Bach & Godofsky
Infectious Diseases

6010 Pointe West Blvd
Bradenton, FL 34209
P:(941) 746-2711 F:(941) 746-3433

PATIENT INFORMATION

Name:		**Address:**
Date of Birth:	Marital Status: S M D W	Social Security Number:
Home Phone (____)_____-_____	Mobile Phone(____)_____-_____	Work Number(____)_____-_____

Preferred Method of Contact: ☐Home Phone ☐Mobile Phone ☐Work Number ☐Email

- **I agree to receive automated phone calls from Bach & Godofsky on my mobile phone about appointments, test results, or any other information. ☐Yes ☐No**
- **I agree to receive automated text alerts from Bach & Godofsky regarding appointments, test results, or any other information. ☐Yes ☐No**

Email for Portal Contact_____ **☐ NO ACTIVE EMAIL**

EMERGENCY CONTACT/RELEASE OF MEDICAL INFORMATION

Name:	Phone Number	☐Spouse ☐Partner ☐Parent ☐Child ☐Other_____
Name:	Phone Number	☐Spouse ☐Partner ☐Parent ☐Child ☐ Other_____
Name:	Phone Number	☐Spouse ☐Partner ☐Parent ☐Child ☐ Other_____

I authorize the practice of Bach & Godofsky to speak with the CONTACTS listed above regarding my Private Healthcare Information (PHI). ☐Yes ☐No

LOCAL PHARMACY:	**MAIL ORDER PHARMACY:**	**LAB:**
_____	_____	**☐QUEST ☐LABCORP**
Address or Cross Streets:_____	Address_____	**☐Manatee Memorial**
City_____ St_____	City_____ St_____	**☐Blake Medical Center**
Zip_____	Zip_____	**☐Other**_____
Phone (____)_____-_____	Phone (____)_____-_____	**☐None Preferred**

HEALTH TEAM MEMBERS: (Please note that the physicians listed below will be provided with a visit summary and access to your medical record)

Primary Care Physician _____ Phone(____)_____-_____

Referring Physician _____ Phone(____)_____-_____

Other physicians that you see:

_____

Check the boxes as authorization and sign/date below.

☐PRIVACY STATEMENT ACKNOWLEDGEMENT: I have received the Patient Privacy Statement information from the practice of Bach & Godofsky. I am aware that the Patient Privacy Statement will be available for viewing in the office or via the Patient Portal.

☐ AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY: I authorize the download of my medication history into the electronic medical records of Bach and Godofsky Infectious Diseases.

☐ PERMISSION TO COMMUNICATE VIA PATIENT PORTAL: I have reviewed the Bach & Godofsky Patient Portal Authorization form and agree to participate in the portal voluntarily.

Patient/Representative:_____ **Date:**_____

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Financial Policy

The Physicians and staff of Bach & Godofsky Infectious Diseases are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and understanding of our financial policy.

Health Insurance

If you will be using health insurance, you must present your current insurance card prior to your initial visit. **Your insurance company requires us to collect any applicable co-payments at the time of service**. You will be responsible for all amounts not paid by them, including amounts denied, applied to deductible, or considered non-covered as permitted by your insurance company.

Self-Pay

If you are self-pay, you will be expected to pay the day's charges **prior** to seeing the physician. If it is determined that you require prolonged infusion therapy, one weeks payment will be collected prior to receiving treatment each week.

Patient Responsibility

I understand that I am financially responsible for payment of my medical services to Bach & Godofsky Infectious Diseases regardless of any insurance benefits that I might have. I consent to the treatments considered necessary that will be performed by physicians and employees of the practice. **I understand that I will be charged a $25.00 cancellation fee for any appointment not cancelled 24 hours prior to the scheduled time.** I understand that I will be charged a $25.00 fee for any check returned from the bank due to non-sufficient funds.

Billing Statements and Questions

Patients with a personal balance will receive a monthly statement. These statements are due upon receipt. Questions or concerns regarding your account or insurance claim should be directed to our Billing Representative. This highly trained expert has been instructed to make every effort to clarify any issues regarding your account. Please notify us immediately if you feel an error appears on your statement or if you have any questions or concerns. Failure to pay your balance due upon receipt of a statement can lead to your account being turned over to collections.

Insurance Information Authorization

I authorize the release of any medical information necessary to process insurance claims. I further authorize payment of the medical benefits to Bach & Godofsky Infectious Diseases for services provided to me. I permit a copy of this authorization to be used in the place of the original.

Medicare Part B Signature Authorization

I authorize Bach & Godofsky Infectious Diseases to release to the Social Security and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or related Medicare claims. I further authorize payment of Medicare benefits to Bach & Godofsky Infectious Diseases for services provided to me. I permit a copy of this authorization to be used in the place of the original.

I HAVE READ AND COMPLETELY UNDERSTAND THE FINANCIAL POLICY OF BACH & GODOFSKY INFECTIOUS DISEASES.

_____ _____

Signature of Patient and/or Responsible Party Date

Bach & Godofsky

Bach Godofsky Infectious Diseases
Patient Information

DATE:					
Patient Status:	[ ]New Patient	[ ]Return Patient	[ ]Hospital Follow-Up		
Current Problem					
What/where are your current problems?					
Was this a work related accident?	[ ]YES [ ]NO				
Is this a result of an auto accident?	[ ]YES [ ]NO				
Date your symptoms/problems began:					
TREATMENT HISTORY					
Have you ever been treated at a hospital or by another physician for this problem?			[ ]YES	[ ]NO	
If yes, where/by whom and when?					
Have you had any of the following for this problem:					
Endoscopy	[ ]YES	[ ]NO	If YES, when/where?		
Antibiotic	[ ]YES	[ ]NO	If YES, when/where?		
X-rays	[ ]YES	[ ]NO	If YES, when/where?		
MRI	[ ]YES	[ ]NO	If YES, when/where?		
CT Scan	[ ]YES	[ ]NO	If YES, when/where?		
Bone Scan	[ ]YES	[ ]NO	If YES, when/where?		
Culture	[ ]YES	[ ]NO	If YES, when/where?		
Biopsy	[ ]YES	[ ]NO	If YES, when/where?		
Circulation Tests	[ ]YES	[ ]NO	If YES, when/where?		
Ultrasound	[ ]YES	[ ]NO	If YES, when/where?		
Stress test	[ ]YES	[ ]NO	If YES, when/where?		
Echocardiogram	[ ]YES	[ ]NO	If YES, when/where?		
Colonoscopy	[ ]YES	[ ]NO	If YES, when/where?		
Have you had surgery for this	[ ]YES	[ ]NO	If YES, when/where?		
Personal/Social History					
Do you live alone?	[ ]YES	[ ]NO			
Marital Status:	[ ] Single	[ ] Married	[ ] Widowed	[ ] Divorced	[ ] Significant Other
Race:	[ ] Caucasian	[ ] Hispanic	[ ] American Indian	[ ] African American	[ ] Asian
Ethnicity:	[ ] Not Hispanic/Latino		[ ] Hispanic/Latino	[ ] Other:	
Language:	[ ] English	[ ] Spanish	[ ] Other:		
Employment	[ ] Currently working	Occupation:			
	[ ] Retired				
	[ ] Disabled				
Do you consume alcohol?	[ ] Never	[ ] Past	[ ] Current		
Average number of drinks per week (now or past)?			[ ] 7 or less	[ ] 8 to 15	[ ] 15 or more
How many days in the past YEAR have you had heavy drinking consumption?			[ ] none	# DAYS_____	
Do you smoke?	[ ] Never	[ ] Past	[ ] Current------->		
How many packs per day?	[ ]1/4 PPD	[ ] 1/2 PPD	[ ] 1 PPD	[ ] 1 PPW	[ ] 2 PPW [ ] 3 PPW
How many years have you smoked?		[ ] 5 or less	[ ] 6-10	[ ] More than 10	
Years of Smoking? _____					
Do you use other tobacco products?		[ ] Never	[ ] Past	[ ] Current	
Do you use recreational drugs/marijuana?		[ ] Never	[ ] Past	[ ] Current	

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Patient Information

ALLERGIES: Check if applicable.

[ ] Contrast/Iodine Allergy [ ] Medication Allergy [ ] Latex Allergy [ ] No known allergies

If you have a medication allergy, please list the mediation(s) that have given you a bad reaction. Include the reaction such as hives, rash, itching, nausea, diarrhea, shortness of breath, swelling of lips/face, etc

MEDICATION	REACTION

MEDICATION(S): List all prescription medications and over the counter medications you are currently taking.

[ ] I do not currently take any medications. [ ] SEE LIST

Medication	Dose	Frequency

FAMILY HISTORY

[ ] UNKNOWN

Check box if a parent, grandparent or sibling have had history of any of the following:

[ ] Alcohol Abuse	[ ] Cirrhosis	[ ] Hypertension	[ ] Tuberculosis
[ ] Autoimmune Hepatitis	[ ] Colon Cancer	[ ] Irritable Bowel Syndrome	[ ] Ulcer Disease
[ ] Bleeding Disorder	[ ] Diabetes	[ ] Liver Cancer	[ ] Other
[ ] Blood Clots	[ ] Hepatitis B	[ ] Mental Illness	
[ ] Cancer	[ ] Hepatitis C	[ ] Stroke	

SURGERIES: Check the box for all surgeries you have had.

[ ] Amputation	[ ] Hip Replacement	[ ] Liver Transplant
[ ] Appendectomy	[ ] Hysterectomy	[ ] Shoulder Surgery
[ ] Back Surgery	[ ] Kidney Transplant	[ ] Sinus Surgery
[ ] Brain Surgery	[ ] Knee Arthroscopy	[ ] Stent Placement
[ ] Breast Surgery	[ ] Knee Replacement	[ ] Vasectomy
[ ] Cholecystectomy	[ ] Lens Implant	OTHER: _____

IMMUNIZATIONS: Check the box of the vaccines you have received.

[ ] Hepatitis A/Date:_____ [ ] Hepatitis B/Date:_____ [ ] Flu Vaccine/Date:_____ [ ] Pneumonia Vaccine/Date:_____

[ ] Shingles Vaccine/Date:_____

ADVANCE DIRECTIVE

Do you have a Healthcare Surrogate, a Living Will or other medical advance directive? YES NO

PAST MEDICAL HISTORY

Check the box if have a history of any of the following conditions:

[ ] Anemia
[ ] Antibiotics in the past 2 months
[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Blood clots
[ ] Cancer
[ ] Circulation Problems
[ ] Cirrhosis
[ ] Constipation
[ ] Crohn's Disease
[ ] Dementia
[ ] Depression
[ ] Diabetes
[ ] Diverticulitis/Diverticulosis
[ ] Drug Abuse
[ ] Elevated cholesterol/triglycerides
[ ] Emphysema/COPD
[ ] Gout
[ ] Hearing Problems
[ ] Heart Disease
[ ] Hemorrhoids
[ ] Hepatitis A
[ ] Hepatitis B
[ ] Hepatitis C
[ ] Hepatitis D
[ ] Herpes
[ ] Intranasal Cocaine Use
[ ] Iron Overload
[ ] Kidney Problems
[ ] Liver Disease
[ ] Migraines
[ ] MRSA Infection
[ ] Osteoporosis
[ ] Pancreatitis
[ ] Physical disability
[ ] Pneumonia/Pneumocystis
[ ] Seizure Disorder
[ ] Sickle Cell Anemia
[ ] Stroke
[ ] Swelling of the abdomen/Ascites
[ ] Syphilis
[ ] TB
[ ] Thyroid disease
[ ] Travel Outside of the US
[ ] Treatment with a Blood Thinner
[ ] Urinary Tract Infections
[ ] OTHER: _____

CURRENT SYMPTOMS

Check any that apply

CONSTITUTIONAL	[ ]NONE	[ ] fever	[ ] night sweats	[ ] weight gain	[ ] weight loss
		[ ]exercise intolerance			
EYES	[ ]NONE	[ ] dry eyes	[ ] irritation	[ ] vision change	
EAR, NOSE,MOUTH,THROAT	[ ]NONE	[ ] difficulty hearing	[ ] ear pain	[ ] nose bleeds	[ ] sinus problems
		[ ] sore throat	[ ] dry mouth	[ ] mouth ulcers	
CARDIOVASCULAR	[ ]NONE	[ ] chest pain	[ ] palpitations		
		[ ]heart murmer			
RESPIRATORY	[ ]NONE	[ ] cough	[ ] wheezing	[ ] shortness of breath	
		[ ] use of home O2	[ ] blood in sputum		
GASTROINTESTINAL	[ ]NONE	[ ] abdominal pain	[ ] diarrhea	[ ] vomiting	[ ] constipation
		[ ]vomiting blood			
GENITOURINARY	[ ]NONE	[ ] painful urination	[ ] frequent urination	[ ] pelvic pain	[ ] dark urine
		[ ] urgency	[ ] blood in urine		
MUSCULOSKELETAL	[ ]NONE	[ ] pain	[ ] stiffness	[ ] achiness	[ ] weakness
SKIN	[ ]NONE	[ ] open wound	[ ] rash	[ ] abscess	[ ] redness
		[ ] itching	[ ] swelling	[ ] drainage	
NEUROLOGICAL	[ ]NONE	[ ] headache	[ ] dizziness	[ ] seizure	[ ] weakness
		[ ] fainting	[ ] migraine	[ ] tremors	[ ] difficult speech
PSYCHIATRIC	[ ]NONE	[ ] suicidal thoughts	[ ] panic attacks	[ ] anxiety	[ ] depression
		[ ] difficulty sleeping			
ENDOCRINE	[ ]NONE	[ ] heat intolerance	[ ] cold intolerance	[ ] excessive hunger	
		[ ] excessive thirst			
HEMATOLOGIC/LYMPHATIC	[ ]NONE	[ ] easy bruising	[ ] prolonged bleeding		
ALLERGIC/IMMUNOLOGIC	[ ]NONE	[ ] runny nose	[ ] sinus issues	[ ] itching	[ ] hives

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FOR HEPATITIS C PATIENTS ONLY

When were you first diagnosed with Hepatitis C?

[ ] Within 6 months of this visit
[ ] 6 months to 1 year ago
[ ] More than 1 year ago

Have you been treated for hepatitis C? [ ]YES [ ]NO

If YES, please mark the treatments you received:

[ ] Intron A alone
[ ] Intron A plus ribavirin
[ ] Pegylated interferon alone
[ ] Pegylated interferon plus ribavirin
[ ] Experimental treatment
[ ] Direct Acting Antiviral
[ ] Do not know

FOR HEPATITIS C PATIENTS ONLY

Identify your risk factor(s) for Hepatitis C:

[ ]Intravenous Drug Use
[ ]Intranasal Cocaine Use
[ ]Tattoos
[ ]Organ Transplant
[ ]Occupational Risk
[ ]Unknown
[ ]Childhood Vaccines in a foreign country
[ ]Body Piercings
[ ]Blood Transfusion
[ ]Congenital Exposure
[ ]Sexual Risk
[ ]Dialysis

Other: _____

What year was the your FIRST exposure to the above risk factor?_____