EMERALD COAST GASTROENTEROLOGY
Mariusz J. Klin, M.D., PhD

Patient Information Form

Name: _____
First Middle Initial Last
Home Phone:_____ Work Phone:_____ Cell Phone:_____

Home Address:_____City:_____Zip Code:_____

E Mail_____

Social Security #:_____ Date of Birth _____Sex: (M) (F)

Employer: _____ Occupation: _____

Marital Status: (M) (S) (D) Spouse's Name:_____ Work Phone #: _____

Emergency Contact: _____ Phone: _____Relationship_____

How did you hear about us _____

REFERRING PHYSICIAN: _____ Phone #:_____

PRIMARY CARE PHYSICIAN: _____ Phone # _____

RACE: White Black Asian Hispanic Pacific Islander Other

LANGUAGE: English Spanish Other:_____

INSURANCE INFORMATION
(Present Insurance Cards to our staff)

PRIMARY INSURANCE:_____
Name of Policy Holder:_____Relation:_____
Address (if different from patient)_____
Date of Birth_____SS#_____

SECONDARY INSURANCE: _____
Name of Policy Holder:_____Relation:_____
Address (if different from patient)_____
Date of Birth_____ SS#_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. If, for any reason, the account should become delinquent, I agree to pay any billing charges, collection costs, and reasonable legal fees. I have read all their information and certify this information is true and correct to the best of my knowledge.

_____ _____
Signature of Responsible Party **Date**

PATIENT MEDICAL HISTORY FORM

The following information is very important. Please take time to completely fill out both pages.

Name:_____ **DOB:**_____ **Height**_____

Reason for visit:_____ **or** ☐ **Colon Cancer Screening**

Allergies To Medications:

Are you allergic to any medicines? ☐ **No** ☐ **Yes (If yes, please complete the allergy information below)**

Medications you are Allergic to:	Type of reaction you experience:

Past Surgical History:

Type of operation	Date or age at time of operation

Past Medical Problems:

Type	Date or age when problem began

Current Medications: (Please include over the counter medicines, vitamins, and supplements) **Pharmacy**_____

Medication	Dose	Frequency	Medication	Dose	Frequency

Are you required to take antibiotics before procedures? ☐ **No** ☐ **Yes**

Are you on Oxygen or CPAP? ☐ **No** ☐ **Yes**

Do you have a pacemaker? ☐ **No** ☐ **Yes** **Defibrillator?** ☐ **No** ☐ **Yes**

Have you ever had a ☐ **Cardiac ECHO** ☐ **Cardiac Cath When and where done**_____

Is there a chance you may be pregnant? ☐ **No** ☐ **Yes**

Social History:

	Yes	No	
Do you smoke?	☐	☐	If yes, how many packs per day? _____ How many years?_____
Have you ever smoked?	☐	☐	If yes, when_____
Do you drink coffee/soda?	☐	☐	Coffee _____cups/day Soda _____ cans/day
Do you drink alcohol	☐	☐	If yes, how often? Occasionally Socially Regularly Past Abuse

Recently,have you had any

lab work	O	Yes	O	No	when_____where_____
CAT scan	O	Yes	O	No	when_____where_____
Mri	O	Yes	O	No	when_____where_____
other	O	Yes	O	No	when_____where_____

Have you been in the hospital recently: O Yes O No when_____where_____

Emerald Coast Gastroenterology

Mariusz J. Klin MD., PhD
2202 STATE AVENUE, SUITE 301
Panama City, Fl. 32405
(850) 215-7071

CONSENT FOR ROUTINE RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____

Patient Name **Patient D.O.B.**

I_____ give my permission for Emerald Coast Gastroenterology, Mariusz J. Klin MD.,PhD to release and obtain any information to and from all health care providers, agencies, schools, and institutions for the purpose of the patient's diagnosis, care, and treatment.

I authorize release of the information below only to the following:

_____ _____

_____ _____

Initial Selection and Specify dates when appropriate:

__General Medical Record
__History and Physical
__X-Ray/Imaging Reports __All
__Laboratory Results __All
__Progress Notes __All
__Referral Consultation_____
__Other: (specify)_____

By my initials I specifically consent to release information relating to:

__STD ___HIV/AIDS __TB __Drug/Alcohol

_____
Printed Name

_____
Patient Signature

_____
Date

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INITIATION OF SERVICES, GENERAL RELEASE, AND ACKNOWLEDGEMENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

FLORIDA AND FEDERAL LAW REQUIRES THAT INFORMATION CONTAINED IN YOUR MEDICAL RECORDS BE HELD IN STRICT CONFIDENCE AND NOT BE RELEASED WITHOUT YOUR WRITTEN CONSENT. THE CONSENT YOU SIGN ON THIS PAGE WILL REMAIN IN EFFECT UNTIL YOU REQUEST IN WRITING THAT YOUR CONSENT BE WITHDRAWN, WHICH YOU MAY DO AT ANY TIME. YOU HAVE THE RIGHT TO REQUEST AND OBTAIN A COPY OF THIS CONSENT.

PART I CONSENT TO RELEASE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I, _____(Patient Name) do hereby consent to Emerald Coast Gastroenterology and any physician or health care provider or authorized agent, examining or treating me to use or disclose protected health information for treatment, payment or health care operations including release to any third party payer, any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted diseases, tuberculosis, AIDS, HIV, or case management information, including any information received from other health care providers, concerning diagnosis and treatment for its use in determining claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

PART III MEDICARE PATIENT CERTIFICATION AUTHORIZATION TO RELEASE AND PAYMENT REQUEST

I,_____certify that the information given by me in applying for payment under Title XVIII of the Social Security act is correct. I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers. Information needed for this or a related Medicare claim may be released. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician's services to Mariusz J. Klin MD., PhD/Emerald Coast Gastroenterology and authorize it to submit claim to Medicare for payment of my behalf.

PART III ASSIGNMENT OF BENEFITS

I,_____ hereby assign to Mariusz J. Klin MD., PhD all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the _____. All payments under this paragraph are to be made to Mariusz J. Klin MD., P.A. I am personally responsible for charges not covered by this assignment.

PART IV BY MY SIGNATURE BELOW I ACKNOWLEDGE THE ABOVE AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____

Patient Signature Date

PART V WITHDRAWAL OF CONSENT

I, _____ Withdraw this consent, effective _____(Date).

Patient Name_____

D.O.B._____

SS#_____