Michael J. Paciorek MD, P.C.

Welcome to our practice! Please complete the following information prior to your appointment.

PATIENT NAME______________________________________**DATE OF BIRTH**_____________**AGE**______

*Reason For Today's Visit*____

PRIMARY HEALTH CARE PROVIDER_____________________________*Did They Refer You Here?* Yes No

YOUR HEIGHT____________**WEIGHT**____________**CIRCLE:** GLASSES CONTACTS HEARING AIDS

*What Pharmacy Do You Use?*______________________________ *Pharmacy Phone #*________________

HAVE YOU HAD COVID-19? Yes No *Date Of Illness?*________________________

ARE YOU HAVING SYMPTOMS OF COVID? Yes or No *Patient Temperature*_____________________

Fever or Chills, Cough, Shortness of Breath, Muscle or Body Aches, Headache, Loss of Taste or Smell

HAVE YOU BEEN VACCINATED FOR COVID-19? YES OR NO **FLU VACCINATION?** YES OR NO

LIST MEDICATION ALLERGIES	**CURRENT MEDICATIONS YOU ARE TAKING**
____	____
____	____
____	____
____	____
____	____
____	____
____	____
____	____

PLEASE LIST YOUR PAST SURGICAL HISTORY____

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FAMILY HISTORY *please list all medical illnesses effecting your IMMEDIATE family*

Mother Living? Yes or No Age Medical Problems______________________________________

____

Father Living? Yes or No Age Medical Problems______________________________________

____

Siblings Living? Yes or No Age Medical Problems______________________________________

Siblings Living? Yes or No Age Medical Problems______________________________________

Siblings Living? Yes or No Age Medical Problems______________________________________

Siblings Living? Yes or No Age Medical Problems______________________________________

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____

YOUR CURRENT OCCUPATION______________________________ **UNEMPLOYED?** Y N **RETIRED?** Y N

MARITAL STATUS: S M D W **DO YOU LIVE ALONE:** Y N

CIRCLE THE CURRENT USE OF ANY: ALCOHOL SMOKING VAPING CHEWING RECREATIONAL DRUGS

WHEN DID YOU QUIT SMOKING?_________________________

PLEASE FILL OUT FRONT AND BACK OF FORM

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PATIENT NAME____

PLEASE REVIEW THE SYSTEMS AND CIRCLE ANY THAT APPLY TO YOU

CARDIOVASCULAR

- CHEST PAIN Y N
- HYPERTENSION Y N
- IRREGULAR PULSE Y N
- HEART MURMUR Y N
- HIGH CHOLESTEROL Y N
- HEART ATTACK Y N
- STROKE Y N
- ATRIAL FIB Y N
- COR ARTERY DISEASE Y N
- CON HEART FAILURE Y N

GASTROINTESTINAL

- REFLUX/HEART BURN Y N
- NAUSEA OR VOMITING Y N
- LIVER DISEASE Y N
- JAUNDICE Y N
- ULCERS Y N
- COLON CANCER Y N
- HEPATITIS Y N
- HERPES Y N

NEUROLOGICAL

- SEIZURES Y N
- MEMORY PROBLEMS Y N
- DISORIENTATION Y N
- FACIAL WEAKNESS Y N
- DIFFICULT SPEECH Y N
- FAINTING SPELLS Y N
- HEADACHES Y N
- DEPRESSION Y N
- ANXIETY Y N

GENITOURINARY

- PAINFUL URINATION Y N
- BLOOD IN URINE Y N
- INCONTINENCE Y N
- KIDNEY STONES Y N
- DIFFICULTY URINATING Y N

EYES

- INFECTIONS Y N
- GLAUCOMA Y N
- CATARACTS 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 THROAT Y N
- MOUTH SORES Y N
- DENTURES Y N
- HOARSENESS Y N
- TONGUE TIED Y N
- EAR TUBES Y N

MUSCOLOSKELETAL

- ARTHRITIS Y N
- RHEUMATIOD Y N
- FIBROMYALGIA Y N

ALLERGY/IMMUNOLOGIC

- FOOD ALLERGIES Y N
- NASAL ALLERGIES Y N

HEMATOLOGY/LYMPHATIC

- ANEMIA Y N
- SWOLLEN GLANDS Y N
- BLOOD DISORDER Y N

LUNGS

- ASTHMA Y N
- COPD/EMPHYSEMA Y N
- BRONCHITIS Y N

ENDOCRINE

- DIABETES Y N
- THYROID DISEASE Y N
- EXCESSIVE THIRST Y N
- INCREASED APPETITE Y N
- HORMONE PROBLEMS Y N

HAVE YOU EVER HAD CANCER? YES OR NO

*WHAT TYPE OF CANCER?*____________________________________

IF YOU CIRCLED ANY OF THE ABOVE PLEASE EXPLAIN:______________

____

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____

PATIENT SIGNATURE____________________________________ ***DATE***__________

*REVIEWED BY PROVIDER*____________________________________ *DATE*__________

PATIENT INFORMATION AND INSURANCE/FINANCIAL POLICY

PATIENT NAME: ____ AGE: ________ DATE: _______________

ADDRESS: ____ CITY/STATE _________________ ZIP________

HOME PHONE: ____ CELL PHONE: _________________________________

DATE OF BIRTH: _________________________ RELATIONSHIP STATUS: SINGLE MARRIED WIDOW DIVORCE

NAME OF REFERRING PHYSICIAN: ____

NAME OF YOUR EMPLOYER____ SSN #_____________________

EMPLOYER ADDRESS: ____ PHONE: _______________________

NAME OF YOUR SPOUSE OR YOUR PARENT: ____

SPOUSE OR PARENT EMPLOYER: ____

EMPLOYER ADDRESS: ____PHONE:_____________________________

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE______________________________	NAME OF INSURANCE______________________________
IDENTIFICATION #_________________________________	IDENTIFICATION #_________________________________
GROUP #____	GROUP #____
SUBSCRIBER NAME_________________________________	SUBSCRIBER NAME_________________________________
SUBSCRIBER DOB__________ RELATIONSHIP___________	SUBSCRIBER DOB__________ RELATIONSHIP__________

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

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

ASSIGNMENT OF BENEFITS: *I HEARBY AUTORIZE 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.*

FINANCIAL POLICY: *YOU ARE RESPONSIBLE FOR ANY CO-PAY AT TIME OF VISIT. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER YOU ARE RESPONSIBLE FOR FULL PAYMENT OF THE CHARGES FOR YOUR VISIT. WE WILL SUBMIT CHARGES ON YOUR BEHALF FOR REIMBURSEMENT. PRIOR REFERRALS OR PRIOR AUTHORIZATIONS REQUIRED BY YOUR INSURANCE COMPANY ARE YOUR RESPONSIBILITY, OTHERWISE YOU WILL BE RESPONSIBLE FOR FULL PAYMENT. FINANCIAL ARRANGEMENTS WILL BE MADE PRIOR TO SURGERY FOR INSURANCES REQUIRING DEDUCTIBLES OR NON COVERED PROCEDURES. ANY PARENT, GUARDIAN OR ADULT LEGALLY ACCOMPANYING A MINOR IS RESPONSIBLE FOR PROVIDING CURRENT INSURANCE INFORMATION, AND OR PAYMENT IN FULL OF ANY CO PAY DUE AT TIME OF SERVICE, AND BALANCE DUE. THERE WILL BE A* ***$20.00 RETURNED CHECK FEE****. IF NO PAYMENT IS MADE AT TIME OF SERVICE, YOU ARE RESPONSIBLE TO CONTACT THE BILLING OFFICE TO SET UP PAYMENT ARRANGEMENTS. IF YOU DO NOT COMPLY WITH PAYMENTS, YOU WILL BE SENT TO COLLECTIONS. A* ***$50.00 FEE WILL BE OWED IF YOU FAIL TO KEEP YOUR SCHEDULED APPOINTMENT WITHOUT A 24 HR NOTICE****. WE ACCEPT CASH, CHECKS AND MOST CREDIT CARDS. I HAVE READ OR BEEN ADVISED TO READ THE ENTIRE FINANCIAL POLICY.* ***I ACCEPT AND AGREE TO PAY, AGREE TO THE RELEASE OF INFORMATION, AGREE TO THE ASSIGNMENT OF BENEFITS AND AGREE TO THE FINANCIAL POLICY.***

PATIENT OR GUARANTOR SIGNATURE ____ ***DATE***_______________

PLEASE FILL OUT FRONT AND BACK OF FORM

HIPAA PRIVACY PAGE

*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 DESCRIBES THE WAYS WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION. A COPY OF OUR CURRENT NOTICE WILL BE AVAILABLE IN THE RECEPTION AREA.**IN ORDER TO GUARD YOUR HEALTH INFORMATION PLEASE INDICATE YOUR AUTHORIZATION BELOW.***

I ____AUTHORIZE DR PACIOREK'S STAFF TO LEAVE

PERMISSION TO LEAVE MY APPOINTMENT INFORMATION ON THE FOLLOWING:

PLEASE CHECK ALL THAT APPLY

___ HOME PHONE (INCLUDE AUTO CALL)

___ CELL PHONE (INCLUDE AUTO CALL)

___ MOBILE TEXT (INCLUDE AUTO CALL)

___ ON OFFICE VOICE MAIL

___ WITH ANOTHER PERSON – I AUTHORIZE THOSE LISTED BELOW TO DISCUSS MY **APPOINTMENTS**:

____

___ BY MAIL (INCLUDE REMINDER CARDS)

___ BY MY EMAIL/PORTAL EMAIL ADDRESS____

PERMISSION TO LEAVE MY MEDICAL INFORMATION ON THE FOLLOWING:

PLEASE CHECK ALL THAT APPLY

___ HOME PHONE (INCLUDE AUTO CALL)

___ CELL PHONE (INCLUDE AUTO CALL)

___ MOBILE TEXT (INCLUDE AUTO CALL)

___ ON OFFICE VOICE MAIL

___ WITH ANOTHER PERSON – I AUTHORIZE THOSE LISTED BELOW TO DISCUSS MY **MEDICAL** INFORMATION:

____

___ BY MAIL (INCLUDE REMINDER CARDS)

___ BY MY EMAIL/PORTAL EMAIL ADDRESS____

I ACKNOWLEDGE RECEIPT OF DR MICHAEL PACIOREK'S PRIVACY POLICY

SIGNATURE____DATE____________