CONSULTANTS IN PAIN MEDICINE, INC.

TELEPHONE (757) 395-6450
FAX (757) 622-2750
INTERNET www.beachpain.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 note: Your appointment requires:

___ Nothing to eat or drink _____hours prior to your procedure.

___ Someone must be present and remain in office during procedure to drive you home .

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 $53. If the directions are unclear in any way, please do not hesitate to call us or visit our website at www.beachpain.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

****Please note: You should take all heart and blood pressure medication with a sip of water at the usual time in the morning before your appointment**

**MEDICATION GUIDELINES PRIOR TO PROCEDURES

Please continue to take all your **regular** (ie. blood pressure) medications on the day of your appointment 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 **5 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

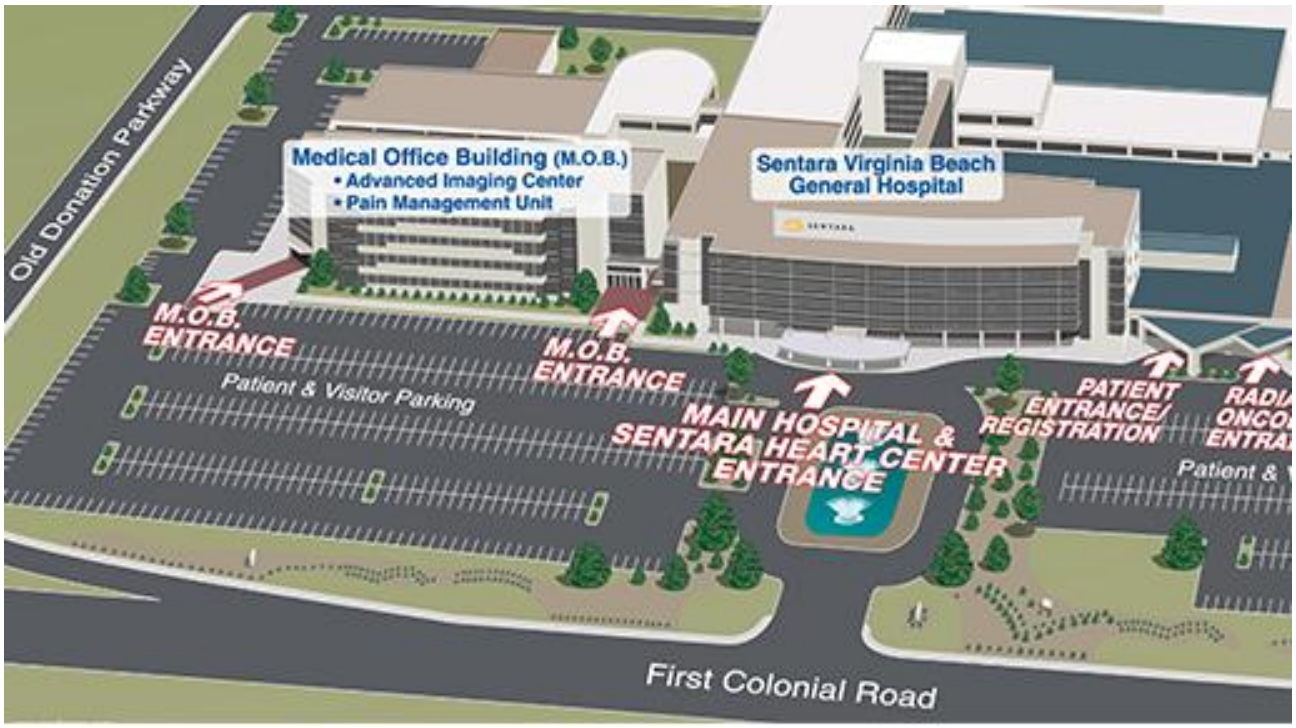
Please carefully review the contents of your current medications because many over the counter drugs and herbal supplements contain aspirin (acetylsalicylic acid): Aggrenox (aspirin/dipyridamole), Anacin, Bayer (including Back and Body Pain formula), BC Powder, Bexophene, Bufferin, Darvon Compound, Ecotrin,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

Please contact our office or visit our website at www.beachpain.com 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.



CONSULTANTS IN PAIN MEDICINE, INC.
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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.beachpain.com.

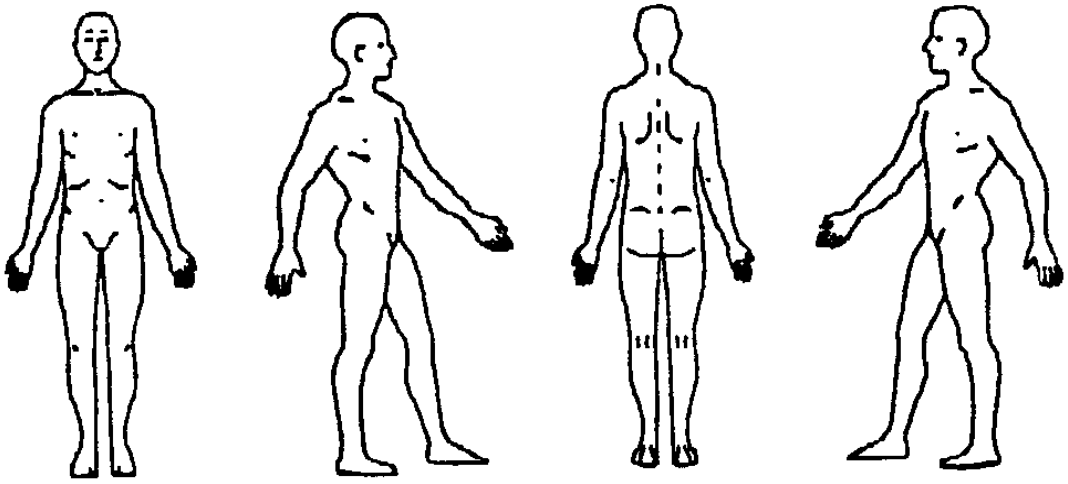
M.D. Signature_____

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: _____



When did you first notice your pain:_____

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

_____

Please describe what your pain feels like: _____

_____

_____

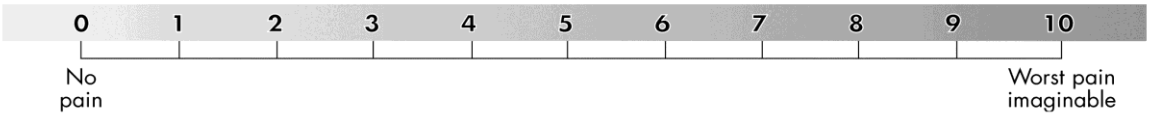
_____

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:_____

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

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 medications have you taken BEFORE and stopped:_____
_____

Please indicate if you have had the following treatments for your pain:

□ Epidural Steroid Injection □ Physical Therapy □ Chiropractor

□ Acupuncture □ Trigger Point Injections □ 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 remember your fasting and medication instructions. If you have not received this information, please call the office at 395-6450 or visit www.beachpain.com.

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

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

Please list all drug **ALLERGIES**:_____

Are you taking any **BLOOD THINNING MEDICATIONS**: □ Yes □ No
What is your current occupation:_____
Does it involve lifting or bending:_____
Are you currently out of work on disability:_____
Do you consume more than 7 alcoholic drinks per week, or more than 3 per occasion: □ No □ Yes
Would you like information on alcohol consumption cessation: □ No □ Yes
Do you consume tobacco: □ No □ Yes
Would you like information on tobacoo consumption cessation: □ No □ Yes

Do you use recreational drugs:_____

Is your mother or father deceased, if so from what illness and at what age:_____
_____
Do you have any brothers or sisters, please list their ages:_____
Has anyone in your immediate family had a similar medical problem as the one that has brought you here today:_____

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:

. **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