DEARBORN SURGICAL ASSOCIATES, P.C.

PATIENT REGISTRATION FORM

DATE_____

NAME: (LAST)_____(FIRST)_____SS#:_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____SEX: (M) (F)

EMAIL ADDRESS_____DATE OF BIRTH_____MARITAL STATUS: S M W

ARE YOU CURRENTLY WORKING: (Y) (N) EMPLOYER:_____

OCCUPATION _____SUPERVISOR_____PHONE_____

SPOUSE'S NAME_____BIRTHDATE_____EMPLOYER_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE_____

PRIMARY PHYSICAN_____PHONE_____

REFERRING PHYSICAN _____PHONE_____

HEALTH INSURANCE OR WORKERS COMPENSATION INFORMATION

PRIMARY _____ SECONDARY_____

SUBSCRIBER'S NAME_____ SUBSCRIBER'S NAME _____

DATE OF BIRTH_____ DATE OF BIRTH_____

PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

****PLEASE ANSWER ALL QUESTIONS BELOW****

ARE YOU CURRENTLY TAKING: ____COUMADIN ____ PLAVIX ____ ASPIRIN

ARE YOU ON DIALYSIS: (Y) (N) DIALYSIS DAYS: M T W T F S (PLEASE CIRCLE) FACILITY NAME:_____

CARDIOLOGIST: DR. _____

HEART TROUBLE: (Y) (N) PACEMAKER (Y) (N) STENT (Y) (N)

DEFIBRILLATOR (Y) (N) PAST HEART ATTACK (Y) (N) HEART BYPASS: (Y) (N)

DIABETIC (Y) (N) ALLERGIC TO LATEX (Y) (N) DO YOU SMOKE (Y) (N)

SEE OTHER SIDE →

DEARBORN SURGICAL ASSOCIATES, P.C.

PATIENT NAME_____DATE OF BIRTH_____

MEDICAL HISTORY:

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING PROBLEMS LISTED BELOW?

(CHECK ALL THAT APPLY):

___ AIDS	___ANEMIA (LOW BLOOD)	___ASTHMA	___BLEEDING DISORDERS
___CANCER	___CIRCULATION DISORDERS	___COLITIS / BOWEL DISORDERS	
___DEPRESSION	___DIABETIC	___EMPHYSEMA	___EPILEPSY
___ERECTILE DYSFUNCTION	___GALLBLADDER	___HEART DISEASE	___HEMORRHOIDS
___HERNIA	___HIGH BLOOD PRESSURE	___JAUNDICE	___KIDNEY PROBLEMS
___LEG ULCERS	___PNEUMONIA	___PHLEBITIS	___SEIZURES
___STOMACH DISEASE	___STROKE	___THYROID	

PREVIOUS SURGICAL HISTORY - PAST HOSPITALIZATIONS OR SURGERIES:

DATE	**REASON**
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL INFORMATION RELEASE

THE FOLLOWING PERSON(S) HAVE CONSENT FOR ACCESS TO MY MEDICAL INFORMATION:

1._____--_____
PRINT NAME RELATIONSHIP TO PATIENT

2._____--_____
PRINT NAME RELATIONSHIP TO PATIENT

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

THIS INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COPAYS, DEDUCTIBLES, AND SERVICES RENDERED NOT COVERED BY INSURANCE. I WILL BE RESPONSIBLE FOR ANY **NSF FEES, REASONABLE ATTORNEY FEES** AND **COSTS OF COLLECTIONS** IN THE EVENT OF A DEFAULT OF ANY **UNPAID BALANCES** WITHIN **60** DAYS OF RECEIPT OF STATEMENT.

AND

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DEARBORN SURGICAL ASSOCIATES FOR PAYMENT.

AND

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY.

PATIENT/RESPONSIBLE
PARTY SIGNATURE:_____DATE_____

PRINTED NAME:_____

DEARBORN SURGICAL ASSOCIATES, P.C.

OAKWOOD MEDICAL OFFICE BUILDING
18181 OAKWOOD BLVD. SUITE 209, DEARBORN, MI 48124

TELEPHONE: (313)271-8560
FAX: (313)271-2831

JAMES R. LULEK, M.D., GENERAL & VASCULAR SURGERY

GERALDINE L. PAWLIK, M.D., GENERAL SURGERY

MICHAEL R. ISRAEL, M.D., GENERAL & VASCULAR SURGERY

DANIEL BACAL, M.D., GENERAL & BARIATRIC SURGERY

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our policy notice.

PATIENT SIGNATURE:_____

PRINT NAME:_____**DATE:**_____