

**CONSULTANTS IN PAIN MEDICINE, INC.**

TELEPHONE (757) 395-6450  
FAX (757) 622-2750  
INTERNET [www.beachpain.com](http://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 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.beachpain.com](http://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**

**Consultants in Pain Medicine, Inc.**

## MEDICATION GUIDELINES PRIOR TO PROCEDURES

### THESE ONLY APPLY TO THE DAY OF THE PROCEDURE, NOT YOUR INITIAL CONSULTATION

Please continue to take all your **regular** (ie. blood pressure) medications on the day of your procedure 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 **6 days** before your procedure.

Heparin - contact the office for specific directions.

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

Pletal-stop **2 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 **1 day** prior to your procedure.

Eliquis-(Apaxiban) stop **3 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.beachpain.com](http://www.beachpain.com) if you have questions.

## DIRECTIONS TO 1080 MEDICAL OFFICE BUILDING

### From Interstates 64 and 664:

Take 264E to exit 21B (2<sup>nd</sup> 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 2<sup>nd</sup> 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 2<sup>nd</sup> 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 2<sup>nd</sup> floor in Suite 201.



**CONSULTANTS IN PAIN MEDICINE, INC.**

TELEPHONE (757) 395-6450

FAX (757) 622-2750

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.**

M.D. Signature \_\_\_\_\_

Date \_\_\_\_\_

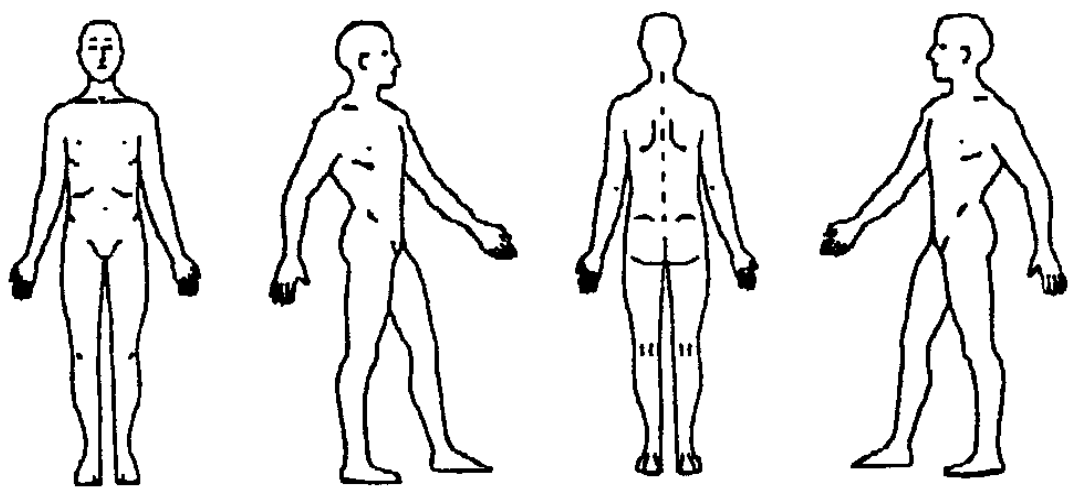
Name: \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

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: \_\_\_\_\_

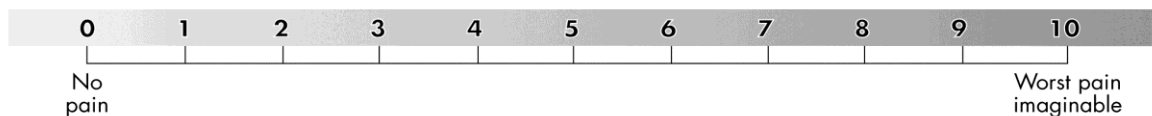
Please describe what your pain feels like: \_\_\_\_\_

**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: \_\_\_\_\_  
 \_\_\_\_\_

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     Electromyogram / 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:**

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

**OTHER:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Lumbar /Back        | <input type="checkbox"/> Heart Bypass           | <input type="checkbox"/> Hysterectomy         |
| <input type="checkbox"/> Neck                | <input type="checkbox"/> Lung _____             | <input type="checkbox"/> Caesarian Section    |
| <input type="checkbox"/> Gallbladder Removal | <input type="checkbox"/> Aortic Aneurysm Repair | <input type="checkbox"/> Tubal Ligation       |
| <input type="checkbox"/> Appendix Removal    | <input type="checkbox"/> Carotid Artery Repair  | <input type="checkbox"/> Brain                |
| <input type="checkbox"/> Tonsil Removal      | <input type="checkbox"/> Leg Artery Bypass      | <input type="checkbox"/> Bowel Removal _____  |
| <input type="checkbox"/> Bladder             | <input type="checkbox"/> Kidney Stone           | <input type="checkbox"/> Exploration of Bowel |
| <input type="checkbox"/> Broken Bone _____   | <input type="checkbox"/> Cataract               | <input type="checkbox"/> Prostate             |

**OTHER:**

\_\_\_\_\_  
 \_\_\_\_\_



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

TELEPHONE (757) 395-6450

FAX (757) 622-2750

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: \_\_\_\_\_

**CONSULTANTS IN PAIN MEDICINE, INC.**  
TELEPHONE (757) 395-6450  
FAX (757) 622-2750  
**WEBSITE-www.beachpain.com**

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.**

**ACKNOWLEDGEMENT 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 \_\_\_\_\_  
SUBSCRIBER'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.

A SUBSIDIARY OF ATLANTIC ANESTHESIA, INC.

12

PATIENT GUARANTOR SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

CONSULTANTS IN PAIN MEDICINE WITNESS \_\_\_\_\_

DATE \_\_\_\_\_