Tracy S. Fansler. MD., LLC
12955 Seminole Boulevard
Largo, Florida 33778

Date: ____/____/____

Name: _____ Referred by: _____
Date of Birth ____/___/____ Age____ Marital Status _____
Occupation _____
States in which you have lived: _____
Countries in which you have lived: _____
Last Medical Attention: Reason _____ Date: ____/____/_____
Primary Care Doctor/Pediatrician/Gynecologist _____
Primary Care/Pediatrician/ Gynecologist's Phone Number _____

Please list all symptoms of PRESENT medical problems and reason for visit:

1. _____ 4. _____
2. _____ 5. _____
3. _____ <> Routine Check-Up No Symptoms

Family History: Please Encircle Yes or No

		State Whom/ Type of Cancer
Cancer	Yes/No	_____
Tuberculosis	Yes/No	_____
Diabetes (Type)	Yes/No	_____
High Blood Pressure	Yes/No	_____
High Cholesterol	Yes/ No	_____
Stroke	Yes/No	_____
Epilepsy	Yes/No	_____
Mental Illness/Depression/Anxiety	Yes/No	_____
Suicide Attempt	Yes/No	_____
Osteoporosis	Yes/No	_____
Alcoholism	Yes/No	_____
Alzheimer's	Yes/No	_____
Heart Disease	Yes/No	_____

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Mother	_____		_____	
Father	_____		_____	
Brother	_____		_____	
Brother	_____		_____	
Sister	_____		_____	
Sister	_____		_____	

Personal History:

Coffee, Cups per day: _____ Tea, Cups per day _____
Cigarettes, <> Past Use-Date you quit_____ <> Current Use- Packs per day _____
Alcoholic Beverages: Type_____ Quantity per week _____
Have you ever been treated for Alcoholism <> Yes <> No
Regular Physical Exercise <> Yes <> No Type of Exercise _____
Hobbies_____ Sleep-How many hours per night _____

In the past 10 years, have you had:

PPD (TB Skin Test) Yes/No
Tetanus Shot Yes/No
(If OVER 40, test for blood in stool)
Hemoccult Yes/No
(If OVER 50) Colonoscopy Yes/No

(65 or older) Pneumovac Yes/No
(If under 27) Gardasil (HPV) Vaccination Yes/No

Have you ever had:

<> Red Measles
<> German Measles
<> Mumps
<> Whooping Cough
<> Diphtheria
<> Small Pox
<> Chicken Pox
<> Typhoid Fever
<> Influenza
<> Pneumonia
<> Scarlet Fever
<> Tuberculosis
<> Meningitis
<> Polio

Current Medications:

_____

_____

Allergies to Medications/State type of Reaction: _____

_____

Past Medical History:

<> Heart Trouble
<> High Blood Pressure
<> High Cholesterol
<> GERD/Reflux
<> Cancer _____
<> Diabetes
<> Migraines/ Headaches
<> Osteoporosis
<> Osteopenia
<> Other _____

Surgical History: (Please state what kind of surgery and date)

<> Tonsillectomy _____
<> Chest/Heart/Vascular Surgery _____
<> Head and Neck Surgery _____
<> Orthopedic Surgery _____
<> OB/GYN Surgery _____
<> Other _____

Pregnancy (please state the date, type of delivery (Vaginal/C-Section), and any complications)

1. _____
2. _____
3. _____
4. _____

Gynecological History:

1. Age at first menstrual cycle (menarche) _____
2. How often do they occur? (i.e. 21-35 days) _____
3. Duration (i.e. 3-7 days) _____
4. Age at final menstrual cycle (menopause) _____
5. Have you ever used oral contraceptives? Yes/No
   How many years? _____
   Are you currently using OCP's _____
6. Did you ever contract a sexually transmitted disease? Y/N

Please Circle:

Chlamydia Gonorrhea Human Papilloma Virus HIV
Genital Warts Syphilis Hepatitis Herpes

7. Have you ever had an abnormal pap smear? Y/N
If Yes, What treatment did you receive?
Please Circle:

Repeat Pap Smear Colposcopy Cryotherapy
Cold Knife Cone Biopsy Hysterectomy LEEP

Date of Last Pap Smear _____/_____/_____
Date of Last Dexa Scan _____/_____/_____
Date you last had Routine labs done _____/_____/_____

Date of Last Mammogram _____/_____/_____
History of Abnormal Mammograms? Yes/No
If Yes, What Kind of Treatment? _____

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Patient Name_____DOB_____

PLEASE ANSWER QUESTIONS BELOW

ALL FEMALE PATIENTS:

Date of last Mammogram:_____Results: (circle one) **NORMAL** **ABNORMAL**

Date of last Pap:_____Results: (circle one) **NORMAL** **ABNORMAL**

Date of last Dexa:_____Results: (circle one) **NORMAL** **ABNORMAL**

ALL MALE PATIENTS:

Date of last PSA:_____Results: (circle one) **NORMAL** **ABNORMAL**

ALL PATIENTS:

Date of FLU vaccine:_____

Date of Pneumonia vaccine:_____

Date of Shingles vaccine:_____

Date of TB vaccine:_____

Date of last Tetanus:_____

ALL DIABETIC PATIENTS:

Date of last foot exam:_____

Date of last eye exam:_____

Date of last Hgb A1C:_____

PATIENT PROFILE

Last Name _____ First Name _____ Middle Name _____

Gender _____ Social Security Number _____ Marital Status _____ Date of Birth _____

Race _____ **Ethnicity:** Hispanic **OR** Non-Hispanic **(CIRCLE ONE)** Preferred Language _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address (Please Do Not Leave Blank) _____ Place of Employment _____

Emergency Contact _____ Relationship _____ Phone Number _____

PHARMACY INFO

Pharmacy Name _____

Pharmacy Address (You can use intersections) _____

Pharmacy Phone Number _____

PRIMARY CARE PHYSICIAN

Primary Care Physician _____ Specialists _____

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Tracy S. Fansler, M.D., LLC
12955 Seminole Boulevard
Largo, Florida 33778
727-584-9500
Fax: 727-584-9502

I authorize **Tracy S. Fansler, M.D.** to use and disclose my medical records for the purpose of Treatment, Payment and Health Care Operations.

- **Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This authorization includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.
- **Payment** includes activities involved in determining your eligibility for health plan coverage, billing, and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.
- **Health Care Operations** include the necessary administrative and business functions of our office.

I further authorize **Tracy S. Fansler, M.D.** to disclose health and medical information to the following:

_____ Relationship to Patient _____
_____ Relationship to Patient _____
_____ Relationship to Patient _____
_____ Relationship to Patient _____

I understand and authorize my designated caregiver or personal representative to receive information described above.

I understand that I have the right to revoke this Authorization provides that I do so in writing, except to the extent that Tracy S. Fansler, M.D. has already used or disclosed the information in reliance on this authorization. Unless revoked, this authorization will remain in effect for the period reasonably needed to complete this request.

I have received a copy of the "Notice of Privacy Practices" _____ **Your initials**

Signature _____ Date _____

Signature of Person Authorized by Law or Client _____

Dr Tracy Fansler, M.D.

Please note that the completion of FMLA, Disability, Credit Card Deferment, School Education, Disability Assessments, and detailed Work release forms. These forms are time consuming as well as above the normal provisions of medical care.

The requesting facilities, employers and insurance companies do not cover this cost. Therefore, it is necessary for us to charge a fee for the time and effort that it takes to complete such forms.

There is no charge for simple "Return to Work" or excuses for work or school notes.

For FMLA paperwork, there will be a charge of $25.00 for each form to be completed.

For Disability paperwork, there will be a charge of $50.00 for each form to be completed.

For detailed Work Release forms, Credit Card Deferment forms or Extended School Education forms, there will be a charge of $50.00 for each form completed.

Any other forms or requests will be handled on an individual basis.

We thank you for understanding.

Dr Tracy Fansler, M.D.

Printed name of patient or person authorized to sign for patient

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Signature of patient or person authorized to sign for patient

Financial Policy

Welcome to our medical practice. We are committed to providing you with the best possible care and service. If you have insurance, we are anxious to help you receive your maximum plan benefits. In order to achieve these goals, we need your assistance, and your understanding of our payments policies.

Balances owed for services rendered are due at the time services are rendered unless payment arrangements have been approved in advance by our billing office. Co-pays will be collected in advance of your appointment. We accept cash, checks, Visa, Mastercard and Discover. We will file claim for your primary insurance. A fee of $25.00 will be charged for any returned checks. Patient balances greater that 30 days old will be charged a monthly administrative fee of $3.00 with each patient statement.

Please realize that:

1. Insurance is a contract between you, your employer, and the insurance company. We are not a party to that specific contract.
2. We have established our charges based on the actual value of the service. We do, however, provide significant adjustments to those services with many insurance companies.
3. Not all services rendered are a covered benefit with all insurance company contracts that you or your employer may have chosen. It is important for you to have an understanding of the benefits and regulations associated with your health plan.

We emphasize that as a health care provider, our relationship is with you, not your insurance company. Follow up on outstanding claims with your insurance company may require your intervention; and we appreciate your working with us in that regard. We realize that temporary financial problems may affect timely payment of your account. However, if such problems occur, we expect you to contact us promptly for assistance. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. **WE ARE HERE TO TRY TO HELP YOU.**

POLICIES RELATED TO MEDICARE AND MEDICARE SUPPLEMENT INSURANCE

We are a participating provider with the Medicare part B program; and as such are obligated to write off the difference between Medicare's allowed amount and our charge. Medicare pays 80% of that allowed amount to us directly. The 20% co-pay and annual deductible are the patient's responsibility.

POLICIES OF CONTRACTED MANAGED CARE COMPANIES

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is impossible for us to keep track of all the individual requirements of the many various plans. Each one has different stipulations regarding what services may be rendered and, even more importantly, where and who those services may be performed by. Even within the same insurance company, the plans differ greatly depending upon what types of contracts you or your employer have requested.

Providing quality medical care for our patients is our primary concern. We will provide that care within your contract guidelines, but we expect you to contact your plan and to actively participate in knowing your plan regulations as services are rendered. **If a treatment authorization is required by your plan, please be sure that our office is in receipt of that authorization PRIOR to your appointment or your appointment may require re-scheduling.**

If you do not inform us of any special requirements in your contract, and we subsequently order services such as lab work, medical equipment, outpatient diagnostic services, hospitalization, or any other services recommended by your physician that are not covered, we or the selected medical facility will have no alternative but to bill you directly for those charges. Payment for those charges is then your responsibility.

With your cooperation and direction you should be able to receive all the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Any cancellations must be made at least 24 hours prior to appointment time or you will be billed a $35.00 cancellation fee. Medical records request fee is $1.00/per page plus postage.

Accounts over 90 Days are subject to a $25.00 collection fee.

Thank you for understanding our Financial Policy.

Signature_____ Date_____

Witness_____

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)						
Name	Tracy S. Fansler, M.D., LLC			Phone	727-584-9500/fax 727-584-9502	
Address	12955 Seminole Blvd					
City/State Zip		Largo		FL		33778

RECORDS FROM (Who is **Releasing** the Records):						
Name				Phone		
Address						
City/State Zip				FL		

For the Following Purposes:

	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
	Office Notes and Reports		Most recent one year history		Most recent three-year history
	Rx History		Transcribed hospital reports		Laboratory reports
	Billing Statements		Diagnostic Reports		Diagnostic Films
	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____ Other: _____

I **understand** that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I **also understand** that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, **further understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____