Beata I. Styka M.D.

12130 S. Harlem Ave, Ste B

Palos Heights, IL 60463

Phone: 708-448-5500

Your Appointment is scheduled for _____ with Dr. Beata Styka.

Please fill out the attached form to the best of your knowledge and ability. Please bring them with you to your appointment along with your photo ID and Insurance cards so we may make a copy.
If you have a co-pay it must be paid on the day of your appointment. We accept cash, check or credit card.
If you take any medications, please bring them with you- including any vitamins.
If you have any questions, please contact the office.

Beata I. Styka M.D 12130 S. Harlem Ave, Ste. B Palos Heights, IL 60463 (708) 448-5500

Patient Name: _____ Date: _____

Sex: Male Female Birth Date: _____

Street Address: _____ Apt./Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular Phone: _____

Email: _____ SS#: _____

My Pharmacy: _____

Marital Status: _____ Language Spoken: _____

Ethnicity: Hispanic Not Hispanic or Latino Decline to Answer

Race: African American/Black American Indian or Alaskan Multi-Racial

Asian Caucasian/White Other Decline to Answer

How did you hear about us? _____

In case of emergency, contact (Name, phone): _____

Primary Insurance: _____ Address: _____

ID#: _____ Group: _____

Insurance Provided Through: Current Employment COBRA Retirement Other

- Do you have a living will? **YES** **NO**
- Do you have a Durable Power of Attorney for Healthcare? **YES** **NO**
- Do you have an order to DO NOT RESUSCITATE (DNR)? **YES** **NO**

  (Please provide us with copies if you have answered yes)
- Please provide dates and location of immunizations in the last 5 years:

I authorize the release of any information concerning my health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of

insurance benefits otherwise payable to me directly to Dr. Styka, realizing I am responsible to pay any non-covered service.

Signature: _____ Date: _____

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Patient Name: _____ Primary Phone: _____

Completed by office personnel only - Medical record #

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

I hereby authorize the protected health information regarding the above-named person to be exchanged to: Beata I. Styka M.D 12130 S. Harlem Ave, Ste. B Palos Heights, IL 60463 (708) 448-5500

I authorize the release of information pertaining to the following time periods:

From date(s): _____ To date(s): _____

The following types of information to be disclosed are as follows:

___ History and physical examinations
___ Consultation reports
___ Progress notes
___ Operative reports
___ Abstract (documents summarizing history)
___ Diagnostic reports (labs, x-ray, etc.)
___ X-ray films
___ Other: _____

The following high CONFIDENTIAL items MUST be checked off to be included in disclosures:

___ HIV/AIDS related health information/records
___ Behavioral or mental health information/records
___ Drug/alcohol diagnosis, treatment, referral information
___ Genetic testing information and/or records
___ The release of information, direct or indirect payment to Beata I. Styka, MD from a third party:

The purpose of this authorization is: _____

The authorization expires (day/month/year): _____ If not specified, this release will expire one year after the date of signature on this Authorization form.

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by law. **I understand** that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclosure of my health information. Written revocation must be sent to the physician's office: 12130 S. Harlem Ave, Ste. B Palos Heights, IL.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize beata I. Styka, M.D. to use or disclose my health information in the manner described above.

Printed name of patient or legal guardian, or authorized agent: _____

Signature of patient or legal guardian, or authorized agent: _____

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the Individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home Telephone _____
- ❑ OK to leave messages with detailed information
- ❑ Leave messages with call-back number only

- ❑ Cellular Telephone _____
- ❑ OK to leave messages with detailed information
- ❑ Leave messages with call-back number only

Release of Medical Information

Please list any person(s) with whom we may discuss your medical information or appointments.

Name	Relationship	Medical Information	Make, change or cancel appointments

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Patient Acknowledgement

I have received the Notice of Privacy Practices, the HIPAA forms and the Patient Bill of Rights. I have been provided the opportunity to review these documents.

Patient Signature: _____ Date: _____

Print Name: _____

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HIPAA FORM

I, _____, hereby give my consent to Beata I Styka, MD, to use or disclose for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change her privacy practices that are described in the notice. I also understand that a copy of Revised Notice will be provided to me or made available upon request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Patient Signature: _____ Date: _____

Print name: _____

If you are not the patient, please specify your relationship to the patient:

_____

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Patient Name: _____ Date: _____

Sex: Male Female Birth Date: _____

Street Address: _____ Apt./Unit: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular Phone: _____

Insurance Company: _____ Prescriptions Covered? **YES NO**

Reason(s) for today's visit: _____

_____

Medical History (please check all that apply)

- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood Disorder
- ❑ Depression
- ❑ Panic Attacks
- ❑ Sleeping Disorder
- ❑ Problems with Anger
- ❑ Memory Loss
- ❑ High Blood Pressure
- ❑ Fatigue
- ❑ Eating Disorder
- ❑ Drug/Alcohol Abuse
- ❑ Stroke
- ❑ Diabetes
- ❑ Seizure Disorder
- ❑ Glaucoma
- ❑ Wear Glasses/Contacts
- ❑ Hearing Problems
- ❑ Dentures
- ❑ Neck/Back Pain
- ❑ Thyroid Disease
- ❑ Heartburn
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Chronic Bronchitis
- ❑ Diverticulosis
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Diarrhea/Constipation
- ❑ Liver Disease
- ❑ Gout
- ❑ Acne
- ❑ Skin Disease

  _____
- ❑ Heart Disease

  _____
- ❑ Cancer

  _____
- ❑ Sexually Transmitted Disease

  _____
- ❑ Other

  _____

  _____

  _____

❑ Surgeries/Hospitalizations

_____

_____

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PATIENT HISTORY & PHYSICAL | Social History (please check all that apply)

Marital Status ❑ Married ❑ Separated ❑ Single ❑ Widowed ❑ Divorced

Highest Education Level: _____ Occupation: _____

❑ Smoking If yes, how many packs per day? _____ Years: _____ Quit Date: _____

❑ Alcohol If yes, how many packs per day? _____ Years: _____ Quit Date: _____

❑ Recreational Drugs: (list Type) _____

❑ Caffeine ❑ Coffee ❑ Tea ❑ Soda/Pop Amount per Day: _____

Currently Sexually Active? **( )YES ( ) NO** **( )** Multiple Sexual Partners Number: _____

( ) I have a Living Will/Advance Directive **( )**Religious Preferences: _____

Family History (please check all that apply and use the key below to describe who in your family has/had disease)

M=Mother F=Father S=Brother/Sister GF=Grandfather GM=Grandmother D/S =Son/Daughter

Disease	**Who in Family**	**Disease**	**Who in Family**
( ) Arthritis	_____	**( )** High blood Pressure	_____
( ) Asthma/Allergies	_____	**( )** Kidney Disease	_____
( ) Birth Defects/Inherited Disease	_____	**( )** Lung Disease	_____
( ) Blood Disorders	_____	**( )** Mental Illness	_____
( ) Bowel Problems	_____	**( )** Skin Disease	_____
( ) Cancer	_____	**( )** Stroke	_____
( ) Diabetes	_____	**( )** Thyroid Disease	_____
( ) Epilepsy/Seizures	_____	**( )** Tuberculosis	_____
( ) Glaucoma	_____	**( )** Ulcers	_____
( ) Gout	_____	**( )** Other _____	_____
( ) Headaches/Migraines	_____	_____	

Current Medications

Medication Name	**Dose and Times per Day**

Allergies or Reaction to Medicines/Food/Other Agents

Medication Name	**Reaction or Side Effect**

Immunizations: **( )** Measles **( )** Rubella **( )** Pertussis **( )** Polio **( )** Chicken Pox **( )** Flu **( )** Mumps **( )** Diphtheria **( )** Tetanus **( )** Hepatitis **( )** Pneumonia **( )** Tdap **( )** Shingles **( )** PCV13 **( )** PPSV23

( ) Other: _____

Current Primary Doctor: _____ Current Specialist: _____

PATIENT HISTORY & PHYSICAL

Patient Name: _____ Date of Birth: _____

Female History

Age at first menstrual period: ____ Flow: Heavy ____ Moderate ____ Light ____ Cycle Length ____

Number of Pregnancies ____ Live Births ____ Miscarriages ____ Elective Abortions ____ Living Children ____

Date of last menstrual period: _____ Birth control method: _____

Abnormal vaginal discharge YES or NO If yes, please describe: _____

_____

Review of systems Please indicate if you have any of the following: (Please Circle)

Blood Transfusion	Shortness of Breath	Headache
Chicken Pox	Wheezing	Fainting Spells
Rheumatic	Chronic Cough/Bronchitis	Confusion/Memory Loss
Undesired Weight Loss	Coughing up Blood	Muscle Weakness
Sweats	Bloody or Black Stools	Moodiness
Fatigue	Hemorrhoids	Sleeping Difficulty
Changes in Vision	Change in Bowel Habits	Nervousness
Wear Glasses or Contacts	Diarrhea	Hot Flashes
Ear Infections	Swallowing Difficulty	Hot or Cold Intolerance
Dizziness	Heartburn/Acid Reflux	Excessive Urination
Dentures	Gallbladder/Liver Problems	Recurrent Bleeding or Bruising
Hearing Problems	Abdominal Pain	Excessive Sweating
Voice Changes	Watery Eyes	Sinus Problems
Pain with Intercourse	Constant Runny Nose	Chest Pain
Loss of Bladder Control	Reaction to Bee Sting	Heart Murmur
Bladder Infections	Breast Tenderness	Leg Pain With Walking
Skin Disorder	Breast Tenderness	Varicose Veins
Hives/Itching	Swollen Ankles	Muscle/Joint/Bone Pain
Poor Circulation	Broken Bones _____	Other _____

TESTS AND PROCEDURES TEST	Approx Date	TEST	Approx Date
Flex Sig/Colonoscopy	_____	Dental EXAM	_____
Stool Test for Blood	_____	Hearing Test	_____
Rectal Exam	_____	Eye Exam	_____
Prostate/PSA	_____	Chest X-ray	_____
Exercise Stress Test	_____	EKG	_____
Pap Smear	_____	TB Test	_____
Mammogram	_____	Blood Work	_____
Cholesterol	_____	Other	_____

Which of the following tests have been abnormal? Please explain

_____

_____

Is there anything else you think I should know? _____