

# John S. Walczyk M.D., P.C.

## Patient Registration Form

Name: \_\_\_\_\_  Jr  Sr  
*First Middle Last*

Prefer to be called: \_\_\_\_\_ Title:  Mr.  Mrs.  
 Ms.  Miss

Sex:  Male  Female

Address: \_\_\_\_\_  
*Street # Street Name Apt #*

\_\_\_\_\_ *City State Zip*

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
*Name*

If Student:  Full Time  Part Time Name of School: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Alternate/Cell Phone #: ( ) \_\_\_\_\_

Date of Birth:     /     /     Social Security #: \_\_\_\_\_  
*M D Y*

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth:     /     /      
*M D Y*

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services or co-payments. In the event that your account must be turned over to collections, a \$10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Do we have your permission to:**

- Leave a message on your answering machine at home?  Yes  No
- Leave a message at your place of employment?  Yes  No
- Discuss your medical condition with any member of your household?  Yes  No

If yes, with whom: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Insurance Information**

Primary Insurance Name: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Patient's ID #: \_\_\_\_\_

Patient's ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

Patient's Relationship to Policy Holder: \_\_\_\_\_

Patient's Relationship to Policy Holder: \_\_\_\_\_

**Policy Holder Information (If Different from Patient)**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: / / \_\_\_\_\_

**Pharmacy of Choice:** \_\_\_\_\_

**Phone #:** ( ) \_\_\_\_\_

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)**

With my consent, John S. Walczyk, M.D., P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to John S. Walczyk M.D., P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. John S. Walczyk, M.D., P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to John S. Walczyk, M.D., O.C. Privacy Officer.

With my consent, John S. Walczyk, M.D., P.C. may call my home or other designated location and leave a message on voice mail of in person in reference to any items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, John S. Walczyk, M.D., P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, John S. Walczyk, M.D., P.C. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that John S. Walczyk M.S., P.C. restrict how it uses or discloses my PHU to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to John S. Walczyk M.D., P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, John S. Walczyk, M.D., P.C. may decline to provide treatment to me.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# MEDICAL HISTORY

**Patient's Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

**Are you allergic to any medications?**       YES       NO      **If yes, please list:**

1. \_\_\_\_\_      2. \_\_\_\_\_      3. \_\_\_\_\_

**List all medications you are currently taking:**

1. \_\_\_\_\_      2. \_\_\_\_\_      3. \_\_\_\_\_

4. \_\_\_\_\_      5. \_\_\_\_\_      6. \_\_\_\_\_

**Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)**

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy		
			or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vascular:</b>					
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>			
Do you need pre-medication?	<input type="checkbox"/>	<input type="checkbox"/>			

Do you drink alcohol?       Yes     No    If Yes \_\_\_\_\_ per day

Do you use IV drugs?       Yes     No    If Yes, what? \_\_\_\_\_ How much? \_\_\_\_\_

Have you had or have you been exposed to HIV (AIDS)?  Yes     No

Have you ever had dental anesthesia (Novocaine)?  Yes     No

Any bad reaction?       Yes     No

**Skin:**

When you are exposed to sun do you:       Tan only       Tan and burn       Burn

Have you ever had skin cancer?       Yes       No      If yes, where? \_\_\_\_\_

Has anyone in your family had skin cancer?       Yes       No      If yes, who? \_\_\_\_\_

Do you have a history of any specific skin diseases?       Yes       No

If yes, please list: \_\_\_\_\_

List any other disease or condition we should know about: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

**Please answer the following questions:**

A. Do you smoke?       Yes       No      If yes, how much: \_\_\_\_\_

B. Do you bleed easily?       Yes       No

C. (Women) Are you pregnant?       Yes       No      If yes, Due Date: \_\_\_\_\_

D. Do you have artificial joint(s)?       Yes       No      Do you need pre-meds?     Yes       No

E. What is your occupation? \_\_\_\_\_

F. What are your hobbies? \_\_\_\_\_

**Completed by:**     Patient  
                            Medical Assistant

\_\_\_\_\_  
 Initials

\_\_\_\_\_  
 Signed by Physician

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Reviewed by

\_\_\_\_\_  
 Date

