Cruz Fana-Souchet, M.D. **Andrew Sakla, DO**

Phuong Bui, MCMSc, PA-C **Benjamin Love, MCMSc, PA-C**

Office Hours: 8:00 a.m.-5:00 p.m.
Lab Hours: 7:30 a.m.-4:00 p.m.

Dear Patient,

We would like to take a moment to welcome you into our office as the newest member of our growing family of patients. We appreciate the confidence and trust that you have placed in us and look forward to meeting you.

We recognize that each patient is an individual and our goal is to improve your health and well-being for a lifetime of caring.

Enclosed you will find helpful information about our practice. Please take a moment to review the following information to help us better serve you and provide you with a lifetime of caring.

IMPORTANT INFORMATION **PAGES**

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Insurance Accepted: Humana

125 Patricia Avenue Suite B • Dunedin, FL 34698 • Tel: (727)331-8740 • Fax: (727)331-8744

PHYSICIAN ACCESS. Our providers are available 24 hours a day, 7 days a week for urgent health care issues. If you have a question or concern regarding your medical care please don't hesitate to contact us.

HOSPITAL AFFILIATION: Our doctors are affiliated with the following hospitals in the area:

- **Morton Plant Hospital**
- **Mease Dunedin Hospital**
- **Mease Countryside Hospital**

REFERRALS. Your insurance plan may require referrals for most services provided outside the AMA Medical Group clinic. If you are not sure if you need a referral, please contact our office and ask to speak to our referral specialist. ***Please allow 3 business days for processing.*** These services include, but are not limited to:

- Office visit with a specialist
- Radiology (X-ray, Ultrasound, Mammography, etc.)
- Therapy services
- Home health care, walkers, and wheelchairs

URGENT AND EMERGENT CARE. ***For Urgent Care ANYTIME contact us at (727) 331-8740. Our doctors are available 24 hours a day, 7 days a week. If you have a life-threatening emergency, you should dial 9-1-1 or go to the nearest hospital emergency room.***

- ***In the event you go to the Emergency Room or become hospitalized, please inform the hospital staff that you are a patient of AMA Medical Group, (Dr. Fana-Souchet and Dr. Sakla) clinic and ask them to notify our office.*** By doing so, our doctors will be informed and will help to ensure that you receive the proper care that you deserve.
- ***After being discharged from hospital or Emergency Room visit, please call our office so we can schedule a hospital follow up appointment immediately.*** You should make an appointment with our clinic within 3 days of being discharged. This is very important for many reasons: (1) your doctor will update any changes to your medications and will update the medical history with information from your admission. (2) Studies show that continuity of care with a primary care physician after a hospital discharge reduces the patient's risk of getting readmitted to a hospital and or improves the patients' health status overall.

PRESCRIPTION REFILLS. ***Please contact your pharmacy at least 3 days before you run out of your medicine(s).*** This protocol serves to minimize the possibility of errors when filling prescriptions. Your pharmacist will in turn contact us by phone, fax, or electronically, if approval is required.

- ***If you need your medication sooner*****,** please contact us during regular office hours, 8:00 a.m. to 5:00 p.m. Monday through Friday, so we can help facilitate your refill request. Prescription refills of routine medications are processed at the end of the day after we finish seeing all scheduled patients.

- ***You must be an active patient of AMA medical Group and have been seen by our doctor within the past 6 months*** in order for you to receive a prescription refill.

- ***Refills on Controlled Substances*** will only be made during regular office hours. Please allow 24 hours before picking up your prescription. Refills will **NOT** be given after hours, on weekends, or on holidays. If the prescription is lost, misplaced, stolen or if you used the medication more rapidly than it was originally prescribed we won't be able to replace it. Please refer to our pain management agreement.

PRESCRIPTION REQUESTS. Most third-party payers now have formularies of approved medications that are selected based on documented effectiveness and cost control. Your physician also follows this methodology in selecting medications to treat your conditions.

Our providers are acutely aware of the high cost of medications and will select the most cost-effective drug available to treat your condition.

Brand-name medications are covered in most cases by health care plans in which there is not a generic formulation available or when you have failed treatment on generics. Plans are now requiring your doctor to document that you have failed treatment on the formulary medications on your plan.

******We ask that you please keep all your medications in a safe place and out of reach of children at all times.***

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OUR SERVICES

AMA Medical Group provides a wide variety of medical services for all of your healthcare needs. Our providers are pleased to offer the following services among others:

- Health screens & Comprehensive physical exams
- Immunizations
- Well woman exams/ Pap smear
- Preventive health screening
- Disease management
- Minor dermatological procedure
- In house laboratory and EKGs
- Ultrasounds and Echocardiogram
- Hospital and Nursing home care
- Pharmacist counseling services
- Joint injections
- Vitamin B-12, Testosterone injections
- Wound Care

IN HOUSE LABORATORY

- Routine blood work
- Urinalysis
- Coumadin therapy

OUT OF STATE/AREA CARE. ***Helpful Tips while outside the service area:***

- ***Prior to leaving town, contact us to: (1) make a routine appointment checkup***, ***if you have not been seen in 4 months***, (2) refill on medications, (3) answer any questions you may have about your medical care while out of town.
- ***Contact us prior to receiving medical care.*** Our providers can be reached after hours and on weekends by calling the office number and leaving a message with the answering service to have the provider return your call.
- ***In the event you go to the Emergency Room or become hospitalized, please inform the hospital staff that you are a patient of AMA Medical Group, (Dr. Fana-Souchet or Dr. Sakla) clinic and ask them to notify our office***. By doing so, our doctors will be informed and will help to ensure that you receive the proper care that you deserve. Once you are released from the hospital, any medical care you receive becomes your responsibility to contact your primary care physician to request referrals.
- ***When laboratory services are needed to be drawn out of state,*** it is very important to use a participating lab covered by your insurance (For example, LabCorp and Quest). If you are unable to find a lab in your area, please contact us and we will assist you in locating a participating lab.

DIABETES RECOGNITION PROGRAM (DRP)

AMA Medical Group has been recognized by the National Committee of Quality Assurance (NCQA) and The American Diabetes Association. Our clinicians have achieved DRP recognition to show their peers, patients, and others in the Diabetes community that they are part of an elite group that is publicly recognized for their skill in providing the highest-level diabetes care. Our providers use evidence-based measures and provide excellent care to their patients with diabetes.

HEART/STROKE RECOGNITION PROGRAM (HSRP)

AMA Medical Group has been recognized by the National Committee of Quality Assurance (NCQA), the American Heart Association, and the American Stroke Association. Our clinicians use evidence-based measures and provide excellent care to persons with cardiovascular disease or who have had a stroke.

Please visit our website to learn more about us at www.AMAmedicalgroup.com

Finally, we want to thank you again for choosing AMA Medical Group as your healthcare provider.

We look forward to meeting you.

Kindest Regards,

Cruz Fana-Souchet, M.D. & AMA Staff

Again, we welcome you to our practice and look forward to providing you with a lifetime of caring.

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In affiliation with

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

GENERAL INFORMATION:

______________________ ______________________ ______ ____/___/____
Patient Last Name First Name MI DOB

(________)______________________ (_______)______________________
Home # Cell Phone #

____
Home Address City State Zip

SS#: __________ - ________ -__________ Male Female (Please Circle) Single Married Divorced Widowed (Please Circle One)

____
Employer Email Address

______________________________ ______________________
Primary Insurance Carrier Policy ID

HMO PPO POS Other (Type of Plan) (_____)______________________ Insurance Carrier Phone #

______________________________ ______________________
Second Insurance Carrier Policy ID

HMO PPO POS Other (Type of Plan) (_____)______________________ Insurance Carrier Phone #

IMPORTANT: In case of emergency, who would we contact?

______________________________ ______________________________
Name Relationship

______________________________ (_______)______________________
Address (Street/City/Zip) Home Phone #

(________)______________________ (_______)______________________
Cell Phone # Work #

"I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give AMA Medical Group consent to perform medical treatment."

______________________________________ ______________
Patient/Guardian Signature Date

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Patient Medical History

Patient Last Name: ____________________ Patient First Name:___________________ D.O. B________________

Date of last physical exam: ______________ Previous Physician Name: ______________________________

Physician Address: ____

PAST HISTORY (Personal and Allergies): Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	CVA/TIA	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Nervous Breakdown	☐	☐
Alcohol Overuse	☐	☐	Emphysema/COPD	☐	☐	Ostomies ___________	☐	☐
Allergies (other than medications)	☐	☐	Falls	☐	☐	Paralysis	☐	☐
Arthritis	☐	☐	Gallbladder Disease	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Gout	☐	☐	Seizures	☐	☐
Bleeding Disorder	☐	☐	HIV / AIDS	☐	☐	Sexually Transmitted Diseases	☐	☐
Cancer location___________________	☐	☐	Heart Attack / MI	☐	☐	Sickle Cell Anemia	☐	☐
Cardiac Arrhythmias Pacemaker _______________	☐	☐	Other Heart Disease (CHF / CAD)	☐	☐	Sleep Disorder	☐	☐
Chicken Pox	☐	☐	Hepatitis	☐	☐	Stomach Ulcers	☐	☐
Colitis	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Depression	☐	☐	Jaundice	☐	☐	Vascular Disease	☐	☐
			Kidney Disease	☐	☐			
			Measles / Mumps	☐	☐			

PERSONAL HABITS:

1) Have you ever smoked? ☐Yes ☐No If yes, are you are regular smoker now? ☐Yes ☐No

Have you used chewing tobacco? ☐Yes ☐No If yes, Number of yrs ____ If No, when did you quit? _____________

2) Do you regularly drink alcohol: ☐Yes ☐No If yes, how often: ________________________________

3) Have you ever used any of the following: Marijuana☐ LSD☐ Heroin☐ Cocaine☐ Speed☐ Other☐

OPERATIONS: List and indicate approximate year.

____
____
____

SERIOUS INJURIES: List injuries & give approximate dates.

____
____
____

HOSPITALIZATIONS: (Other than operations)

List reasons and approximate dates

____
____
____

DIAGNOSTIC TESTS/EXAMS:

LAST TEST/EXAM	DATE	LOCATION/PROVIDER
EYE EXAM:		
FOOT EXAM:		

IMMUNIZATIONS: (Please give date) Hepatitis B ______________Flu _____________ Polio ____________

Typhoid___________Smallpox__________Tetanus____________Pneumococcal________Chicken Pox _____

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Patient Last Name: __________________ Patient First Name:_________________ D.O. B______________

FAMILY HISTORY	Circle Sex	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brothers/Sisters	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters	M F				
	M F				

Check if any blood relative has or had any of the following and enter their relationship:

	Yes	No	Relationship to you		Yes	No	Relationship to you
Arthritis	☐	☐	______________	High Blood Pressure	☐	☐	______________
Asthma	☐	☐	______________	Intestinal Polyps	☐	☐	______________
Bleeding Tendency	☐	☐	______________	Kidney Disease	☐	☐	______________
Cancer	☐	☐	______________	Leukemia	☐	☐	______________
Colitis	☐	☐	______________	Migraine	☐	☐	______________
Congenital Heart Disease	☐	☐	______________	Nervous Breakdown	☐	☐	______________
Diabetes	☐	☐	______________	Rheumatic Fever	☐	☐	______________
Emphysema	☐	☐	______________	Sickle Cell Anemia	☐	☐	______________
Epilepsy	☐	☐	______________	Stomach Ulcers	☐	☐	______________
Goiter	☐	☐	______________	Stroke	☐	☐	______________
Gout	☐	☐	______________	Suicide	☐	☐	______________
Hay Fever	☐	☐	______________	Tuberculosis	☐	☐	______________
Heart Attack	☐	☐	______________	Other	☐	☐	______________

MEDICATIONS:

☐ Asthma Wheezing Medicine	☐ Sleeping Pills/Tranquilizers
☐ Aspirin, Bufferin, Anacin, Tylenol or Similar Products	☐ Thyroid Medicine
☐ Blood Pressure Pills	☐ Stomach/Digestive Medicine
☐ Cortisone, Prednisone	☐ Weight-Reducing Pills
☐ Cough Medicine	☐ Blood Thinners or Coumadin
☐ Digitalis or Heart Medicine	☐ Dilantin or Seizure Medications
☐ Hormones	☐ Water Pills or Diuretics
☐ Insulin or Diabetic Pills	☐ Antibiotics
☐ Anemia Medications	☐ Phenobarbital/Barbiturates
☐ Laxatives	☐ Vitamins
	☐ Other Prescription or Over the Counter Drugs

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Patient Last Name: ____________________ Patient First Name:___________________ D.O. B________________

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

Medication	Dosage	How Often?	When Started?

Are you allergic to any medications: Yes ☐ No ☐ If yes, please list medications and the reactions.

Medication	Reaction

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Patient Last Name: ____________________ Patient First Name:__________________ D.O. B_______________

Social / Lifestyle History:		Primary Language __________________
Is there someone that lives in your residence?	YES NO	If yes, please list name and relationship:
Type of Residence		Apartment Mobile Home House One Story Two Story Assisted Living Facility Facility Name_____________Other_____________
Durable Medical Equipment	YES NO	Wheelchair _____________ Oxygen _____________ Walker _____________ Nebulizer _____________ Cane _____________ CPAP/BIPAP _____________ Other _____________
Can you afford medicines?	YES NO	Potential Referral to Patient Assistance Program
Transportation provided by?		
Nutritional History:		
Current Weight _____ **Lbs**		Current Height Weight Changes in the past 6 months? **Yes / No** _____ Ft _____ In
Current Diet Plan		
Exercise / Activity:		
Current Activity		How Often
Physical Limitations:		
Activities of Daily Living:		
Do you require assistance to bathe or groom?	YES NO	If yes, Explain: ____ ____
Do you require assistance for your toilet needs?	YES NO	If yes, Explain: ____ ____
Do you require assistance to eat?	YES NO	If yes, Explain: ____ ____
Do you have hearing loss?	YES NO	Do you wear hearing aids? Yes ☐ No ☐ Last hearing exam date: ____________________

Additional Comments and Notes:

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____

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Patient Last Name: ____________________ Patient First Name:___________________ D.O. B________________

Preventative Service History

Preventive Services	**Date Rec'd**	**Findings and Recommendations**
Bone Mass Measurement (Density)		
Cardiovascular Disease Screening Cholesterol >>>>>>>>>>>>>>>>>>>>>>>>>>> LDL >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> EKG >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	 ________________ _________________ _________________	Hypercholesterolemia ☐ Hyperlipidemia ☐ Other ☐ ____________________________ EKG Results:
Colorectal Cancer Screening Flexible Sigmoidoscopy>>>>>>>>>>>>> Barium Enema >>>>>>>>>>>>>>>>>>>>>>>> Colonoscopy (not high risk)>>>>>>>>>> Fecal Occult Blood Test>>>>>>>>>>>>>	 __________________ __________________ __________________ __________________	
Diabetes Screening Hg A1C >>>>>>>>>>>>>>>>>>>>>>>>>> Foot Exam >>>>>>>>>>>>>>>>>>>>>>>>>> Eye Exam >>>>>>>>>>>>>>>>>>>>>>>>>>	 _________________ _________________ _________________	 Cataracts ☐ Other _______________________
Glaucoma Screening		Glaucoma ☐
PAP and Pelvic Examination		
Prostate Cancer Screening Digital Rectal Exam (DRE) Prostate Specific Antigen Test (PSA)		
Mammogram Screening Breast Self Exam Mammogram		

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Date reviewed Physician Signature