Jaroslaw Paszkowiak, MD

Patient Registration

Patient name:	Sex: M F	Birth Date ___/___/___ Age _____	Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence Address: City State Zip Phone			Patient Social Security #
Person financially responsible for account	Self [ ] Spouse [ ] Parent [ ]	Responsible party birth date ___/___/___	Responsible party social security #
Preferred pharmacy and location:	Email Address:		
Race	Nationality		
Name of employer Address		Business Phone	Occupation
Name of Spouse/Parent	Birth date	Social Security #	Business phone
Reason for visit	Referred by (include address and phone)		
Person to contact in case of emergency:	Relationship to patient:		Phone
Insurance carrier:	Insurance Subscriber:	Subscriber birth date:	Subscriber Social Security #

Insurance Authorization for Assignment of Benefits/Information Release:

I authorize the release of medical information necessary to process this claim or provide medical information to my insurance carriers, or to any physician or medical facility. I authorize payment of medical benefits to Jaroslaw Paszkowiak, MD for all professional goods and services rendered. I understand that I am financially responsible for any charges whether or not covered by insurance.

_____ _____

Patient Signature Date

HIPPA:

I hereby request to be contacted at the number(s) below to receive personal private health information. I also designate another person listed below to receive appointment information as well as limited health information regarding my care as I designate. I acknowledge that I received/reviewed a copy of Provider's Notice of Privacy Practices. I am aware of my privacy rights. I understand that this authorization will remain in effect until revoked in writing by me.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Additional designated persons other than the patient, relationship, and contact number:

_____ _____

_____ _____

Social History:

1. Use of Alcohol: ___ Never ___Rarely
___ Moderate ___ Daily

2. Tobacco Use: ___ Previously, but quit
___ Never ___ Currently
___ Packs per day

3. Use of Drugs: ___ Previously, but quit
___ Never ___ Currently

Type of drugs used: _____
_____
_____
_____

Hospitalizations and Surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Women Only

Pap Smear: ____Yes ____ No
Date of last PAP: _____

Colonoscopy: _____ Yes _____ No
Date of last Colonoscopy: _____

Mammogram: ____ Yes _____ No
Date of last Mammogram: _____

Bone Density: ____ Yes ____ No
Date of last Bone Density: _____

Men Only

Colonoscopy: ____ Yes ____ No
Date of last Colonoscopy: _____

PSA: ____ Yes ____ No
Date of last PSA: _____

Bone Density: ____ Yes _____ No
Date of last Bone Density: _____

Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Allergies to Medications:

_____
_____
_____

Immunizations:

Flu shot: _____ Yes _____ No
Date flu shot given _____

Pneumonia shot: _____ Yes _____ No
Date Pneumonia shot given _____

Tetanus: _____ Yes _____ No
Date Tetnus shot given _____

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Individual's Request for Protected Health Information

Notice to Patient: Your request for access to your protected health information only is applicable to the information maintained by the office of Dr. Paszkowiak. If you would like access to your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider.

Last:_____ First:_____ Middle:_____

Other Names Used: _____ Date of Birth:_____ SSN:_____

Address:_____ City:_____ State:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Insurance Carrier:_____

Name of Previous Physician:_____

I hereby request access to the following information maintained or created by the providers listed above. I agree to be billed $1.00 for the first page and then $0.50 per page of paper records for releasing the requested records.

- □ Patient History
- □ Information created or received from other providers
  Specify which ones or all:_____
- □ Hospital and consulting physician summaries
- □Billing Records
- □ Entire Designated Record Set
- □ Lab Reports
- □ X-rays
- □ Radiology Report
- □ Pathology Report
- □ Other

_____

Release to: □ I will pick up the copies of my records
□ Mail copies of my records to:
____myself ____Legal Representative

Name: _____
Address: _____
Phone: _____ Fax: _____

The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Deficiency Syndrome ("AIDS") and/or mental health information. The information authorized for release may also include records related to mental health and/or substance abuse treatment. I also give permission for the physician to inquire about all medications prescribed by other physicians.

I understand this authorization is only valid ninety (90) days from the date of the signature below.

_____ _____ _____
Signature of Patient Relationship to Patient Date