Medical History Form Peter Zdankiewicz, M.D.

Name: ______________________________ Date: ______________

Age: ________ Chief Complaint: ____________________________________

Medication	Dose	Medication	Dose
Herbals	**Times/daily**	**Herbals**	**Times/Daily**
Allergies	**Reaction**	**Blood Thinners**	**Yes/No**
Latex?		***Coumadin?***	
		Plavix?	
		Aspirin?	

Surgical History	
Operation	**Date**

Medical History/Disorders		

☐ Former Smoker: Quit Date: ____________ ☐ Never Smoker

Alcohol Use: ______________________ Occupation: ______________________

____

Height: _____’ _____” Weight: ________ lbs

PCP: ______________________ Cardiologist: ______________________

Other: ______________________ Pharmacy/phone: ______________________

PETER ZDANKIEWICZ , M.D. LLC
GENERAL SURGERY VEIN THERAPY

HIPAA

I consent to the use or disclosure of my protected health information by Peter Zdankiewicz, M.D. LLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Peter Zdankiewicz, M.D., LLC may be conditioned upon my consent as evidence by my signature on this document.
I understand I have the right to request restrictions to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Peter Zdankiewicz, M.D. LLC is not required to agree to the restrictions that I request. The restriction is binding on Peter Zdankiewicz, M.D., LLC.
I have the right to revoke this consent, in writing at any time, except to the extent that Peter Zdankiewicz, M.D., LLC has taken action in reliance of this consent.
My "protected health information" means health information, including demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identified me, or there is a reasonable basis to believe the information may identify me.
I understand I have the right to review Peter Zdankiewicz, M.D., LLC Notice of Privacy Practices prior to signing this document. The notice of privacy practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Peter Zdankiewicz, M.D., LLC . The notice of privacy practices for Peter Zdankięwicz, M.D. LLC is also provided at 10 Main Street South, Southbury, CT 06488, and 1211 West Main Street, Waterbury, CT 06708. This notice of privacy practices also describes my rights and Peter Zdankiewicz, M.D., LLC duties with respect to my protected health information.
Peter Zdankiewicz, M.D., LLC reserves the right to change the privacy practices that are described in the notice of Privacy Practices. I may obtain revised notices of privacy practices by calling the office and requesting a revised copy be sent to me by mail, or asking for one at the time of my next visit.
I understand that no information about me may be shared with anyone without my consent except for the above stated persons/companies.

I hereby authorize my health heath information may be shared with:

______________________________ ____________________
Name Relation

______________________________ ____________________
Signature of patient or personal representative Date

PETER ZDANKIEWICZ, M.D. LLC
GENERAL SURGERY VEIN THERAPY

Insurance/Payment Agreement

I authorize any holder of medical and/or other information about me to be released to the Social Security Administration and heath care financing administration and/or its intermediaries, carriers, agents, insurance carriers, and agents or insurance companies -. Any information needed to determine the benefits for this or a related claim may be obtained.

Also, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

I understand that if I do not have insurance, I am responsible for payment of my medical bills incurred, and payable to Peter Zdankiewicz, M.D., LLC.

X______________________________ X____________________
Patient signature Date

X______________________________ X____________________
Responsible party signature Date

10 Main Street South
Southbury, CT 06488

Phone: (888) 338-8356
Fax: (888) 366-1189

1211 West Main Street
Waterbury, CT 06708