

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATIONS

Please list all medications that you are taking.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PAST SURGICAL HISTORY

Please list any surgeries you have had.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your height? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What is your weight? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**

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**

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**

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

**GENITOURINARY**

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

**EAR, NOSE, THROAT, MOUTH**

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

**EYES**

Infections Y N  
Glaucoma Y N  
Cataracts Y N

**HEMATOLOGY/LYMPHATIC**

Anemia Y N  
Bleeding Disorders Y N  
Swollen Glands Y N

**MUSCULOSKELETAL**

Arthritis Y N

**Endocrine**

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

**LUNGS**

Asthma Y N  
COPD/Emphysema Y N

**ALLERGY/IMMUNOLOGIC**

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

### SECONDARY INSURANCE

NAME OF INSURANCE _____	NAME OF INSURANCE _____
IDENTIFICATION NO. _____	IDENTIFICATION NO. _____
GROUP # _____	GROUP # _____
SUBSCRIBER'S NAME _____	SUBSCRIBER'S NAME _____
RELATIONSHIP _____ SUBSCRIBER'S DOB _____	RELATIONSHIP _____ SUBSCRIBER'S DOB _____
SUBSCRIBER'S SSN _____	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 information. 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 \_\_\_\_\_