Andrew L. Kulik, D.O., F.A.O.A.S.
3446 Park Boulevard, San Diego, CA 92103
(619) 295-3470, (619) 295-3495 FAX

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: **Single** ☐ **Mar** ☐ **Div** ☐ **Sep** ☐ **Wid** ☐	
Is this your legal name? ☐ Yes ☐ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:**	**Age:**	**Sex:** ☐ M ☐ F	
Street address:		**Social Security no.:**		**Home phone no.:** ( )		
P.O. box:	**City:**		**State:**	**ZIP Code:**		
Occupation:	**Employer:**		**Employer phone no.:** ( )			
Blood Type:___ Lang: ____ Ethnic: ___		**Pharmacy:**	**Phone:**			
Alcohol:	**H= Heavy**	**M= Moderate**	**S= Social N= No**	**Drivers License #**		
(Info. For Your Insurance)	**Do You Smoke: Y/N**	**How Many Packs Per Day? :**	**Cigars: Y/N:**			

INSURANCE INFORMATION

(**Please give your insurance card to the receptionist.)**

Primary Insurance:	**Carrier Name:**	**Insurance Address :**	**Insurance Phone #:** ( )
HMO INSURANCE? ☐ Yes ☐ No			
Work Related:	**Yes / No**	**Identification #:**	**Group #:**
Co- Payment Amount:	$	**Work Comp Insurance:**	**DOI:**
Claim #		**Adjuster Name:**	**Phone #:**
Secondary Insurance:	**Carrier Name:**		
Insurance Address:			
Identification #: **Insurance Phone #:**		**Group #:**	
(Office Use Only)	**Rev. By:**	**Date Received Information:**	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Andrew Kulik or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ **Date** _____

Referred By:

Please Send Copy Of Insurance Card

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FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION "FORM BEFORE SEEING THE DOCTOR

INSURANCE

Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. (We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists.) We file insurance claims as a courtesy to our patients. We will not become involved in the disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc, other than to supply factual information as necessary. You are responsible for the timely payment of your account.

If you have insurance, we will assist you by filing and, except for deducible and co-payment/ patient responsibility portion, will often accept assignment of reasonable insurance payments. Our insurance assignment form must be completed and signed.

Since insurance companies are making it more difficult for physicians to receive payments in a reasonable time frame, we request that you pay the deductible and co-payment at the time of services rendered, or make special arrangements prior to treatment.

WE ACCEPT CASH, CHECKS AND VISA/MASTERCARD/DISCOVER

If your insurance company has not paid with 45 days of billing, you must make arrangements to pay the balance. Late payment charges may be added to accounts after 45 days from date of last payment. If your insurance pays more than the balance due, we will send a refund check to you immediately.

MINORS

Parents (or guardians) are responsible for financial arrangement, and if unaccompanied, the minor must have a signed authorization for treatment which includes the financial/insurance information.

MEDICARE/MEDI-CAL/CHAMPUS/WORKER'S COMPENSATION

If you are covered by Medicare, Medi-Cal, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to date of service. If your secondary insurance payment does not come to our office directly, it is your responsibility to forward that to us immediately.

MISSED APOITNEMENTS

Our office policy requires 24 hours notice for cancelled appointments. If we do not receive 24 hours notice, we will bill you for the appropriate charges. (Your insurance will not pay for missed appointments.)
THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE QUESTIONS OR CONCERNS.

Responsible Party Signature: _____ Date: _____

History & Physical

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Name _____
Date _____ SS# _____
Address _____
Occupation _____ Phone (Home) _____
(Work) _____ Date of Birth _____
Chief Complaint _____
Insurance# _____

Hospitalization or Surgery

Date	Reason	Date	Reason

Drug Allergies

Medications

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus		Pneumonia		Rectal/Stool		Tuberculosis	
Flu		Other_____		Cholesterol		Other_____	

Medical History

❑ Ringing In Ear_____
❑ Ear Infections - *Frequent* _____
❑ Dizziness/Fainting _____
❑ Hair Loss_____
❑ Failing Vision _____
❑ Eye Infections _____
❑ Nose Bleeds_____
❑ Sinus Trouble _____
❑ Sore Throats - *Frequent* _____
❑ Hayfever/Allergies_____
❑ Pneumonia _____
❑ Bronchitis/Chronic Cough_____
❑ Asthma/Wheezing _____
❑ Chest Pain _____
❑ Hair Loss_____
❑ High Blood Pressure _____
❑ Heart Murmur _____
❑ Swollen Ankles _____
❑ Leg Pain - *Walking*_____
❑ Varicose Veins/Phlebitis _____
❑ Loss of Appetite _____
❑ Difficulty Swallowing _____
❑ Indigestion or Heartburn _____
❑ Persistent Nausea/Vomiting _____

❑ Peptic Ulcers _____
❑ Abdominal Pain - *Chronic*_____
❑ Gall Bladder Trouble _____
❑ Jaundice/Hepatitis _____
❑ Change in Bowel Habits _____
❑ Diarrhea ❑ Constipation _____
❑ Diverticulosis ❑ Crohn's/Colitis ____
❑ Bloody or Tarry Stools _____
❑ Hemorrhoids _____
❑ Hernia _____
❑ Urine Infections - *Frequent* _____
❑ Blood In Urine _____
Urination-❑ Overnight > than twice
❑ Painful ❑ Loss of Control
❑ Decrease in Force/Flow
❑ Kidney Stones _____
❑ Venereal Disease_____
❑ Urethral Discharge _____
❑ Chronic Fatigue _____
❑ Weight Loss - *Recent*_____
❑ Anemia ❑ Bruise Easily _____
❑ Cancer_____
❑ Diabetes _____
❑ Thyroid Disease _____

❑ Convulsions/Seizures _____
❑ Stroke _____
❑ Tremor/Hands Shaking _____
❑ Muscle Weakness _____
❑ Numbness/Tingling Sensations _____
❑ Headaches - *Frequent* _____
❑ Arthritis/Rheumatism_____
❑ Osteoporosis _____
❑ Back Pain - *Recurrent* _____
❑ Bone Fracture/Joint Injury _____
❑ Gout _____
❑ Foot Pain ❑ Cold Numb Feet _____
❑ Rashes ❑ Hives _____
❑ Psoriasis ❑ Eczema_____
❑ Nervousness ❑ Depression_____
❑ Memory Loss _____
❑ Moodiness - *Excessive* _____
❑ Phobias _____
❑ Mental Illness_____
❑ Lactose Intolerance _____
❑ Prostate Disease _____
❑ Sexual/Menstrual Dysfunction ____
❑ Frequent Infections _____
❑ Diphtheria _____

❑ Tetanus _____
❑ Chicken Pox ❑ Polio ❑ Mumps ❑ Measles ❑ Rubella ❑ Rheumatic Fever ❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
❑ Other _____
❑ Other _____
Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period_____
❑ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method_____
B.C. Pill (Name) _____
❑ Flushing/Menopause
Date of Last PAP Test _____
❑ Normal ❑ Abnormal
Date of Last Mammogram _____
Normal ❑ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Hair Loss	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High Blood Pressure	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Migraine	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Other_____						

Habits

❑ Alcohol: Type _____
Amount_____
❑ Diet: Salt Intake _____
Fat Intake _____
Other _____

❑ Sleep: Difficulty Falling Asleep _____
Continuity Disturbances _____
Early Morning Awakening _____
Daytime Drowsiness _____
Other_____

❑ Smoke: Packs Daily _____
How Long _____
Interested in Stopping?_____
❑ Exercise Routine: _____

❑ Coffee: Cups Daily_____
Other Caffeine _____

Other Information

Have you completed Advance Healthcare Directives? Yes ___ No ___
(Living Will or Durable Power of Attorney for Healthcare)

If yes, please provide the name and contact information for your Healthcare Care Power of Attorney:

_____

If no, whom would you prefer as a surrogate decision maker should you need one?

_____

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PATIENT'S RIGHTS AND RESPONSIBILITIES

Our patients have the rights to:

- Be treated with dignity, consideration, respect, and with timely attention to their needs.
- Know how to voice an opinion and how to recommend changes in our policies and procedures.
- Receive information about our services and our providers.
- Be fully informed about the care and treatment which will be provided by the physicians and others, how much it will cost, how payment will be handled and the portion they are responsible for.
- Receive from their health care providers, complete information about their diagnosis, and proposed procedure or treatment alternatives, including non-treatment, in order to give informed consent.
- Participate actively in the decisions about their health care and treatment plan.
- Experience continuity in the health care that is provided.
- Change their primary-care provider by contacting member services of their insurance carrier.
- Have 24-hour access to their provider or covering physician.
- Have the freedom to make a compliant or recommend chang4es in services or in policy.
- Be informed or the grievance procedure.
- Receive prompt and reasonable responses to questions and requests.

As a patient, have the responsibility to:

- Know the benefits and exclusion of their coverage.
- Provide our office with complete and accurate information
- Follow the treatment plan that they and their health-care providers have agreed to.
- Notify health-care provider at least 24 hours in advance of appointment cancellation of changes.
- Advise health-care provider of any changes in their insurance coverage, employment, address, etc.
- Be courteous to office staff.

Please initial receipt of this document. The original will be given to you and a copy in the chart.

_____ DATE: _____

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HIPAA PRIVACY

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

This consent is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Accountability **Act** of **1996** (**HIPAA**), 42. U.S.C. ž **132d** et seq.,

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

_____ Accepted _____ Denied

Signature_____

Date: _____

Emergency Contact:

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____