

Millennium Medical

Treating People, not Symptoms

5088 66th Street N.

St. Petersburg, FL 33709

Ph: 727-541-2675

Fax: 727-541-3956

www.millmd.com

WELCOME

Welcome to Millennium Medical, a place where we emphasize “patient care” rather than “symptom care” – offering a more effective way of achieving long-term wellness than the temporary damage control so common in today’s traditional medicine. Our goal is to provide excellent care where patient and doctor work together in a caring, nurturing and supportive environment.

Your first day in the office is a fact-finding mission. Consultation, examination, blood work and X-rays may be performed to help us thoroughly understand your complete medical picture. Only by understanding the origins of a medical issue can we take the first step towards achieving good health. Depending on your individual case, you may be referred to one of the many specialists here at Millennium Medical for additional testing and/or consultation.

Your next visit will more than likely consist of a report of findings, at which time a complete explanation of your condition will be given. You will have an opportunity to have your questions answered, our goals will be defined, and your treatment schedule will be discussed. We encourage and promote patient involvement, and we strive to give you a choice of treatment options, including traditional and alternative care.

In closing, we are excited to be involved in your healthcare. It’s time to rediscover what feeling your best feels like. It’s time to make **you** a priority. Please feel free to contact our patient services department if you need anything.

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ENROLLMENT FORM

Date: _____ Email Address: _____

Name: _____
First Middle Initial Last

Address: _____
Number & Street City State Zip

Birth Date: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relation: _____

Emergency Phone: _____ Spouse's Name: _____

Employer: _____ Work Phone: _____

Date of last doctor appt.: _____ Dr. Name: _____

Do you have a Living Will? _____ Yes _____ No

How were you referred to our office: _____

Have you been injured in an accident? Yes No When? _____

Work Related? Yes No or Auto related? Yes No

Primary Insurance Company: _____

Policy Holder: _____ Date of Birth: _____

Secondary Insurance Company: _____

Policy Holder: _____ Date of Birth: _____

Millennium Medical

New Patient History and Symptom Survey

Why are you here today? _____

HEALTH QUESTIONS

Women's Health:

Last PAP _____ Last Mammogram _____ Last Colonoscopy _____

Last Dexa Scan _____ # of Living Children _____ Type of Delivery _____

Contraception _____ Last Menstrual Period _____ Cycle _____

Days of Flow _____ Quality _____ Age Menstruation started _____

Are you pregnant? ____ Yes ____ No If yes, what is your due date: _____

Problems: _____

Men's Health:

Breast Lump Lump in Testicles Last Colonoscopy _____

Erection Difficulties Penile Discharge/Sore Prostate Problem

Problems: _____

Medical History:

High BP Heart Disease Diabetes Stroke Lung Disease Stomach Disease

Surgeries: _____

Family: Cancer Diabetes Heart High BP Respiratory Mental

Mother

Father

Brother

Sister

Infectious Diseases:

HIV Hepatitis TB HSV Viral STD

Current Medications: _____

Allergies/Reaction: _____

Review of Systems (Mark all that Apply)				
	X		X	X
Constitutional:		Respiratory (Lungs):		Endocrine:
Fatigue		Asthma		Muscle Spasm
Weight Loss		Wheezing		Frequent Thirst
Weight Gain		Short of Breath		Frequent Hunger
Fever		Chronic Cough		Hair Loss
Chills		COPD		Cold Intolerance
Loss of Appetite		Bronchitis		Heat Intolerance
Weakness		Pneumonia		Blood / Lymph:
Integumentary:		Emphyzema		Bruising
Skin sores		Gastro:		DVT's
Bruising		Diarrhea		Excessive Bleeding
Dry Skin		Constipation		Slow Clotting
Rashes		Indigestion		Swelling of Lymph Nodes
Moles		Hemorrhoids		Anemia
Skin Tags		Nausea		Allergies:
Eyes:		Vomiting		Hay Fever
Vision Changes		Blood in Stool		Food Allergies
Blurred Vision		Number of BM's per day		Animal Allergies
Double Vision		Poor Appetite		Seasonal Allergies
Glasses		Bloating		Post Nasal Drip
Contacts		Gas		Medication Allergies
Cataracts		Bowel Changes		Other Allergies:
Glaucoma		Urinary:		Breast / Chest:
Macular Degeneration		Incontinence		Breast Pain
Eye Disease		Urgency		Breast Mass
Ears, Nose & Throat:		Stress Incontinence		Nipple Leakage
Headaches		Blood in Urine		Breast Implants
Earaches		Dysuria		Breast / Chest Tenderness
Sore Throat		Frequent Urination		Nipple Discoloration
Sinus Problems		Musculoskeletal:		
Mouth Sores		Muscle Pain		
Cough		Muscle Aches		
Tooth Pain		Joint Pain		
Post Nasal Drip		Neck Pain		
Hearing Loss		Mid Back Pain		
Cardiac (Heart):		Low Back Pain		
Chest Pain		Knee Pain		
Palpitations		Shoulder Pain		
Chest Tightness		Other Pain:		
Angina		Psychological:		
Swelling - Leg		Depression		
Swelling - Ankle		Anxiety		
Swelling - Foot		Insomnia		
Previous Heart Attack		Excessive Sleep		
Heart Valve Disorder		Change in Sex Drive		
Pacemaker		Eating Disorder		

Pain:

Where is your pain? _____

What caused your pain and when did it start? _____

Is your pain: Constant Occasional Moderate Severe

Rate your Pain from 1-10 (1 being the mildest and 10 being the most severe) _____

What aggravates your pain? _____

What makes your pain subside? _____

Does your pain keep you awake at night or wake you up during the night? _____

Does your pain get progressively worse during the day? _____

Does your pain cause weakness in your arms or legs? _____

Does your pain radiate? Yes No If yes, where? _____

Have you had previous treatment for this pain? Yes No If yes, when and by whom? _____

What are your job duties daily? _____

What do you do for pleasure? _____

Does your pain interfere with your work or pleasure activities? _____

Do you exercise? _____

Are you seeking pain relief only or correction of the problem? _____

When was your last X-Ray taken? _____ What part of your body? _____

Have you had Chiropractic Care? Yes No

If so when _____ Dr. Name: _____

Social History (Check all that Apply)

Marital Status	X
Single	
Married	
Separated	
Divorced	
Widowed	
Living Arrangements	
Own home	
Rent home	
Live alone	
Does not live alone	
Children at home	
No children at home	
No children	
Have a will	
Have a living will	
Signed DNR	
Need other legal assistance	
Education	
Currently attending school p/t	
Currently attending school f/t	
Some High School	
High School Graduate	
GED	
Vocational School	
Some College	
College Graduate	
Graduate Degree	
Post Graduate Degree	
Employment Status	
Working full time	
Working part time	
Disabled	
Retired	
Not Working	
Occupation/Exposure	
Agricultural	
Construction	
Manufacturing	
Medical/Hospital	
Office Work	
Painter	
Salesperson	
Homemaker	
Other occupation	
Exposure to dust	
Exposure to noise	
Exposure to radioactivity	
Other Exposure:	

Alcohol	X
Never	
Rarely	
Daily	
Hard liquor 1-2 oz. per day	
Hard liquor over 3 oz. per day	
Beer: 1 bottle per day	
Beer: 2 bottles per day	
Beer: 3 or more bottles per day	
Wine: 1 glass per day	
Wine: 2 glasses per day	
Wine: 3 or more glasses per day	
In recovery	
Smoking	
Current every day smoker	
Current some day smoker	
Smoker	
Former smoker	
Never smoker	
Current status unknown	
Unknown if ever smoked	
Number of Years:	
Packs per day:	
Year quit:	
Does not use other nicotine products	
Uses the following nicotine product(s):	
Caffeine Usage	
Does not drink caffeinated beverages	
Drinks Coffee (cups per day)	
Tea (Cups per day)	
Pain relievers containing caffeine (Excedrin, etc)	
Caffeinated soft drinks (12 oz. per day)	
Energy drinks	
Caffeine supplements (No Doz, Alert, Vivarin, etc)	
Substance Use	
Never used	
Occasional use	
Regular use	
Amphetamines	
Cocaine	
GHB	
Inhalants	
LSD	
Cannabis	
MDA/Ecstasy	
Methamphetamine	
Opiates	
Pain medication	
PCP	
Sleep aids	
Steroids (anabolic)	
Received treatment for abuse	

Diet	X
Eat less than 3 meals per day	
Unrestricted diet	
Diabetic diet	
Low sodium diet	
Low carbohydrate diet	
Low fat diet	
Vegetarian diet	
Vegan diet	
Other diet:	
Use community services for meals	
Exercise	
Regularly	
Occasionally	
Rarely	
Never	
Activities of Daily Living	
Use a cane	
Use a walker	
Use a wheelchair	
Use a hearing aid	
Use a catheter for urine	
Aids are in good order	
Aids are not in good order	
Have problem using toilet	
Does not have problem using toilet	
Able to drive	
Unable to drive	
Rely on others for transportation	
Rely on public transportation	
Lifestyles	
Not sexually active	
Sexually active	
Partner opposite sex	
Partner same sex	
Partners both sexes	
Consistently use contraceptives	
Does not consistently use contraceptives	
Foreign Travel/Living	
Has recently lived outside of U.S.	
Has not recently lived outside of U.S.	
Has recently traveled outside of U.S.	
Has not recently traveled outside of U.S.	

Mark all that Apply

Previous Treatment	X	Diagnostic Studies	X
Nothing		X-rays	
Chiropractic Care		Head and/or Neck	
Acupuncture		Left Upper Extremity	
Injections		Right Upper Extremity	
Other:		Left Lower Extremity	
		Right Lower Extremity	
Physical Therapy		Chest	
Stretching		Cervical-Spine	
Strengthening		Thoracic-Spine	
Traction		LumboSacral Spine	
Iontophoresis/Topical Steroid		Pelvic	
Tens			
Massage		Scans of the Body / Brain	
Ultrasound		CT	
Heat/Ice		MRI	
Therapeutic Ball		PET	
		U/S	
Medications			
Muscle Relaxants		Cancer Treatments	
Pain Medications		Chemo Therapy	
Anti-Inflammatory (Prescription)		Radiation	
Anti-Inflammatory (Over the counter)			
		Alternative Therapies	
		Nutritional Medicine	
		Botanical Medicine (e.g. Herbal remedies, Chinese medicine)	
		Oxidative Medicine (e.g. HBO)	
		Hormone Balancing (e.g. Bioidentical hormone replacement)	
		Environmental Medicine (e.g. Detoxification treatments)	
		Energy Medicine (e.g. Acupuncture, yoga)	
		Physical Medicine (e.g. Chiropractic, massage therapy)	
		Other:	
		Previous Blood Transfusion	
		Yes	
		No	
		When:	
		Blood Type:	

Millennium Medical

Controlled Substances Agreement

Patient Name: _____ Date of Birth: _____

This agreement is to inform you about the controlled substances policies of the Medical Department of Millennium Medical. Pain control is a partnership effort between you and your doctor. This agreement is adapted from guidelines set forth by the Florida Board of Osteopathic Medicine on a review of Rule 64B15-14.005 of the State of Florida. Millennium Medical's controlled substances policy must be agreed to by you, the patient, in its entirety. The policy is as follows:

1. Controlled substances are to be prescribed by only one doctor and filled at only one pharmacy. If you receive a controlled substance from another physician, you must report it to our office within one (1) business day.
2. Prescriptions are only available at regularly scheduled office appointments. These medications will not be called into the pharmacy and prescriptions will not be written without an appointment.
3. Any lost, stolen or otherwise missing prescriptions will not be replaced – no matter what the circumstances. There are no early refills and no exceptions.
4. The patient agrees to urine and/or serum drug lab testing as requested by the doctor without advanced notice (the cost of which becomes the patient's responsibility). Furthermore, the patient agrees to abstain from any recreational or illegal drugs and alcohol while under treatment.
5. We generally **DO NOT** write prescriptions for the following medications or compounds containing them: **Morphine, Oxycodone, Percodan, Percoset, Fentanyl, Demerol and Dilaudid.**
6. You are entitled to know about your medicine including risks, benefits, side effects, and other pertinent information. Your doctor will be glad to discuss these with you. Please relay any concerns or questions to your doctor so that your comfort and safety are ensured.
7. We generally **DO NOT** write prescriptions for narcotics for chronic pain on your initial visit to Millennium Medical. If, after discussion with you, we agree that part of your care plan includes the need for narcotic pain medication, we will limit your initial prescription to one week's worth of medication. We also reserve the right to call your pharmacy or other healthcare facilities to confirm compliance with our policy
8. If your care plan includes other therapies, such as massage, chiropractic, physical therapy or acupuncture, we will expect you to comply with that plan.
9. We will be glad to refer you to a pain management specialist if these policies do not meet your pain management needs.

On a scale from 1 to 10, please rate your pain when it's at its worst (0 = no pain, 10 = worst pain): _____

What are your goals in regards to your pain treatment? (Check all that apply)

Pain relief Increased activity Ability to work Ability to sleep Other: _____

Do you now, or have you ever used/abused any drugs? Please list them and dates used.

Do you now, or have you ever used/abused alcohol? Please list what kind, how much, and when.

By signing here, I agree to the controlled substance policy of the Medical Department of Millennium Medical. I understand that any violations of this policy, including refusal to submit to requested testing, failure to keep appointments, or other violations, will result in immediate cancellation of all controlled substance prescriptions, and possible dismissal from the practice. This cancellation will remain in effect until these violations have been remedied to the satisfaction of the attending physician.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Millennium Medical

Laboratory and Prescription Information

Patient Name: _____ Date of Birth: _____

Laboratory Policy

If you are required by your insurance company to use a specific laboratory, please list the name of the laboratory as you will be responsible to know this information:

If no laboratory is indicated, we will use Clinical Pathology Laboratory.

The laboratory used will bill you separately for services rendered. If you have any questions regarding these bills you may contact the laboratory directly or contact our medical department at 727-541-2675.

Prescription Policy

We refill prescriptions only during office hours. It may take up to **72 hours** for these requests to be completed. It is our office policy that on-call doctors will NOT be paged for refills. In order to obtain your refill in the timeliest manner please call your pharmacy and have them fax over your refill request.

Controlled substances will be filled **only via regularly scheduled appointments with the medical doctors**, no matter what the circumstances. **Any** lost, stolen, or otherwise missing controlled substance prescriptions will **not** be refilled.

If you have any questions regarding prescriptions services, please contact our medical department at 727-541-2675.

My signature below is an agreement that I have read and understand the above information.

Patient Name: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Millennium Medical

Missed Appointment Policy

Patient Name: _____ Date of Birth: _____

We are glad you have chosen us to provide your care, but if you miss appointments, you compromise that care. We want to remind you of our office policies regarding missed appointments. A missed appointment is when you fail to show up for an appointment without a phone call, or cancel without at least 24 hours notice.

We feel the doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the same courtesy of a call when you are unable to keep your appointment.

Our office follows the process below if you miss your appointment.

1. 1st missed appointment: we will call and offer to reschedule the appointment. You *may* be charged a missed appointment fee of \$25.
2. 2nd missed appointment: we will call and offer to reschedule the appointment. You *will* be charged a missed appointment fee of \$25.
3. Consecutive missed appointments: you *will* be charged a missed appointment fee of \$25 and this *may* result in discharge from the practice.

For Functional Medicine, with Dr. Bangtson, our office follows the process below if you miss your appointment.

1. 1st missed appointment: we will call and offer to reschedule the appointment. You *may* be charged a missed appointment fee of \$50.
2. 2nd missed appointment: we will call and offer to reschedule the appointment. You *will* be charged a missed appointment fee of \$50.
3. Consecutive missed appointments: you *will* be charged a missed appointment fee of \$50 and this *may* result in discharge from the practice.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Millennium Medical

Patient Consent for Use and Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

I hereby give my consent for Millennium Medical to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Millennium Medical describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Millennium Medical reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to, the Office Manager at Millennium Medical located at 5088 66th St. North, St. Petersburg, FL 33709.

With this consent, Millennium Medical may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Millennium Medical may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

Millennium Medical has my permission to discuss / disclose my PHI to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing this form, I am consenting to allow Millennium Medical to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Millennium Medical may decline to provide treatment to me.

MILLENNIUM MEDICAL NOTICE OF PRIVACY/PATIENT RIGHTS AND RESPONSIBILITIES

I, the Patient or his/her legal guardian, understand that by signing this agreement I voluntarily authorize provision of products and services to Patient by the provider named above. I have received written and /or oral information about the prescribed treatment and I understand the risks involved. I understand that products and services are prescribed by the Patient's physician, and it is necessary the Patient remain in the care of his/her physician throughout the course of treatment. I have reviewed information about Patients right/Responsibilities, Privacy Notice and Advance Beneficiary notice and had the Patients Right/Responsibilities explained to me.

Your health information is contained in a medical record that is the physical property of Millennium Medical. Millennium Medical uses health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Under the federal HIPAA regulations, you and Millennium Medical have certain rights and restrictions relating to the uses and disclosures of your information. Among its obligations, Millennium Medical is required to maintain the privacy of protected health information; provide you notice of its legal duties and privacy practices; notify you if we are unable to agree to a requested restriction on how your information is used or disclosed; accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and obtain your written authorization to use or disclose your health information for certain defined reasons. **THE FULL TEXT OF MILLENNIUM MEDICAL'S PRIVACY NOTICE IS ON DISPLAY IN THE MAIN WAITING AREA. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Patient Signature: _____ **Date:** _____

Parent or Guardian Signature: _____ **Date:** _____

Millennium Medical

Financial Agreement

Patient Name: _____ **Date of Birth:** _____

This agreement is to inform you about Millennium Medical’s policy for Self-Pay patients. You have been given this agreement because you have no insurance, have failed to provide us with valid insurance, or are electing to not use your insurance for services and/or products received at Millennium Medical.

All self-pay patient’s are required to pay at the time services are rendered or products are received.

Please be prepared to make this payment with the front desk personnel before or after the visit.

Should you have insurance at the time of your visit, please inform the front desk personnel before services are rendered and/or products are received. If Millennium Medical receives this information after services are rendered or products are received, a refund will be issued to you after payment is received from your insurance company.

Millennium Medical, Inc. reserves the right to revise any estimates based upon changes in physician order. Any and all estimates given are subject to change.

By signing this you are agreeing to pay reasonable attorneys’ fees and costs of collection of any past due patient balances if this account is referred to an attorney or agency for collection.

Payment for supports (braces, cervical pillows, etc.) and supplements (vitamins and/or herbs) are expected at time of receipt. All sales are final. Our office accepts Visa/MasterCard, American Express, Discover, Debit cards, cash, or checks for services and products. Please contact the office if you are confused about any aspect of your treatment or bill. We are here to help you, but you need to inform us about any problem or confusion you may have.

I have read this document completely before signing. I completely understand this document or have had any questions about this document fully explained to me. My signature below is my agreement that I fully understand this document and fully agree to the terms of this document.

Patient Signature: _____ **Date:** _____

Parent or Guardian Signature: _____ **Date:** _____