Patient Registration Form

Norman J. Chideckel, M.D., F.A.C.S.

PATIENT INFORMATION *(Person seeing the Doctor today)*

Last Name	First Name			Middle Initial
Home Address *(Street, Apt #)*	City		State	Zip
Mailing Address (if different from home)	City		State	Zip
Home Phone Number	Cell Phone Number		Social Security Number	
Date of Birth	Gender (M-F)	Emergency Contact *(Name of Person to call)*	Emergency Phone Number	
Patient Employer *(Company Name)*	Work Address *(Complete: street, city, state, zip)*		Work Phone Number	
Referring Doctor *(Doctor who referred you to Dr. Chideckel. If not referred, please write "none")*			Patient Marital Status	

BILLING INFORMATION *(Person responsible for any balances not covered by insurance; also called "Guarantor")*

Name of Person responsible for bill	Home Address *(Complete: street, city, state, zip)*	Home Phone Number

INSURANCE INFORMATION *(Person whose insurance is used for today's Doctor visit; also called "Subscriber")*

Name of First (Primary) Insurance Company	Address of First (Primary) Insurance Company *(see back of your insurance card)*		Insurance Company Phone Number
Group Number	Policy Number or Insured Person ID Number		Relationship to Patient
Subscriber's Name *(Policy holder of insurance)*	Subscriber's Home Address *(Complete: street, city, state, zip)*		Subscriber's Home Phone Number
Subscriber's Date of Birth	Gender (M-F)	Social Security Number	Name of Company where Subscriber works
Name of Second Insurance Company	Address of Second Insurance Company		Insurance Company Phone Number
Group Number	Policy Number or Insured Person ID Number		Relationship to Patient
Subscriber's Name *(Policy holder of Insurance)*	Subscriber's Home Address *(Complete: street, city, state, zip)*		Subscriber's Home Phone Number
Subscriber's Date of Birth	Gender (M-F)	Social Security Number	Name of Company where Subscriber works

WORKER'S COMPENSATION INFORMATION *(Complete this section only if you are seeing Doctor for work-related injury)*

Employer (Company Name)	Address of Employer / Company *(Complete: street, state, zip)*	Phone Number (Employer / Company)
Date of Injury	Name of Insurance Adjuster	Phone Number of Insurance Adjuster
W / C Claim # (if any)	Brief Description of Injury *(example: twisted ankle, broken leg, burned fingers, etc.)*	

I hereby authorize Dr. Chideckel's office to perform medical services and to bill my insurance company(s) for services. I authorize the release of these reports requested by my physician, insurance company and/or to their designate(s) when necessary to process the claim or for clinical review. Dr. Chideckel's will send the claim to the listed insurance company(s) as a courtesy. **The subscriber is responsible for understanding the parameters of their insurance, i.e., in-network, out of network, deductibles, co-pay and if a preauthorization is needed for ordered tests. The subscriber is ultimately responsible for payment.** – *Thanks!*

Signature (Responsible Party): ______________________ Date: __________

NORMAN CHIDECKEL, M.D. VASCULAR SURGERY VEIN CENTER

Patient information

Patient Name:	Date of birth:
Street Address:	Gender: ☐ Male ☐ Female
City, State, Zip:	Weight: Height:
Home telephone:	Marital Status:
Alternate phone number: Work / Cell	Occupation:

May we leave messages on your answering machine? ☐ Yes ☐ No
***(note: the representative from our office will never leave any personal health information on an answering machine)

Name of Legally Responsible Representative:

Relationship to Patient:
***A copy of Power of Attorney must be on file, if one exists.

Street Address:

City, State, Zip:	Telephone:

Insurance Information

Company Name:	Primary insured Social Security #:
Name of primary insured:	ID number:
Claims Address:	Group number:
City, State, Zip:	Company Telephone:

Referring Physician Information

Physician Name:	Is this the primary care giver? ☐ Yes ☐ No
Street Address:	If not, name of PCP:
City, State, Zip:	Telephone:

Patient Medical History

*** please use back of form if more space is needed

ALLERGIES: (list all meds and reactions)

List all Present Illnesses/ Recent Diagnosis:

Have you ever had an endoscopic procedure? ☐ Yes ☐ No | Reason: | Date:

Past Medical History:

Past Surgical History:

CURRENT MEDICATIONS: (***list all medications including the dosage and frequency of use; include any vitamins/supplements/over the counter medication and herbals):

Do you take any of the following medications? Coumadin/ warfarin Plavix Aspirin NSAIDs Other:

Do you have a personal or family history of any of the following? (***If other than self, please describe relationship to patient.)

	Yes	No		Yes	No
Abdominal Pain/ cramps	☐	☐	Heart Disease	☐	☐
Acid reflux/ heartburn	☐	☐	Hepatitis	☐	☐
Anemia	☐	☐	High Blood Pressure	☐	☐
Asthma or Lung Disease	☐	☐	High Cholesterol	☐	☐
Cancer (type)	☐	☐	Irritable Bowel Syndrome	☐	☐
Constipation	☐	☐	Kidney problems	☐	☐
Crohn's disease	☐	☐	Mitral Valve prolapse	☐	☐
Diabetes	☐	☐	Nausea/ Vomiting	☐	☐
Diarrhea	☐	☐	Osteoporosis	☐	☐
Digestive disease	☐	☐	Polyps	☐	☐
Gastrointestinal Bleeding	☐	☐	Ulcers	☐	☐
GERD	☐	☐	OTHER:	☐	☐

I authorize the release of medical information which could include HIV status, communicable disease, or drug abuse information to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits, including Medicare to NORMAN CHIDECKEL M.D.
By signing this form I assure the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand that it is my responsibility to inform the organization of such changes. I have reviewed and understand, and a copy of the following information has been made available to me.

Signature (Responsible Party): ______________________ Date: __________

Bring your Ins. CARD with you.

NORMAN J. CHIDECKEL, M.D., F.A.C.S.
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Notice of Privacy Practice
Patient Acknowledgement

Patient Name: ______________________________ Date of Birth______________________

I have received this practice's Noticy of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and pratice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosure that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information whithout my written consent or authorization.
- A description or uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorizing and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

  - The right to complain to this pratice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retalitory actions will be used against me in the even of such a complaint.

  - The right to request restrictions on certain uses and disclosures of my protected health information and that this pratice is not required to agree to a requested restriction.

  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to obtain a copy of the Noticy of Privacy Practice from this pratice on request.

This practice reserves the right to change the terms of its Notice of Privacy Pratice and to make new provision effective for all protected health information that it maintains. I understand that I can obtain this pratice's current Notice of Privacy Practices on request.

Signature:____ Date:______________________

Relationship to patient (if signed by a personal representative of patient):________________