Sulkowski Family Medicine PLLC **Patient Registration** **Date: _____**

Patient Information

First Name | Last Name | MI | Date of Birth

Address | City | State | Zip

Please check Primary Phone # Home Phone ☐ Work Phone ☐ Cell Phone ☐

Occupation | Employer | Email Address

Gender ☐ M ☐ F | SSN | Preferred language | Driver's License #

Marital Status	Preferred Contact	Ethnicity	Race
☐ Married	☐ Mail	☐ Cambodian	☐ American Indian or Alaskan Native
☐ Single	☐ Home Phone	☐ Filipino	☐ Asian
☐ Divorced	☐ Day Phone	☐ Hispanic/Latino	☐ Black or African American
☐ Separated	☐ Cell Phone	☐ Non-Hispanic	☐ Native Hawaiian/Other Pacific Isl.
☐ Widowed	☐ Patient Portal		☐ White
☐ Life Partner			☐ Other

Responsible Party (Guarantor, if different from patient)

First Name | MI | Last Name | Date of Birth | Relationship

Address | City | State | Zip

Please check Primary Phone # Home Phone ☐ Work Phone ☐ Cell Phone ☐

SSN | Relationship to Patient | Preferred Language | Driver's License #

Emergency Contact (for Minor child, this section may be used for other parent)

First Name | MI | Last Name | Date of Birth | Relationship

Address | City | State | Zip

Please check Primary Phone # Home Phone ☐ Work Phone ☐ Cell Phone ☐

I/We do hereby consent to and authorize the performance of all treatments and medical services deemed advisable by the physicians, Thomas E. Sulkowski, MD to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I also hereby authorize Sulkowski Family Medicine PLLC to release information requested by the insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Please Print) Relationship to Patient

Assignment of Insurance Benefits/Eligibility Certification IRS# 47-1538606

Primary Insurance Plan

Patient Name		Date of Birth
Insurance Plan Name	Policy #	Group #
Insurance Company Address, City, State, Zip		Phone #
Subscriber's Name		Relationship to Patient
Subscriber's SSN	Subscriber's Date of Birth	
Subscriber's Employer	Employer's Phone	
Employer's Address, City, State, Zip		

For Medicare Patients Only

Medicare ID number	Part A Effective Date	Part B Effective Date

Other Insurance Coverage for Patient

Insurance Plan Name	Policy #	Group #
Insurance Company Address, City, State, Zip		Phone #
Subscriber's Name		Relationship to Patient
Subscriber's SSN	Subscriber's Date of Birth	
Subscriber's Employer	Employer's Phone	
Employer's Address, City, State, Zip		

☐ I hereby authorized and request that payment of authorized Medicare/other insurance company benefits, be paid directly to Sulkowski Family Medicine PLLC for any medical services and treatments to me or a member of my family. I authorized any holder of medical or other information about me to release to the social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable to related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

☐ I understand that I am eligible for benefits through my insurance carrier. I understand that my assigned PCP for my benefits is Thomas E. Sulkowski MD. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me), will pay full all such charges.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to patient

Agreement for Financial Responsibility

Thank you for choosing Sulkowski Family Medicine as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, credit cards and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company firs, less any copayment(s) and/or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 15-21 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- We do not render any services for Worker's Compensation medical situations, as your employer should have an assigned provider for your company to provide these services.
- We do not file auto insurance if you are seen in the office for services pertaining to a motor vehicle accident. You will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- We charge a fee for no show appointments and same day cancellations. That fee is $40 and will be the responsibility of the patient and/or responsible party to pay.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If your received services are part of an Out-of-Network benefits, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message your left for your physician's office.
We may communicate with you through mail, secure email and telephone, including leaving messages on your answering machine/voicemail.

Please check all the boxes that you give the SFM staff permission to use for communications:

- ☐ You may contact me by telephone Phone number: _____
- ☐ You may leave a message/voice mail Phone number: _____
- ☐ You may contact me by mail
- ☐ You may contact me through email (Patient Portal)

If your give permission for us to communicate with any else, please complete the list below:

Name/Phone Number	Relationship	Options(check all that applies)
1.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
3.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
4.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (please print) Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Your Name and signature on this forms indicates that you have reviewed and/or received a copy of Sulkowski Family Medicine PLLC Notice of Privacy Practices on the date and time indicated below.

If you have any questions regarding the information contained in Sulkowski Family Medicine PLLC Notice of Privacy Practices, please contact, Dannetta Duncan, our privacy compliance office at 615-900-1381.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____

FOR FACILTY USE ONLY

We attempted to obtain written acknowledgement of patient's receipt of Notice of Privacy Practices, but acknowledgment could not be obtained from the patient for the following reasons:

☐ Individual refused to sign

☐ Emergency situation prevented signature

☐ Patient requested above individual sign on his/her behalf

☐ Other (please specify) _____

Registration Representative Signature: _____ Date: _____

Pharmacy Information

Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address

Medications-List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

_____
_____
_____
_____
_____
_____
_____

Medication and Food Allergies-List all known allergies (drugs, food, animals, etc.)

☐ No known allergies

_____
_____
_____
_____

Medical History-Check if you have ever experienced the following conditions and the year and month of onset.

Condition	Month/Year	Condition	Month/Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer-Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Chicken Pox (history of)	
☐ Diabetes		☐ Other	
☐ Other		☐ Other	

Medical Information Forms continued

Surgical History – Check if you have received the following procedures, and year performed.

Surgical Procedure	Month/Year	Surgical Procedures	Month/Year
☐ None		**Male Only Procedures**	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (trans-urethral resection of Prostate)	
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (Heart Bypass)		☐ Other	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		**Female Only Procedures**	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colonoscopy		☐ Breast Biopsy	
☐ Colostomy		☐ Cesarean section	
☐ Gastric Bypass		☐ D and C	
☐ Hernia Repair		☐ Hysterectomy	
☐ Hip Replacement		☐ Mastectomy	
☐ Knee Replacement		☐ Myomectomy	
☐ LASIK		☐ Reduction Mammoplasty	
☐ Liver Biopsy		☐ TAH/BSO	
☐ Pacemaker		☐ Vaginal Hysterectomy	
☐ Small Bowel Resection		☐ Other	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism							
Anxiety							
Alzheimer's Disease							
CAD (Heart Attack)							
Cancer-Type:							
CVA (Stroke)							
Developmental Delay							
Diabetes							
Eczema							
Hyperlipidemia (High Cholesterol)							
Hypertension (High Blood Pressure)							
Irritable Bowel Disease							
Kidney Disease							
Mental Illness							
Osteoarthritis							
Osteoporosis							
Thyroid Disease							
Tuberculosis							
Other							
Other							
Other							
Other							
Other							

Social History – Please choose the options that apply to you, the patient.

Occupation ☐ Employed ☐ Student	Employer and/or School
What year of education did you complete? ☐ through 12th grade ☐ College ☐ Beyond 4 years of college_____	Who do you Reside with: ☐ Parents ☐ Guardian ☐ Spouse ☐ Partner ☐ Other_____
Is your Mother still alive: ☐ Yes ☐ No	Is your father still alive: ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No	How many?	Female(s)	Male(s)
Tobacco Use ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:	
Are you?: ☐ Married ☐ Divorced ☐ Single ☐ Widowed		Drug Use: ☐ Yes ☐ No	
Alcohol Use ☐ Yes ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:	

Health Maintenance – Check if you have received the following and the date of most recent exam.

Exam	Month/Year	Exam	Month/Year
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot Exam		☐ Tetanus Vaccine	

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy Date Reviewed: