CONSULTANTS IN PAIN MEDICINE, INC.
TELEPHONE (757) 395-6450
FAX (757) 622-2750
INTERNET www.consultantsinpainmedicine.com
MARTIN V.T. TON, MD

This is very important information about your appointment. Please take the time to read and follow the instructions carefully.

Dear _____:

Kindly complete the enclosed forms and bring them with you to your appointment on **(PLEASE DO NOT MAIL FORMS)** _____ at _____ with Dr. Ton. Please arrive at the office at _____.

We are located in the **1080 Medical Office Building**, 1080 First Colonial Rd Suite 201 Virginia Beach, VA 23454.

Please call us at 395-6450 at least 24 hours in advance if you cannot make your appointment or this will result in a missed appointment charge of $60. If the directions are unclear in any way, please do not hesitate to call us or visit our website at www.beachpainhealth.com. Thank you.

Additional Instructions:

-Please bring insurance cards and ID.

-You will need to obtain copies of any radiology films or discs (X-ray, MRI or CT) unless they were taken at a Sentara facility or MRI & CT diagnostics.

-There is a fee for non medical forms such as disability or leave forms
$50 for the first side
$15 for each additional side

Consultants in Pain Medicine, Inc..

**MEDICATION GUIDELINES PRIOR TO PROCEDURES

Please continue to take all your **regular** (ie. blood pressure) medications on the day of your procediure EXCEPT:

Blood Thinners (anticoagulants): DO NOT STOP ANY ANTICOAGULANTS WITHOUT THE AUTHORIZATION OF YOUR PRESCRIBING DOCTOR. Most of our procedures will require that you stop your anticoagulants using these guidelines.

Aspirin -IF PRESCRIBED BY YOUR DOCTOR, you must obtain their authorization before stopping, otherwise stop **6 days** prior to your procedure

Coumadin - stop **5 days** before your procedure.

Heparin - contact the office for specific directions.

Plavix (Clopridogrel) – stop for **7 days** prior to your procedure.

Pletal-stop **6 days** prior to your procedure

Ticlid (Ticlopidine)- stop for **14 days** prior to your procedure.

Arixtra (Fondaparinux)-stop **4 days** prior to your procedure.

Effient (Prasugrel) -stop **10 days** prior to your procedure.

Pradaxa (Dabigatran)-stop **5 days** prior to your procedure.

Brilinta (Ticagrelor)- stop **5 days** prior to your procedure.

Xarelto-(Rivaroxaban) stop **3 days** prior to your procedure.

Aggrenox-stop **7 days** prior to your procedure.

Eliquis-(Apaxiban) stop **5 days** prior to your procedure

Lovenox- stop **24 hours** prior to your procedure

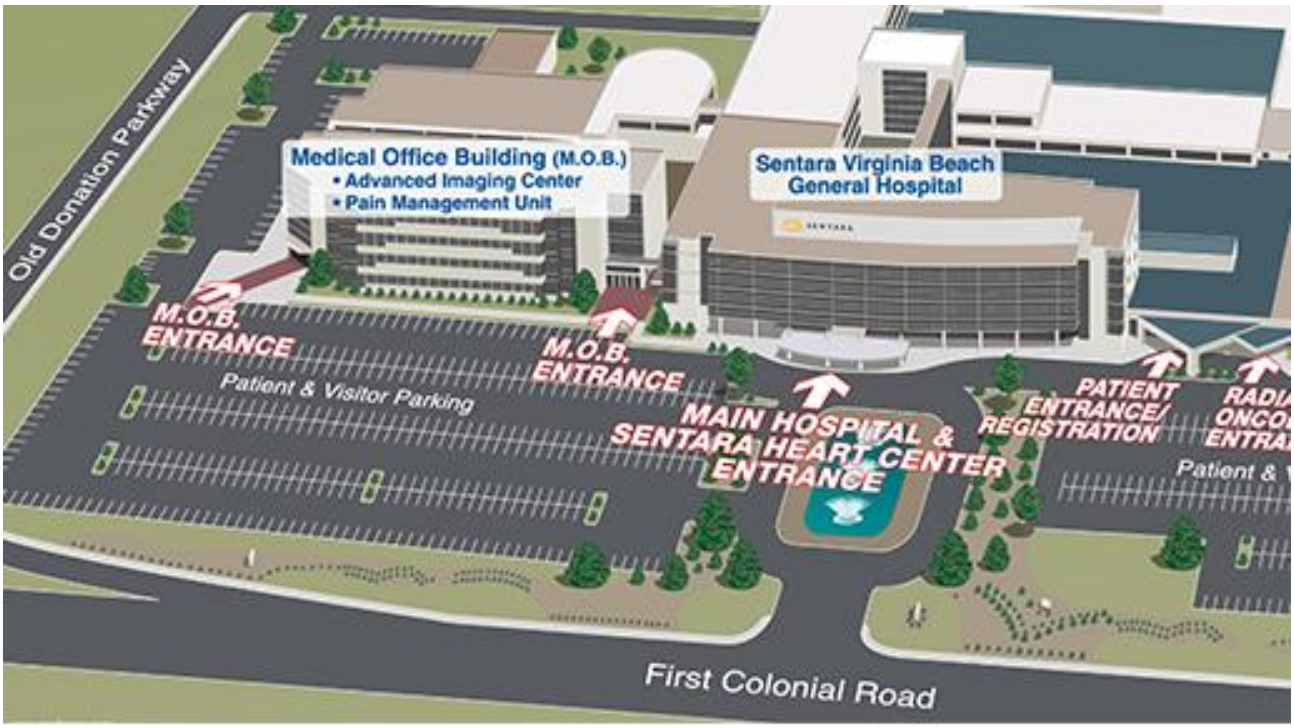
Please carefully review the contents of your current medications because many over the counter drugs and herbal supplements contain aspirin (acetylsalicylic acid): Aggrenox (aspirin/dipyridamole), Anacin, Bayer (including Back and Body Pain formula), BC Powder, Bexophene, Bufferin, Darvon Compound, Ecotrin, Excedrin, Fiorinal (butalbital/aspirin), Goody's, Percodan, Norgesic and Stanback.

Please contact our office or visit our website at www.consultantsinpainmedicine.comcom if you have questions.

DIRECTIONS TO 1080 MEDICAL OFFICE BUILDING

From Interstates 64 and 664:
Take 264E to exit 21B (2nd of two First Colonial Rd exits). Once on First Colonial Rd, go about 1.5 miles to 1080 First Colonial Rd, located just past Virginia Beach General Hospital. Turn Right on Old Donation Parkway to access the parking lot. Use the second building entrance that is closest to the hospital. We are located on the 2nd floor in Suite 201.

From Chesapeake Bay Bridge Tunnel:
After exiting bridge stay in right lane and follow sign towards Beaches/ Shore Dr. Turn left at light onto Shore Dr. Cross the Lesner Bridge. At the 4th traffic light turn right on N. Great Neck Rd. Travel approx. 5 miles and then turn left on First Colonial Rd (Exxon Station on corner). At 2nd traffic light make a left onto Old Donation Parkway. Make the first right into the parking lot for the 1080 Medical Office Building. Use the second building entrance that is closest to the hospital. We are located on the 2nd floor in Suite 201.



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MARTIN V.T. TON, MD

Welcome to Consultants in Pain Medicine.

Our physician, nurses and office staff hope to provide the best care possible with regard to your particular pain condition.

Please fill out the enclosed questionnaire and answer all questions as completely as possible. Bring the completed forms to your appointment. (Please do not mail forms back to our office.) Your information is very important for proper treatment.

Thank you.

Consultants in Pain Medicine

Consultants in Pain Medicine, Inc.

Please remember your fasting and medication instructions. If you have not received this information, please call the office at 395-6450 or visit www.consultantsinpainmedicine.com

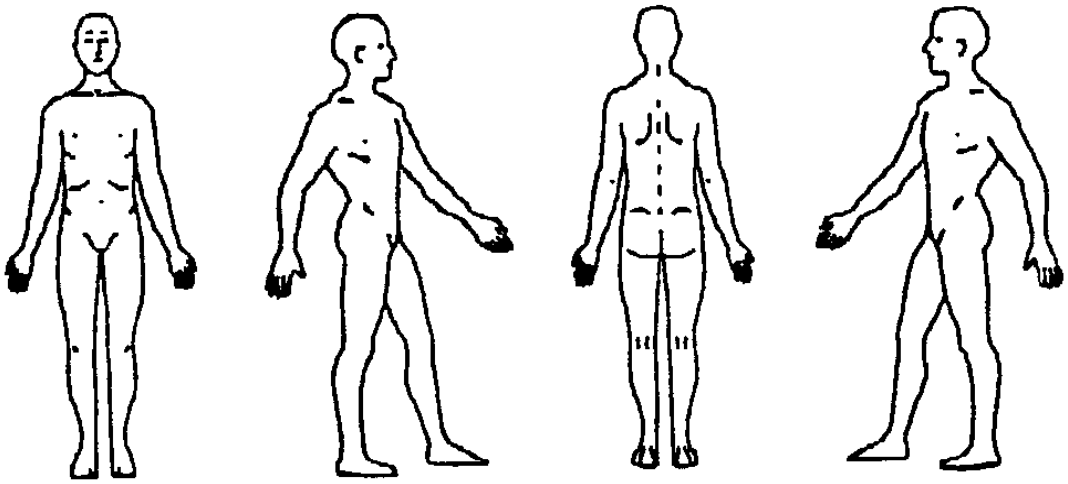
M.D. Signature_____

Date_____

Name: _____ Age_____ Height _____ Weight_____

Vitals: BP_____ HR_____ RR_____ T_____ SaO2_____
(will be completed at consultation)

Please mark exactly where your pain is located: ALLERGY: _____



How long have you had **THIS** episode of pain:_____

Did you injure yourself, if so, what was the nature of your injury: _____

_____

Please describe what your pain feels like: _____

_____

_____

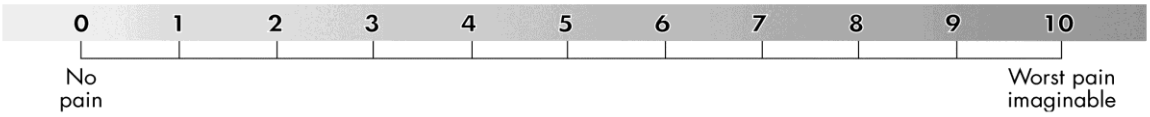
_____

Please mark any of the following that help describe your pain:

☐ Continuous ☐ Shooting ☐ Burning ☐ Sharp ☐ Tearing
☐ Off and On ☐ Dull ☐ Toothache ☐ Pulling ☐ Knife like

PLEASE RATE YOUR PAIN BELOW

0-10 Numeric Pain Intensity Scale



What makes your pain WORSE: _____

What makes your pain BETTER (mark ALL that apply):

☐ Rest ☐ Sitting ☐ Lying down ☐ Standing ☐ Nothing at all
☐ OTHER:_____

Do you have numbness in your arms or legs: ☐ No ☐ Yes
Do you get tingling in your arms or legs: ☐ No ☐ Yes
Do you have weakness in your arms or legs: ☐ No ☐ Yes
Since your pain began, have you lost TOTAL control of your bowel or bladder? _____

What PAIN medications have you taken that DID NOT WORK:_____
_____

What have you done for **THIS** episode of pain?

☐ Home Exercise Program ☐ Physical Therapy ☐ Chiropractor

☐ Acupuncture ☐ Massage Therapy ☐ OTHER:_____

Which has helped your pain:_____

Please indicate if you have had the following tests for your pain:
☐ MRI ☐ CT Scan ☐ Electromyelogram / EMG ☐ Bone Scan ☐ X-Rays

Which other doctors do you see:_____

Please mark all illnesses and disorders for which you are being treated or followed by a doctor:

☐ High Blood Pressure	☐ Diabetes	☐ Liver disease/Hepatitis
☐ Heart Attack	☐ Underactive Thyroid	☐ Kidney Failure
☐ Congestive Heart Failure	☐ Overactive Thyroid	☐ Dialysis
☐ Irregular Heart Beat	☐ Tuberculosis	☐ Urine Infections
☐ Blocked Carotid Artery	☐ Pneumonia	☐ Kidney Stones
☐ Poor Circulation	☐ Asthma	☐ Seizures
☐ Cancer _____	☐ Heartburn	☐ Stroke
☐ Depression	☐ Acid Reflux	☐ HIV / AIDS

OTHER:
_____
_____
_____
_____

Please indicate all **SURGERIES** you have had:

☐ Lumbar /Back	☐ Heart Bypass	☐ Hysterectomy
☐ Neck	☐ Lung_____	☐ Caesarian Section
☐ Gallbladder Removal	☐ Aortic Aneurysm Repair	☐ Tubal Ligation
☐ Appendix Removal	☐ Carotid Artery Repair	☐ Brain
☐ Tonsil Removal	☐ Leg Artery Bypass	☐ Bowel Removal_____
☐ Bladder	☐ Kidney Stone	☐ Exploration of Bowel
☐ Broken Bone_____	☐ Cataract	☐ Prostate

OTHER:_____
_____
_____

Please list all your current **MEDICATIONS** and doses:

DRUG	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all drug **ALLERGIES**:_____

Are you taking any **BLOOD THINNING MEDICATIONS**: ☐ Yes ☐ No

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Would you like information on alcohol consumption cessation: ☐ No ☐ Yes

Would you like information on an Advanced Medical Directive: ☐ No ☐ Yes

Do you currently smoke: ☐ No ☐ Yes

If you smoke, would you like information on quitting: ☐ No ☐ Yes

Do you currently have any of these symptoms:

☐ Severe weight loss	☐ Seizure	☐ Very easy bruising
☐ Very high fever	☐ Stroke	☐ Excessive bleeding
☐ Night sweating	☐ Passing out	☐ Suicidal Thoughts
☐ Nausea / Vomiting	☐ Chest Pain	☐ Hallucinations
☐ Diarrhea	☐ Heart Palpitations	
☐ Constipation	☐ Irregular Heartbeat	
☐ Loss urine control	☐ Chronic cough	OTHER: _____
☐ Constant Urination	☐ Wheezing	_____
☐ Painful Urination	☐ Bloody Sputum	_____

Additional Information:

Oswestry Pain Questionnaire

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking **ONE** box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just mark the box that indicates the statement which most clearly describes your problem.

Pain Intensity

- □ I can tolerate the pain I have without having to use pain killers.
- □ The pain is bad but I manage without taking pain killers.
- □ Pain killers give complete relief from pain .
- □ Pain killers give moderate relief from pain.
- □ Pain killers give very little relief from pain.
- □ Pain killers have no effect on the pain and I do not use them.

Personal Care

- □ I can look after myself normally without causing extra pain.
- □ I can look after myself normally but it causes extra pain.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but manage most of my personal care.
- □ I need help every day in most aspects of self care.
- □ I do not get dressed wash with difficulty and stay in bed.

Lifting

- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives extra pain.
- □ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned for example on a table.
- □ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than 0.5 miles.
- ☐ Pain prevents me walking more than 0.25 miles.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 0.5 hours.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Changing degree of pain

- □ My pain is rapidly getting better.
- □ My pain fluctuates but is definitely getting better.
- □ My pain seem to be getting better, but improvement is slow at present .
- □ My pain is neither getting better nor worse.
- □ My pain is gradually worsening.
- □ My pain is rapidly worsening

Social Life

- □ My social life is normal and gives me no extra pain.
- □ My social life is normal but increases the degree of pain.
- □ Pain has no significant effect on my social life apart from limiting energetic interests such as dancing.
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted my social life to my home.
- □ I have no social life because of pain.

Traveling

- □ I can travel anywhere without extra pain.
- □ I can travel anywhere but it gives me extra pain.
- □ Pain is bad but I manage journeys over 2 hours.
- □ Pain restricts me to journeys of less than 1 hour.
- □ Pain restricts me to short necessary journeys under 30 minutes.
- □ Pain prevents me from traveling except to the doctor or hospital.

. **CONSULTANTS IN PAIN MEDICINE, INC**.

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MARTIN V.T. TON, MD

PATIENT: _____ **DOB: _____**

I hereby give Consultants in Pain Medicine my permission to request and receive any and all medical information from any previous or referring doctors.

SIGNATURE _____ DATE _____

Prescriptions:

If you wish for us to write prescriptions for you, we will need your pharmacy information as follows:

PHARMACY NAME:_____

STREET ADDRESS:_____

CITY:_____

PHONE NUMBER:_____

FAX NUMBER:_____

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MARTIN V. T. TON, M.D.

Date:

Patient:

Insurance:

Our records show that you have the insurance listed above. If this is not correct, please contact our office immediately with the correct information. Please remember to bring your insurance cards and picture ID to your appointment with Dr. Ton.

If your insurance company requires an insurance referral, please make sure that your primary care physician or referring physician issues all the necessary referrals to our office prior to your scheduled appointment.

Please be advised that Consultants in Pain Medicine bills for Dr. Ton's professional services only. We are considered and outpatient facility with Sentara Virginia Beach General Hospital and you will receive a separate bill from the facility. These charges are for the facility, radiology tech and equipment and medication used for your appointment. Your visit will be billed as an outpatient service.

If you have any questions or concerns regarding your insurance, please call our billing office at 473-0044.

Thank you in advance for you payment for services rendered. (cash, check, visa and mastercard are accepted)

_____ _____
Patient signature date

CONSULTANTS IN PAIN MEDICINE
ATLANTIC ANESTHESIA, INC.

ACKNOWLEGDEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of Consultants in Pain Medicine/Atlantic Anesthesia, Inc. and its subsidiaries (AAI) Notice of Privacy Practices ("Notice"):

- It tells me how AAI will use my health information for the purposes of my treatment, payment for my treatment, and AAI's health care operations.
- The Notice explains in more detail how AAI may use and share my health information for other than treatment, payment, and health care operations.
- AAI will also use and share my health information as required/permitted by law.

_____ I have declined to receive a written copy of the Notice for Privacy Practices.
(Initial)

Patient's Complete Legal Name: _____
(Please print)

Patient's DOB: _____ Today's Date: _____

Signature: _____
(Patient or legal representative*)

*May be requested to show proof of representative status

HIPPA Document
Retain for minimum of 6 years

CONSULTANTS IN PAIN MEDICINE
1080 FIRST COLONIAL RD., SUITE 201
VIRGINIA BEACH, VA 23454

PATIENT INFORMATION

PATIENT NAME _____ **M** ___**F** _____**DOB** _____/ ____/ _____

ADDRESS ____ _____ **CITY** _____ **STATE**_____ **ZIP**

SOCIAL SECURITY NUMBER _____ **HOME PHONE** _____

CELLPHONE _____ **WORK PHONE**_____

EMPLOYER _____ **SPOUSE'S NAME**_____

SPOUSES PHONE _____ **SPOUSES SS#**_____ **DOB** _____/ _____/.

REFERRING PHYSICIAN _____
PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____ **ID NUMBER** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

SUBSCRIRER'S NAME _____ **DATE OF BIRTH** _____/ . __ /_____

RELATIONSHIO TO PATIENT _____ **SUBSCRIBER'S EMPLOYER** _____

SECONDARY INSURANCE CARRIER _____ **ID NUMBER** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

SUBSCRIBER'S NAME _____ **DATE OF BIRTH** _____/ . __/_____

RELATIONSHIP TO PATTFNT _____ **SUBSCRIBER'S EMPLOYER** _____

OTHER INSURANCE INFORMATION _____

WORKER'S COMPENSATION INFORMATION

WORKER'S COMPENSATION CARRIER: _____ **DATE OF INJURY** _____

CASE MANAGER _____ **PHONE** _____

EMPLOYER _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I HEREBY AUTHORIZE ANY MEMBER OF CONSULTANTS IN PAIN MEDICINE AND/OR THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT, RELEASE OF INFORMATION PERTAINING TO TREATMENT FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENT FOR PROFESSIONAL TREATMENT OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED VIA PAPER OR ELECTRONICALLY. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR VALID REFERRAL FORMS REQUIRED BY THEIR MANAGED CARE CARRIER OR THEY WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE BALANCE DUE. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR COURT COSTS, 33 1/3% ATTORNEYS FEES ASSOCIATED WITH COLLECTION PROCEDURES BROUGHT BY CONSULTANTS IN PAIN MEDICINE AND A $20 RETURN CHECK CHARGE SHOULD THAT BECOME NECESSARY. IF MY INSURANCE CARRIER DOES NOT PAY MY CLAIM, I GIVE CONSULTANTS IN PAIN MEDICINE PERMISSION TO ALLOW VIRGINIA INSURANCE COMMISSIONER'S OFFICE TO BE CONTACTED ON MY BEHALF.

_____ _____
PATIENT GUARANTOR SIGNATURE **DATE** **CONSULTANTS IN PAIN MEDICINE WITNESS** **DATE**