# PATIENT REGISTRATION

DANIEL BENDETOWICZ, M.D., P.A.

**PLEASE COMPLETE ALL INFORMATION:**

Date: _____

Last Name: _____ Home Phone #: _____

First Name: _____ M.I.: _____ Work Phone #: _____

**If year round resident with only one address, please check here:** ❑ Cell Phone #: _____

## LOCAL ADDRESS

Street Address: _____ Apartment #: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Spouse Name: _____

Zip Code: _____ Sex: ❑ Male ❑ Female Spouse DOB: _____

Social Sec. #: _____ Date of Birth: _____ Spouse Social Sec. #: _____

Employer: _____ Spouse Cell Phone #: _____

## UP NORTH ADDRESS

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

**INFORMATION RELEASE**

LIFETIME MEDICARE B signature authorization for services beginning _____. I authorize any hold of medical or other information about me, including the results of any HIV (human immunodeficiency virus) test, to release to the Social Security Administration and Health Care financing Administration or its intermediaries or carriers, or to my insurance company or any organization or authority, or to the billing agent for Daniel Bendetowicz, M.D., P.A. any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts assignment.

PATIENT'S SIGNATURE: _____ MEDICARE #: _____ DATE: _____

*If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:*

AUTHORIZED SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____

AUTHORIZED SIGNATURE'S NAME: _____ DATE: _____

**FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT**

I authorize treatment of the patient named herein and agree to pay all fees and charges promptly, unless advance credit arrangements are agreed in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect unpaid balance due for medical services rendered, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

PATIENT'S SIGNATURE: _____ DATE: _____

**IF PATIENT IS A MINOR**

I, _____, the _____, of _____,
hereby personally accept financial responsibility for professional services by Daniel Bendetowicz, M.D. P.A., upon the aforementioned child.

SIGNED: _____ DATE: _____

**ASSIGNMENT AND RELEASE**

I/We hereby authorize my insurance benefits, including Medicare Gap Fillers, to be paid directly to the physician and I/We hereby agree to be financially responsible for any amount not covered by insurance. I/We authorize the physician to release any information required by my insurance, including HIV (AIDS) testing/notes, mental health, alcohol and/or substance abuse. Financial information can be released if the Patient's account number is provided by the person making the request.

PATIENT'S SIGNATURE: _____ DATE: _____

*If patient is unable to sign, may be signed by someone who is authorized by patient to sign for him/her:*

AUTHORIZED SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____ DATE: _____

AUTHORIZED SIGNATURE'S NAME: _____ DATE: _____

**NAME** _____ **DATE OF BIRTH** _____

# CONTACT INFORMATION

DANIEL BENDETOWICZ, M.D., P.A.

**EMERGENCY CONTACT:**

Name: _____

Relation to the patient: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____ Cellular Phone Number: _____

**NON-EMERGENCY CONTACT:**

**You may be contacted to remind you of appointments, questions regarding insurance, discuss results of your tests or to talk about your medical conditions. Is there someone else to whom Daniel Bendetowicz, M.D., P.A is authorized to disclose the above information? If yes, provide this person's name and contact information below.**

❑ _____ **If same as above, it is not necessary to repeat all the information. Please check here and initial.**

Name: _____

Relation to the patient: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____ Cellular Phone Number: _____

**This authorization will remain in effect until I cancel it in writing.**

**By signing this form, I authorize the disclosure of the information as above. I acknowledge I have reviewed and understand this authorization form.**

Signature: _____ Date: _____

# FINANCIAL RESPONSIBILITIES

DANIEL BENDETOWICZ, M.D., P.A.

We would like to let you know your financial responsibilities as a patient.

Please be informed of the coverage and limitations of your insurance plan. Due to the number of different plans it is not always easy for us to know all the details and coverage of your particular plan. This is particularly important for complete physical exams. Although important and recommended, sometimes they are not covered by your insurance. The same situation could occur with testing and vaccines that although necessary could be not payable under a given plan.

We suggest you check with your insurance before any testing is done to find out what is your financial responsibility on it. It is also important that you will find out what testing facilities are approved by your insurer for outpatient testing (laboratory, radiology).

**For any billing questions, please contact our billing service.**

## PATIENT FINANCIAL RESPONSIBILITIES ALSO INCLUDE:

- Payment of all co-payments, co-insurance, and deductibles.
- Payment at the time of service.
  *(Please note: As a courtesy, we will try to bill your secondary insurance. After your secondary insurance has paid the co-payments a refund will be made to you, if applicable.)*
- Payment of any final, outstanding balance.
- Providing us with current and complete patient and insurance information.
- Remembering to bring your insurance card to each office visit.

## PAYMENT METHODS:

- Cash
- Personal checks
- Visa
- Master Card
- Traveler checks

Signature: _____ Date: _____

NAME _____ DATE OF BIRTH _____

# ADULT HEALTH HISTORY

DANIEL BENDETOWICZ, M.D., P.A.

## 1. ALLERGIES: LIST ALLERGIES TO MEDICATIONS, LATEX, DYE, ETC.

1. _____ 2. _____ 3. _____

PLEASE INDICATE BELOW THE REACTION IT CAUSES:

1. _____ 2. _____ 3. _____

## 2. MEDICATIONS

LIST ALL CURRENT MEDICATIONS INCLUDING OVER-THE-COUNTER DRUGS, HERBS, SUPPLEMENTS.

| NAME | STRENGTH | HOW OFTEN |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

| NAME | STRENGTH | HOW OFTEN |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

## 3. PATIENT PAST MEDICAL HISTORY

CHECK ALL YOUR MEDICAL CONDITIONS

| | | | |
|---|---|---|---|
| Alcohol Problem ❑ YES ❑ NO | Chronic Bronchitis/ Emphysema ❑ YES ❑ NO | High Cholesterol ❑ YES ❑ NO | Stroke ❑ YES ❑ NO |
| Drug Problem ❑ YES ❑ NO | Diabetes ❑ YES ❑ NO | Kidney Disease ❑ YES ❑ NO | Thyroid Disease ❑ YES ❑ NO |
| Anemia ❑ YES ❑ NO | Glaucoma ❑ YES ❑ NO | Mental Problems ❑ YES ❑ NO | Tuberculosis ❑ YES ❑ NO |
| Arthritis ❑ YES ❑ NO | Gout ❑ YES ❑ NO | Migraines ❑ YES ❑ NO | Stomach Problems ❑ YES ❑ NO |
| Asthma ❑ YES ❑ NO | Heart Disease ❑ YES ❑ NO | Seizures ❑ YES ❑ NO | Intestinal Problems: ❑ YES ❑ NO |
| Cancer ❑ YES ❑ NO | High Blood Pressure ❑ YES ❑ NO | | OTHER: |
| If YES to cancer, where: | | | |
| _____ | | | _____ |

## 4. SURGERIES

LIST ALL THE SURGERIES YOU EVER HAD

| | | | | | |
|---|---|---|---|---|---|
| 1. _____ | Date: _____ | 5. _____ | Date: _____ | 9. _____ | Date: _____ |
| 2. _____ | Date: _____ | 6. _____ | Date: _____ | 10. _____ | Date: _____ |
| 3. _____ | Date: _____ | 7. _____ | Date: _____ | 11. _____ | Date: _____ |
| 4. _____ | Date: _____ | 8. _____ | Date: _____ | 12. _____ | Date: _____ |

## 5. SOCIAL HISTORY

MARITAL STATUS: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

NUMBER OF CHILDREN: _____

OCCUPATION: _____

LAST GRADE COMPLETED: _____

HIGHEST DEGREE RECEIVED: _____

DO YOU HAVE EITHER OF THE FOLLOWING: ❑ Living Will ❑ Healthcare Power of Attorney

DO YOU DRINK ALCOHOL: ❑ Yes ❑ No

IF YES ABOVE: Amount per week: _____ Type: _____

DO YOU CURRENTLY SMOKE? ❑ Yes ❑ No

IF YES ABOVE: Packs per day: _____ # of years: _____

DID YOU EVER SMOKE? ❑ Yes ❑ No

IF YES ABOVE: When stopped: _____ Amount: _____

HAVE YOU EVER USED RECREATIONAL DRUGS? ❑ Yes ❑ No

IF YES ABOVE: Type: _____

PLEASE TURN THE PAGE AND COMPLETE THE BACK ▶

NAME _____ DATE OF BIRTH _____

REVIEWED BY _____ DATE FORM COMPLETED _____

## 6. FAMILY MEDICAL HISTORY

| | AGE | NAME | DISEASES | IF DECEASED, CAUSE OF DEATH |
|---|---|---|---|---|
| Father | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ |
| Brother(s) | _____ | _____ | _____ | _____ |
| Sister(s) | _____ | _____ | _____ | _____ |
| Children | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ | _____ |

ANY FAMILY HISTORY OF:

Coronary artery disease (heart attack, angioplasty, heart surgery): ❑ Yes ❑ No Whom:_____

High blood pressure: ❑ Yes ❑ No Whom:_____

Diabetes (blood sugar): ❑ Yes ❑ No Whom:_____

Cancer: ❑ Yes ❑ No Whom and What type:_____

## 7. IMMUNIZATION HISTORY

PLEASE INDICATE THE MOST RECENT YEAR

Flu Vaccine (Date): _____ Pneumovax Vaccine (Date): _____

Last Tetanus (Date): _____ Hepatitis Vaccine (Date): _____

FOR PATIENTS WITH DIABETES ONLY:

Last visit to the podiatrist (Date): _____

Last visit to the ophthalmologist (Date): _____

## 8. PREVENTATIVE

Colon Cancer Screening ❑ Yes ❑ No

IF YES ABOVE: When _____; What type of screen test: _____

Date of last Bone Density Scan _____

MALES ONLY:

Date of last Rectal Exam _____

Date of last PSA Level _____

FEMALES ONLY:

Date of last Pap Smear/Pelvic Exam _____ Number of pregnancies _____

Date of last Mammogram _____ Number of miscarriages _____

Date of Last menstrual period _____ Birth control method _____

**HOW DID YOU HEAR ABOUT US?**

_____

**NAME** _____ **DATE OF BIRTH** _____

**REVIEWED BY** _____ **DATE FORM COMPLETED** _____

DANIEL BENDETOWICZ, M.D., P.A.

TELL US ABOUT YOUR OTHER DOCTORS

**PRIMARY CARE PHYSICIAN:**

NAME:_____

PHONE NUMBER: _____

ADDRESS:_____

CITY:_____ST:_____

**CARDIOLOGIST:**

NAME:_____

PHONE NUMBER: _____

ADDRESS:_____

CITY:_____ST:_____

**GASTROENTEROLOGIST:**

NAME:_____

PHONE NUMBER: _____

ADDRESS:_____

CITY:_____ST:_____

NAME: _____ DOB: _____

# REQUEST TO OBTAIN MEDICAL INFORMATION


**DANIEL BENDETOWICZ, MD, PA**
**INTERNAL MEDICINE**

I do hereby authorize:

PRACTICE NAME

ADDRESS

CITY STATE ZIP

PHONE NUMBER FAX NUMBER

to release to: DANIEL BENDETOWICZ, M.D., P.A.
6840 INTERNATIONAL CENTER BLVD.
FORT MYERS, FL 33912

PHONE: (239) 985-1050
FAX: (239) 985-1060

the following medical information, including sexually transmitted diseases, HIV/Aids, psychiatric, psychological, alcohol and drug abuse:

- ❑ ALL RECORDS
- ❑ HISTORY & PHYSICAL
- ❑ PROGRESS NOTES
- ❑ CONSULTATION
- ❑ LABORATORY RESULTS
- ❑ RADIOLOGY TEST
- ❑ OTHER: _____

for the purpose of: ❑ CONTINUITY OF CARE ❑ UPDATE ON PATIENT MEDICAL CONDITION ❑ OTHER: _____

From: _____ To: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Daniel Bendetowicz, M.D., P.A. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Daniel Bendetowicz, M.D., P.A.

PATIENT NAME DATE OF BIRTH

SOCIAL SECURITY NUMBER PHONE NUMBER

PATIENT SIGNATURE OR LEGAL REPRESENTATIVE SIGNATURE DATE

IF SIGNED BY LEGAL REPRESENTATIVE, STATE THE RELATIONSHIP TO THE PATIENT

WITNESS SIGNATURE

DANIEL BENDETOWICZ, MD, PA
INTERNAL MEDICINE

# ACKNOWLEDGEMENT OF OFFICE POLICIES

## LATE CANCELLATIONS – NO SHOW APPOINTMENTS

1) I understand and I have been notified that I will be charged a fee in the event that I do not give a minimum of 24 hours cancellation/reschedule notice by phone to Dr. Bendetowicz's office.

The notification should be done during regular working hours. A message left on the answering machine or to the on call physician is not considered a 24 hour notice.

There may be exceptions that will be considered in exceptional situations.

Initials _____

2) I acknowledge that I have been notified that in case that my account goes to a collection agency due to lack of payment, I will be responsible for the collection agency's fees. This is 25% of the debt amount.

Initials_____

## AUTHORIZATION TO RETRIEVE EXTERNAL MEDICATION HISTORY

I authorize Daniel Bendetowicz, MD, PA to retrieve my external medication history. I understand that this may include medication history prior to getting established as a patient of Daniel Bendetowicz MD PA. This medication history may include substance controlled medication, psychiatric drugs, antiviral drugs (for example those ones used in the treatment of HIV/AIDS) and medications used in the treatment of pain.

Initials_____

## AUTHORIZATION TO RETRIEVE MEDICAL RECORDS FROM PRIOR HOSPITALIZATIONS THROUGH WEB SITE PORTALS (INTERNET)

I authorize Daniel Bendetowicz, MD, PA to retrieve my medical history through website portals. I understand that this may include history prior to getting established as a patient of Daniel Bendetowicz MD PA. This history may include substance controlled medication, psychiatric drugs, antiviral drugs (for example those ones used in the treatment of HIV/AIDS).

Initials_____

## NON COVERED SERVICES

There is a charge for non-covered services, payable out of pocket and not billable to insurances. For example a phone consultation.

Initials_____

Signature _____

Name _____

Date _____