Michael J. Paciorek M.D., P.C.

WELCOME TO OUR PRACTICE! Please complete the requested information prior to your appointment.

PATIENT NAME____**AGE**______**DATE OF BIRTH**__________

REASON FOR TODAY'S VISIT____

PRIMARY HEALTH CARE PROVIDER____________________________**DID THEY REFER YOU HERE? YES NO**

WHAT PHARMACY DO YOU USE?______________________**TELEPHONE**________________________

MEDICATION ALLERGIES

Please list any medication allergies and reactions that you may have.

____

____

____

____

____

What is your height?__________

What is your weight?__________

MEDICATIONS

Please list all medications that you are taking.

____

____

____

____

____

____

____

____

PAST SURGICAL HISTORY

Please list any surgeries you have had.

____

____

____

____

____

____

____

FAMILY HISTORY Please list all medical illnesses effecting your immediate family

Family Member	Age	Living	Deceased	Medical Problems
Mother				
Father				

SOCIAL HISTORY

Occupation/Previous Occupation:________________________________Marital Status: S M D W

Do you live alone? Y N Do you drink alcohol? Y N Do you use recreational drugs? Y N

Do you smoke or chew tobacco? Y N If yes, how long have you smoked/chewed?__________How much?__________

If you quit, how long did you smoke or chew?__________

PATIENT'S NAME ______________________________

REVIEW OF SYSTEMS – Please check if you have any of the following conditions.

CARDIOVASCULAR

Condition		
Chest Pain	Y	N
High Blood Pressure	Y	N
Irregular Pulse	Y	N
Heart Murmur	Y	N
High Cholesterol	Y	N
Heart Attack	Y	N
Stroke	Y	N
Congestive Heart Failure	Y	N
Coronary Artery Disease	Y	N

GASTROINTESTINAL

Condition		
Reflux/heart burn	Y	N
Nausea/Vomiting	Y	N
Liver Disease	Y	N
Jaundice	Y	N
Ulcers	Y	N
Colon Cancer	Y	N
Hepatitis	Y	N

NEUROLOGICAL

Condition		
Seizures	Y	N
Memory Problems	Y	N
Disorientation	Y	N
Face Weakness	Y	N
Difficult Speech	Y	N
Fainting Spells	Y	N
Headaches	Y	N
Depression/Anxiety	Y	N

EYES

Condition		
Infections	Y	N
Glaucoma	Y	N
Cataracts	Y	N

GENITOURINARY

Condition		
Painful Urination	Y	N
Blood in urine	Y	N
Incontinence	Y	N
Kidney Stones	Y	N
Difficulty urinating	Y	N

EAR, NOSE, THROAT, MOUTH

Condition		
Hearing Aids	Y	N
Hearing Loss	Y	N
Ear Pain	Y	N
Ear Infections	Y	N
Ringing in ears	Y	N
Balance problems	Y	N
Nosebleeds	Y	N
Nasal Congestion	Y	N
Nasal Drainage	Y	N
Sinus Problems	Y	N
Sore Throats	Y	N
Mouth Sores	Y	N
Dentures	Y	N
Hoarseness	Y	N

MUSCOLOSKELETAL

Condition		
Arthritis	Y	N

Endocrine

Condition		
Diabetes	Y	N
Thyroid Disease	Y	N
Increased appetite	Y	N
Excessive Thirst	Y	N
Hormone Problems	Y	N

HEMATOLOGY/LYMPHATIC

Condition		
Anemia	Y	N
Bleeding Disorders	Y	N
Swollen Glands	Y	N

LUNGS

Condition		
Asthma	Y	N
COPD/Emphysema	Y	N

ALLERGY/IMMUNOLOGIC

Condition		
Food Allergies	Y	N
Nasal Allergies	Y	N

Have you ever had cancer? Y N What kind? ______________________

If the answer to any question is Yes, please explain: ______________________________

____

PATIENT SIGNATURE ______________________________ **DATE** ______________

REVIEWED BY: Provider ______________________________ Date ______________

PATIENT INFORMATION

DATE: ____________________

PATIENT'S NAME: ____________________ AGE: ____________________

ADDRESS: ____________________ PHONE: ____________________

CITY: ____________________ ZIP CODE: ____________________

CELL PHONE NO.: ____________________

MARRIED: ☐ SINGLE: ☐ WIDOWED: ☐ OTHER: ____________________

DATE OF BIRTH: ____________________ SOCIAL SECURITY #: ____________________

WHERE EMPLOYED: ____________________

ADDRESS: ____________________ PHONE: ____________________

REFERRED BY: ____________________

NAME OF SPOUSE OR PARENT: ____________________

SPOUSE OR PARENT'S EMPLOYER: ____________________

ADDRESS: ____________________ PHONE: ____________________

KNOWN MEDICATION ALLERGIES: ____________________

METHOD OF PAYMENT

PRIMARY INSURANCE

NAME OF INSURANCE ____________________

IDENTIFICATION NO. ____________________

GROUP # ____________________

SUBSCRIBER'S NAME ____________________

RELATIONSHIP __________ SUBSCRIBER'S DOB __________

SUBSCRIBER'S SSN ____________________

SECONDARY INSURANCE

NAME OF INSURANCE ____________________

IDENTIFICATION NO. ____________________

GROUP # ____________________

SUBSCRIBER'S NAME ____________________

RELATIONSHIP __________ SUBSCRIBER'S DOB __________

SUBSCRIBER'S SSN ____________________

I AGREE TO PAY ANY OR ALL FEES INCLUDING CO-PAYMENTS AND DEDUCTIBLES.

SIGNATURE ____________________

RELEASE OF INFORMATION:

I HEREBY AUTHORIZE ANY HOSPITAL PHYSICIAN, OR OTHER PERSON WHO EXAMINED ME OR ANY MEMBER OF MY FAMILY TO FURNISH MY INSURANCE CO. OR ITS REPRESENTATIVE WITH ANY INFORMATION IT MAY REQUEST REGARDING ANY ILLNESS OR INJURY, MEDICAL HISTORY, OR TREATMENT, AND COPIES OF HOSPITAL OR MEDICAL RECORDS. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

INSURED'S SIGNATURE: ____________________ DATE: ____________________

ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE PAYMENT DIRECTLY OR DR. MICHAEL J. PACIOREK THE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

INSURED'S SIGNATURE: ____________________ DATE: ____________________

Dr. Paciorek is required by law to protect the privacy of your health Information and to provide you with a copy of our Privacy Notice. This Notice describes the ways we will use and disclose your health informatlon. This Notice also describes your rights and our obligations regarding your health information. A copy of our current Notice will be available in our reception area.

Your privacy is paramount to this office. In order to guard your health information, please indicate your authorization below.

I ____________________________________ authorize Dr. Paciorek's staff to leave appointment information on:

On Home Phone (include Auto Call)?	Yes	No
On Cell Phone (include Auto Call)?	Yes	No
Mobile text (include Auto Call)?	Yes	No
On Office Voice Mail?	Yes	No
w/Another Person?	Yes	No
Send via mail (Include Reminder Cards)	Yes	No
Send Via e-mail / Portal	Yes	No

Email Address ____________________________________

I ____________________________________ authorize Dr. Paciorek's staff to leave medical information on:

On Home Phone (include Auto Call)?	Yes	No
On Cell Phone (include Auto Call)?	Yes	No
Mobile text (include Auto Call)?	Yes	No
On Office Voice Mail?	Yes	No
w/Another Person?	Yes	No
Send via mail (Include Reminder Cards)	Yes	No
Send Via e-mail / Portal	Yes	No

Please list persons authorized to discuss my medical information and appointments with:

____

I acknowledge receipt of Dr. Michael Paciorek's Privacy Policy.

Signature ____________________________________ Date ________________

Michael J. Paciorek, M.D., P.C. Financial Policy

Commercial Insurance Plans: You are responsible for any co-pay at time of visit, co-insurance and/or deductible which applies to any service provided. See Non-Participating Insurances if we do not participate with your plan.

Non-Participating Insurances: If we do not participate with your insurance carrier you are responsible for full payment of the charges at the time of your visit. If you provide our office with the necessary billing information, we will submit the charge on your behalf to your carrier for reimbursement to you. You are also responsible for following up with your insurance carrier regarding any unpaid claims and/or appeals.

HMO/Managed Care/POS: You are responsible for paying co-pays at the time of the visit and for obtaining any referrals/ authorizations your plan may require before the visit. If you fail to take these steps, you will be responsible for the entire payment as per your agreement with your carrier.

Medicare: You are responsible for your deductible each year and any coinsurance.

Self-Pay: If you are uninsured, you are responsible for full payment at the time of service.

Surgery Financial Policy: Financial arrangements will be made prior to surgery for insurances requiring deductibles or noncovered procedures.

Minor Patients: The parent(s), guardian(s) and or adult accompanying a minor is responsible for providing current insurance information for the minor and/or payment In full of any co-pay due at time of service. The adult accompanying the child is responsible of any co-pay or balance due at time of service.

There will be a $20.00 returned check fee. Payment of outstanding balances is expected at time of service unless other arrangements have been made. If no payment is received, you will need to contact our billing department to set up a payment plan. If you fail to comply with the payment plan your account will be turned over to our Collection Agency.

IF YOU FAIL TO KEEP YOUR SCHEDULED APPOINTMENT WITHOUT GIVING 24 HOURS NOTICE, YOU WILL INCUR A $50.00 FEE.

We accept cash, checks and most major credit cards.

I have read and or been advised to read the entire Financial Policy.

Signature of Guarantor ______________________________ Date ______________

Patient Name ____