I understand that my doctor will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program Website regularly throughout my treatment.

____I agree to not use my medicine faster than my prescribed rate and that use of my medicine at a faster rate will lead to me being without medication for a period of time.

____I understand that medication(s) prescribed for pain can be addicting and should be taken ONLY as directed and that these medications have increased risk of side effects and potentially deadly interactions (especially with alcohol and sedatives).

____I AGREE TO FOLLOW THESE GUIDELINES THAT HAVE BEEN FULLY EXPLAINED TO ME. All my questions and concerns regarding my treatment have been adequately answered document.

This agreement is entered into this _____day of _____, 20____.

Patient Name: _____ Patient Signature: _____

Provider Name: **Melanie Cross, M.D.** Provider Signature: _____

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