BART PRICE, MD

CONCIERGEMEDICAL SERVICES

DR PRICE & DR TRAVNICEK

NAME:_____
FIRST MIDDLE LAST

PRIMARY ADDRESS:

_____
STREET CITY STATE ZIP CODE

SECONDARY ADDRESS:

_____
STREET CITY STATE ZIP CODE

PHONE NUMBERS – PRIMARY: _____ HOME:_____

CELL:_____ CELL:_____

EMAIL:_____ DATE OF BIRTH: _____/_____/_____ SEX:_____

PREFERRED PHARMACY:_____PHARMACY PHONE:_____

MARITAL STATUS: _____SINGLE _____MARRIED _____DIVORCED _____WIDOWED

CLOSEST RELATIVE:_____RELATIONSHIP:_____PHONE:_____

PERSON RESPONSIBLE FOR BILL:_____REFERRED BY:_____

YOUR EMPLOYER:_____PHONE:_____

WHEN CALLING WITH RESULTS, WITH WHOM MAY WE LEAVE THE INFORMATION:

_____

MAY WE LEAVE THE INFORMATION ON VOICEMAIL/ANSWERING MACHINE? _____YES _____NO

PERSON(S) WHO WILL ACT AS YOUR HEALTHCARE ADVOCATE IF THERE IS A NEED:

NAME:_____ PHONE:_____

DO YOU HAVE A SIGNED DNR? _____YES _____NO (IF YES, ATTACH COPY)

DO YOU HAVE ADVANCE DIRECTIVES? _____YES _____NO (IF YES, ATTACH COPY)

INSURANCE AUTHORIZATION AND ASSIGNMENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE TO MANASOTA MEDICAL GROUP, LLC FOR ANY SERVICES FURNISHED TO ME. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIES ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 USC 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION.)

_____ _____

SIGNATURE (PRINT THEN SIGN DOCUMENT) DATE

1250 SOUTH TAMIAMI TRAIL, SUITE 301, SARASOTA, FL 34239
OFC (941) 365-1321 FAX (941) 365-4071 WWW.CONCIERGEMEDICAL.SERVICES

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Insurance and Financial Agreement
Assignment of Benefit | Patient Responsibility

Insurance Pre-certification

I understand that I am responsible for any required notification needed by my insurance company in order to pay for services rendered. If this is not done, my benefits may be reduced and I am responsible for all non-covered charges.

Assignment of Benefits

I hereby assign to Manasota Medical Group any and all benefits from my insurance plans or any other protection maintained by the patient. I authorize and direct such benefits to be paid directly to Manasota Medical Group, for services provided. If my insurance plan does not uphold the agreement to pay a claim on my behalf within 30 days of filing, I authorize Manasota Medical Group to file a complaint to the Insurance Commissioner in order to reimburse their offices.

Financial Agreement

The undersigned guarantees prompt payment of all charges for services rendered at time of service. Any unpaid balance due by patient beyond 30 days may be turned over for collection.

Consent for Medical Services

I consent to treatment, diagnostic, and / or therapeutic services as ordered and / or provided by Manasota Medical Group.

Cancellation Policy

I understand there is a 24 hour notice to cancel an appointment and that I may be charged for canceling an appointment without notice.

The undersigned certifies that he/she has read and understands the above and fully accepts all specified terms therein.

Signature of Patient or authorized Legal Representative _____ Date _____

(Print then sign document)

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Current Medications / vitamins / supplements / herbs:

Name of Medication	Strength	Frequency

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Please list the Most Recent date you had any of these tests / services

Name	Date	Name	Date
Abdominal Aortic Ultrasound		Hemoccult Stool Cards	
Annual Physical Exam		Mammogram	
Bone Density		Mini-mental Status Exam	
Cardiac Catheterization		Neuropsychological Testing	
Carotid Ultrasound		PAP	
Chest X-Ray		PSA	
Colonoscopy		Sprirometry Test (Breathing)	
Echocardiogram		Stress Test	
EKG		TB Test	
Eye Exam		Upper Endoscopy	
Hearing Test			

Please list the names of other physicians

Name	Dr Name	Name	Dr Name
Allergy		Ophthalmology	
Cardiology		Orthopedics	
Dermatology		Otolaryngology (ENT)	
Gastroenterology		Pain Management	
Gynecology		Podiatry	
Hematology		Primary Care	
Neurology		Pulmonology	
Nephrology		Psychiatry	
Oncology		Urology	

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Past Personal Medical History

Condition	Year of Onset	Additional Comments
Hypertension		
Diabetes		
Angina		
Heart Attack		
Stent		
Coronary Bypass		
Rheumatic Fever		
Valvular Disease		
Mitral Valve Prolapse		
Congestive Heart Failure		
Pulmonary Edema		
Irregular Rhythm		
Atrial Fibrillation		
Pacemaker		
Asthma		
Chronic Bronchitis		
Emphysema (COPD)		
Pneumonia		
High Cholesterol		
Cancer: Type_____		
Stroke / TIA		
Cataracts		
Lenses		
Glasses		
Lasik Surgery		
Glaucoma		

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Past Personal Medical History

Condition	Year of Onset	Additional Comments
Visual Loss		
Diabetic Retinopathy		
Macular Degeneration		
Color Blind		
Hearing Loss		
Chronic Headaches / Migraines		
Seizure Disorder		
Fainting Spells		
Loss of Consciousness		
Obesity		
Eating Disorder		
Environmental Allergies		
Dental Problems		
Neck Problems		
Thyroid Disease		
Hiatal Hernia		
Reflux Disease (GERD)		
Peptic Ulcer		
Bleeding Ulcer		
H. Pylori		
Gastritis		
IBS		
Chronic Diarrhea		
Chronic Constipation		
Diverticulosis / Diverticulitis		
Crohn's / Colitis / Ileitis		

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Past Personal Medical History

Condition	Year of Onset	Additional Comments
Hemorrhoids		
Abnormal Liver Function		
Hepatitis		
Cirrhosis		
Gallbladder Disease		
Pancreatitis		
Arthritis		
Disc Disease		
Fractures		
Spinal Stenosis		
Osteoporosis		
Osteoarthritis		
Motor Vehicle Accident		
Work Accident		
Seat Belt Use _____% of time		
Anemia		
Lymphoma		
White Blood Cell Disorder		
Impaired Immunity		
Abn. Bleeding Tendencies		
Coumadin Use		
Abn. Kidney Function		
Kidney Stones		
Kidney / Bladder Infections		
Incontinence		
Skin Cancer		

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Past Personal Medical History

Condition	Year of Onset	Additional Comments
Eczema		
Psoriasis		
Seborrhea		
Hair / Nail Disorders		
Sexual Dysfunction		
Infertility		
Positive TB Test		
Herpes		
History of STDs		
Lyme Disease		
Chronic Fatigue Syndrome		
HIV		
Memory Disturbances		
Parkinson's Disease		
Neuropathy		
Multiple Sclerosis		
Tremors		
Balance Problems		
Muscle Spasms		
Restless Leg Syndrome		
Tendonitis		
Polymyalgia		
Gout		
Any Prosthetic Devices		
Insomnia		
Sleep Disorder		

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Past Personal Medical History

Condition	Year of Onset	Additional Comments
Sleep Apnea		
History of Radiation		
Learning Disability		
Dyslexia		
ADD / ADHD		
Anxiety		
Depression		
Phobias		
Manic Depression		
Bipolar Disorder		
OCD		
Adjustment Reactions		
Suicide Attempts		
History of Physical Abuse		
History of Emotional Abuse		
Past or Present Addictions Type:_____		

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Past Personal Surgical History

Surgery Type	Year	Additional Comments
Brain		
Eyes - Cataracts		
Sinus / Nasal / Ear		
Tonsils / Neck		
Breast-Biopsy / Lumpectomy / Mastectomy		
Heart-Bypass / Balloon Angioplasty / Stents / Valves		
Lung / Chest		
Abdominal-Hernia Repair / Appendectomy / Gallbladder / Stomach / Bowel / Hemorrhoids		
Number of Childbirths _____		
Number of Pregnancies _____		
Hysterectomy / Removal of Ovaries / Tubal Ligation		
Kidney / Kidney Stones / Bladder		
Prostate / Vasectomy		
Hip / Knee / Joint Replacement		
Back / Disc		
Cosmetic		
Carpal Tunnel		
Aneurysm Repair		
Varicose Veins		
Skin		
Other: _____		
Other: _____		

PLEASE NOTE: If, while completing this questionnaire, you come across any highly sensitive issues that you find difficult to write about but you would still like to discuss, just indicate the issue with an (*) asterisk and we will talk about it during your examination.

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Review of Symptoms

Please **check** any symptoms you are experiencing:

GENERAL:
Weight loss__
Weight gain__
Night sweats__
Insomnia__
Fatigue__

CARDIOVASCULAR:
Chest pain__
Palpitations__
Ankle swelling__
Calf pain__
Varicose veins__

RESPIRATORY:
Cough__
Coughing blood__
Sputum production__
Wheezing__
Shortness of breath__

ENT:
Deafness__
Nose bleeds__
Runny nose__
Sneezing__
Hoarseness__
Sore throat__

ENDOCRINE:
Excessive thirst__
Excessive hair__
Hair loss__
Hot flashes__
Always hot__
Always cold__
Erectile dysfunction__
Infertility__
Decreased libido__
Pain during intercourse__

GASTROINTESTINAL:
Difficulty swallowing__
Heart burn__
Nausea__
Vomiting__
Diarrhea__
Constipation__
Blood in stools__
Black stools__
Abdominal Pain__
Jaundice__

NEUROLOGICAL:
Double vision__
Headache__
Dizziness__
Fainting__
Weakness__
Numbness__
Tingling__
Ringing in ear__
Tremors__

EYES:
Blurry vision__
Flashing lights__
Itchy eyes__

DERMATOLOGIC:
Suspicious moles__
Skin rashes__
Skin ulcers__
Acne__

GYNECOLOGICAL:
Menopause__
Irregular periods__
Breast tenderness__
Breast lumps__
Vaginal irritation__
Vaginal discharge__
Vaginal dryness__

UROLOGICAL:
Painful urination__
Recurrent infections__
Frequent urine__
Blood in urine__
Incontinence__
Incomplete bladder__
Emptying__
Dribbling__
Slow urine flow__

PSYCHOLOGICAL:
Depression__
Anxiety__
Memory loss__
Hallucinations__
Suicidal thoughts__
Frequent mood__
changes__

ORTHOPEDIC:
Joint pain__
Joint swelling__
Backache__
Knee pain__
Other_____
_____
_____

Please List Your 5 Personal Health Goals:

1 _____

2 _____

3 _____

4 _____

5 _____

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Family History: Genetic & Acquired Predispositions

Disease	Relative	Living	Age at Death
Heart Disease	Mother		
	Father		
	Sister		
	Brother		
	Child		
Cancer	Mother		
	Father		
	Sister		
	Brother		
	Child		
Diabetes	Mother		
	Father		
	Sister		
	Brother		
	Child		
Hypertension	Mother		
	Father		
	Sister		
	Brother		
	Child		
High Cholesterol	Mother		
	Father		
	Sister		
	Brother		
	Child		

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Adult Immunization History

Immunization	Date Received	Never Received	Would Like to Receive
Hepatitis A			
Hepatitis B			
Tetanus / Diptheria			
Influenza			
Pneumococcal			
Meningococcal			
Chicken Pox / Shingles			
PPD / TB Test			
Other:_____			
Other:_____			

Do you have any food or drug allergies?

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Alcohol consumption: How many days a week? _____ How many ounces? _____

Does it interfere with work, school, relationships?_____

Have you ever received treatment? _____ Type:_____Relapses:_____

History of tobacco use: Never used tobacco (Yes _____ No_____)

Present use? (Yes _____ No_____) Type and amount_____

*If you have ever smoked cigarettes, please do the calculation;

# of packs per day_____ X # of years smoked_____ = _____ pack years

Quit date _____ What efforts have you used to stop_____

Are you interested in stopping? (Yes _____ No_____)

Caffeine intake: # of cups of coffee/day _____ # of cups of tea/day _____

# of 8oz servings of cola beverage/day _____

Please describe any "at risk" behaviors, such as car racing, mountain climbing, gliding, etc. or other dangerous work or leisure pursuits or "At risk" sexual practices:

_____

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Nutrition Survey

How would you rate your diet in general? (Please check one)

Very healthy____ Healthy____ Moderately healthy____ Poor____ Very poor____

On average, what is the total number of servings of fruits and vegetables that you have each day? _____

Do you have food allergies or intolerances?

_____

_____

_____

_____

Please describe the healthy and unhealthy aspects of your diet:

_____

_____

_____

_____

Please list any improvements would like to make:

_____

_____

_____

_____

Would you like more information about nutrition? Yes____ or No_____
If Yes, What kind & how can we help you?

_____

_____

_____

_____

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Use of Complimentary Alternative Medicine

Therapy	Have Used	Considered Using
Acupuncture		
Homeopathy		
Naturopathy		
Magnetic Therapy		
Herbal Remedies		
Manual Healing:		
Chiropractic / Massage		
Therapeutic Touch		
Mind & Body Interventions: Meditation / Guided Imaging Hypnosis / Biofeedback / Prayer		
Chelation Therapy		
Aroma Therapy		
Other - Please Describe: _____		

Accident Prevention & Auto Safety Answer, or Check Yes or No

Do you use protective safety equipment when exercising, performing work duties or other physical activities? ____Y ____N	_____ % of time protective equipment used
# Auto miles per year _____	Percentage of time wearing seatbelt _____ %
Do you have a tendency to speed? ____Y ____N	Do you have a visual problem? ____Y ____N
Do you Change lanes often? ____Y ____N	Do you have a hearing problem? ____Y ____N
Are you distracted by music or conversation? ____Y ____N	Movement / Coordination problem? ____Y ____N
Do you use your cell phone while driving? ____Y ____N	Take medication that may make you too sleepy or impair your driving? ____Y ____N
do you feel that your vehicle is sturdy if in a collision? ____Y ____N	# times in the past 10 years you as a vehicle driver were drug or alcohol impaired? _____
# times in the past 10 years have you as a vehicle driver fallen asleep, or were too tired to drive safely? _____	How many people do you think are killed in motor vehicle accidents in the USA yearly? ____

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Exercise Habits

Please describe your exercise

Type:_____

Frequency:_____

Other types of physical activity:

_____

_____

Goals for exercise this year:

_____

_____

How will you achieve these goals?

_____

_____

Sleep

Please check the condition which describes how your sleep is or how it has changed this year:

_____ I have no sleep problems Difficulty staying asleep Sleep apnea

_____ Awaken frequently during the night Sleep too much Not enough

_____ Difficulty getting up Early morning awakenings Sleepy during the day

_____ Difficulty falling asleep Problems with snoring Sleep walking

Social History

Any changes in marital status?_____

Changes in work?_____

New children or grandchildren?_____

New hobbies?_____

Completed by_____

Signature _____ Date_____

(Print then sign document)

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The Burns Depression Inventory

Instructions:
The following is a list of symptoms that people sometimes have. Check the box that best describes how much that symptom or problem has bothered you during the past week.

	Symptom List	0 - Not at all	1 - Somewhat	2 - Moderate	3 - A lot
1	SADNESS: Have you been feeling sad or down in the dumps?				
2	DISCOURAGEMENT: Does the future look hopeless?				
3	LOW SELF ESTEEM: Do you feel worthless or think of yourself as a failure?				
4	INFERIORITY: Do you feel inadequate or inferior to others?				
5	GUILT: Do you get self-critical and blame yourself for everything?				
6	INDECISIVENESS: Do you have trouble making up your mind about things?				
7	IRRITABILITY & FRUSTRATION: Do you feel resentful and angry a good deal of the time?				
8	LOSS OF INTEREST IN LIFE: Have you lost interest in your career, hobbies, family, or friends?				
9	LOSS OF MOTIVATION: Do you feel overwhelmed & have to push yourself hard to do things?				
10	POOR SELF-IMAGE: Do you think you're looking old or unattractive?				
11	APPETITE CHANGES: Have you lost your appetite, or do you overeat or binge compulsively?				
12	SLEEP CHANGES: Do you suffer from insomnia, find it hard to get a good night's sleep, or are you excessively tired & sleeping too much?				
13	LOSS OF LIBIDO: Have you lost your interest in sex?				
14	HYPOCHONDRIASIS: Do you worry a great deal about your health?				
15	SUICIDAL IMPULSES: Do you have thoughts that life is not worth living or that you might be better off dead?				
	ADD UP YOUR TOTAL SCORE FOR THE 33 SYMPTOMS & RECORD HERE				
	DATE				

TOTAL SCORE & DEGREE OF DEPRESSION
0 - 4 = Minimal or No Depression
5 - 10 = Borderline Depression
11 - 20 = Mild Depression
21 - 30 = Moderate Depression
31 - 45 = Severe Depression

The Feeling Good Handbook
David Burns, M.D. - Penguin Group, 1999

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The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently, try to determine how they would have affected you. For each situation, decide whether or not you would have:

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Write down the number corresponding to your choice in the right column, then total your score.

SITUATION	CHANCE OF DOZING
Watching TV	
Sitting inactive in a public place (e.g. theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

Analyze Your Score

Interpretation:

0-7 = It is unlikely that you are abnormally sleepy.
8-9 = You have an average amount of daytime sleepiness.
10-15 = You may be excessively sleepy depending on the situation. Consider seeking medical attention.
16-24 = You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14(6):540-5.

Review all pages to be sure you have filled out each page completely. After completed, print, sign and email to forms@conciergemedical.services or print, sign & mail to: 1250 South Tamiami Trail, Suite 301 Sarasota, FL 34239.