PATIENT INFORMATION

FULL NAME ______________________________ DATE ______________

DATE OF BIRTH ________________ SOCIAL SECURITY # ________________

ADDRESS ____

CITY ______________________ STATE __________ ZIP __________

HOME PHONE ___________________ WORK PHONE __________________

CELL PHONE ________________ E-MAIL ADDRESS ____________________

MARITAL STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ SPOUSE NAME ___________

SECOND ADDRESS ____

PHYSICIAN __________________________ PHONE ________________

PATIENT REFERRED BY ______________________________________

EMERGENCY CONTACT ____________________ PHONE ________________

RELATIONSHIP TO PATIENT __________________

IS THIS VISIT DUE TO AN ACCIDENT? ____________ TYPE ________________

INSURANCE INFORMATION

POLICYHOLDER ________________________ DATE OF BIRTH ___________

RELATIONSHIP TO PATIENT _______________ INSURANCE CO. ______________

MEMBERSHIP ID ____________________ GROUP # ____________________

PATIENT HISTORY

Name ____ Date ________________

Date your problem started _____________ Did pain begin ☐ gradually or ☐ sudden onset?

Describe what happened ____

____

Check each of the following that applies:

- ☐ My back sometimes gets stuck when I bend forward.
- ☐ After walking, bending forward relieves my pain.
- ☐ My back sometimes feels like it is giving way when I bend forward.
- ☐ My pain stops me when I walk a certain distance.
- ☐ I have trouble with urine or bowel control.
- ☐ The pain is worse after exercise or exertion.
- ☐ Walking and moving around is more comfortable then either sitting or standing.
- ☐ Sitting is more comfortable than standing.
- ☐ Standing is more comfortable than sitting.
- ☐ My leg often hurts or tingles when I stand up after sitting.
- ☐ My leg often hurts or tingles when I bend forward.
- ☐ The pain is worse when I wake up in the morning.
- ☐ The pain is worse when I go to bed at night.
- ☐ I am not able to do housework without pain.
- ☐ I am not able to work at my job without pain.

Do you have problems sleeping? _____ Why? ____________________________________

List family members (e.g., mother, sister) with a history of arthritis or back problems.

____

List all medications (*prescribed, over-the-counter or herbal*) you are taking now: ____________

____

____

What is your present state of health? (List your health problems/diagnoses below.)

____

____

If you have a specific question, please write it here. ______________________________

____

LIST ALL DRUG ALLERGIES ____
(IF "NONE", PLEASE INDICATE "NONE")

____

Ver. 6/06/05

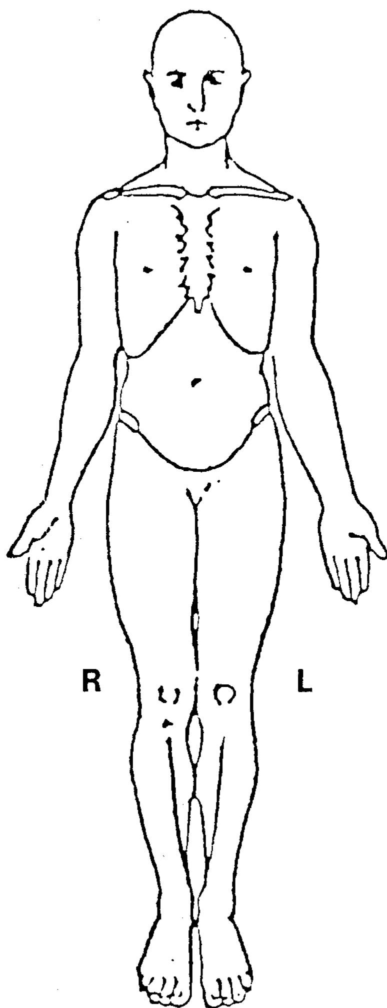
Name ______________________________ Date ______________

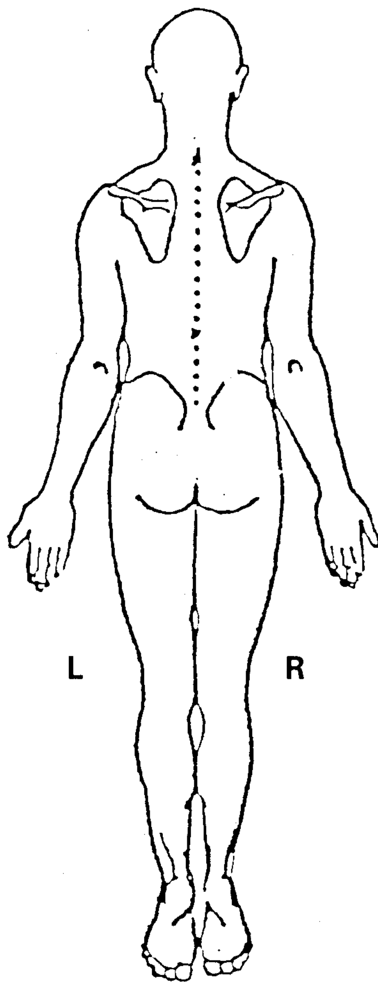
Please mark the diagrams below to indicate where on your body you feel sensations using the following symbols:

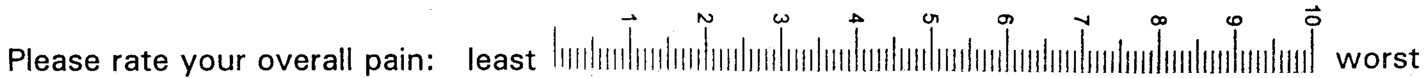
Pain xxx	**Burning** = = =	**Numbness** ooo
Stabbing /////	**Ache** ^ ^ ^	**Numb-like feeling** zzz

....

FRONT **BACK** **Right Side** **Left Side**





Please rate your overall pain: least  worst

FELIX S. LINETSKY, M.D.
611 Druid Road, Suite 303, Clearwater FL 33756
727.787.5555 Voice - www.ProlotherapyFlorida.com Website

PHYSICIAN NOTICE

(This notice is required by Medicare regulations.)

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. It will also deny payment for non-covered services. Dr. Linetsky knows that Medicare will deny payment for the following reason:

PROLOTHERAPY IS A NON-COVERED SERVICE UNDER MEDICARE RULES.

BENEFICIARY AGREEMENT

I have been notified by Dr. Felix Linetsky that Medicare will deny payment for the services identified above for the reason stated. I agree to be personally and fully responsible for such payments.

______________________	______________________
Print Name	Medicare Number
______________________	______________________
Signature	Date

Ver: 33110

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Felix S. Linetsky MD and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

REGENERATIVE INJECTION THERAPY ALSO KNOWN AS

PROLOTHERAPY, SCLEROTHERAPY OR RECONSTRUCTIVE THERAPY

(IN COMMON TERMS KNOWN AS):

INJECTION OF AN IRRITATING SOLUTION INTO THE LIGAMENTS ABOUT A JOINT

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

- **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described generally on the back of this consent form. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.

- **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):

ALLERGY OR ADVERSE REACTION TO ANY COMPONENT OF THE INJECTION; IRRITATION OF SURROUNDING STRUCTURES (INCLUDING POSSIBLE NEURALGIA); ECCEYMOSIS (BRUISING); SWELLING; DIZZINESS; HYPER-TENSION; EPIDURAL INFILTRATION; PAIN ABOUT THE INJECTION AREA AND JOINT; HEADACHE; NAUSEA; PNEUMOTHORAX

- **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):

OPEN SURGICAL REPAIR OF LIGAMENTS; CHRONIC MEDICATION FOR THE RELIEF OF PAIN; EXTERNAL AND INTERNAL SUPPORTS (FUSION) OF THE AFFECTED JOINT;

DO NOTHING

- **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

- **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

- **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

- **OTHER SERVICES.** I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.

- **PHOTOGRAPHY.** I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.

- **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

- **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read and been given a copy of this form.

DATE: ______________________ TIME ______________________ AM/PM

SIGNATURE: ______________________________
(PATIENT, PARENT OR LEGAL GUARDIAN)

TRANSLATED BY (IF APPLICABLE): ______________________________

PHYSICIAN: ______________________________

WITNESS: ______________________________

PLEASE READ THE GENERAL INFORMATION ON BACK.

WHITE-Office Copy   CANARY-Patient Copy

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