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Immediate Past-President, SouthEast Lipid Assn.
Prevention of Cardio-Metabolic Disease and Women's Menopausal Health
Director, CPG Clinical Research

Director, Baltimore Lipid Center
Inaugural Diplomate American Board of Clinical Lipidology
Assistant Professor of Medicine, Johns Hopkins University School of Medicine
Fellow American College of Physicians
Fellow National Lipid Association
Fellow American Society for Preventive Cardiology
NAMS Certified Menopausal Practitioner

TO ALL NEW PATIENTS, WELCOME TO THE BALTIMORE LIPID CENTER!

TO MAKE YOUR FIRST VIST A SUCCESS, PLEASE BE SURE TO:

1) Arrive at LEAST 15 minutes early. Please allow plenty of time for traffic. We are ALWAYS on time and patients who are late may have to reschedule. We want to spend as much time with you as we can!
2) Arrive WITH ALL paperwork completed IN ADVANCE.
3) Please Arrive Fasting, but you can have water and BLACK coffee
4) PLEASE VERIFY in ADVANCE that we HAVE IN FACT received the requested records from your referring PCP and/or specialists (at least 2 recent office visit notes and two sets of recent labwork), preferably at least 48 hours prior to your visit. Dr P always wants to "hit the ground running" knowing as much about you as I can!

Thanx!
"Dr P"

New Patient Registration Form

A. Patient Information

Patient's Full Name _____

Address _____

City, State, Zip _____

Phone: Home _____ Work _____ Alt./Cell _____

Email (Optional) _____

Date of Birth _____ Sex: Male _____ Female _____

Marital Status: Single _____ Married _____ Other _____

Employment Status: Employed _____ F/T Student _____ P/T Student _____ Other _____

Patient's Social Security Number _____

Is you visit today due to: Auto _____ Worker's Compensation _____ Other _____

If you have checked OTHER, please briefly explain the reason for your visit today: _____

B. Insurance Information

Primary Insurance Company Name: _____

Phone _____ Policy Holder Name _____

Policy Holder's Social Security Number _____

Insurance Policy Number _____ Group Number _____

Relationship to Policy Holder _____

Employer's Name _____ Policy Effective Date _____

Insurance Company Mailing Address _____

C. **Secondary Insurance Information**

Secondary Insurance Company _____

Phone _____ Policy Holder Name _____

Policy Holder's Social Security Number _____

Insurance Policy Number _____ Group Number _____

Relationship to Policy Holder _____

Employer's Name _____ Policy Effective Date _____

Insurance Company Mailing Address _____

_____

D. **Responsible Party if Other Than Policy Holder**

Name _____

Address _____

City, State, Zip _____

Phone _____ Social Security Number _____

E. **Emergency Contact**

Name _____ Phone _____ Relationship _____

F. **Patient Assignment of Benefits:** I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company(s), I will be held directly responsible for all fees incurred. I authorize payment of medical benefits to the physician or supplier for all services rendered. I also authorize release of any medical or other information necessary for the processing of my claims.

Patient (or Responsible Party) Signature _____

Date _____

Date ___/___/___

Pt. Name _____

Birth ___/___/___ Sex ___ Chart No _____

PATIENT COMPLETES THIS SECTION

Please use a ballpoint pen to answer all questions in this section. Put a ● next to any answer you would like to discuss with the doctor.

A-REASON FOR VISIT

_____

_____

_____

B-PATIENT PROFILE

☐Married ☐Divorced ☐Single ☐Separated ☐Widowed

Last school grade completed _____

Occupation _____ Since 19___ Check if retired ☐

Hobbies/Interests _____

Time since last complete medical examination _____

C-HEALTH OF FAMILY

	Good	Poor	Died	If died, note age and cause (include fatal accidents and suicides)
Father (natural, biological)	☐	☐	☐	
Mother (natural, biological)	☐	☐	☐	
Brothers/sisters:	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
Spouse:	☐	☐	☐	
Children:	☐	☐	☐	
	☐	☐	☐	

D-IMMUNIZATIONS

Circle those that you have had and enter the year of the most recent if known.

Flu ____ Tetanus ____ Rubella ____

E-ILLNESS

If you have had any of the following, check the appropriate ☑. If a blood relative has had any of the following, check the appropriate ⊘.

☐○ Alcoholism
☐○ Anemia
☐○ Bleed easily
☐○ Diabetes
☐○ Drug abuse
☐ Depression
☐ Eczema, hives, rashes
☐ Liver disease, hepatitis, yellow jaundice
☐ Lung disease
☐○ Epilepsy, seizures
☐○ Glaucoma
☐○ Heart disease
☐○ Stroke
☐○ Suicide attempt
☐ Eye problems
☐ Phlebitis
☐ Thyroid disease
☐ Venereal disease
☐○ Cancer, tumor
☐○ High blood pressure
☐○ Ulcer in stomach or duodenum
☐○ Nervous breakdown
☐ Mumps, measles, chicken pox
☐ Rubella, German measles
☐ Rheumatic fever

F-HOSPITALIZATIONS/SURGERY

List illness or operation, and approximate year. EXCLUDE NORMAL PREGNANCIES.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

G-MEDICINES

List all medicines, birth control pills, or vitamins you take with or without a prescription.

_____

_____

_____

_____

_____

H-MEDICINE ALLERGIES

List all medicines that you are allergic to:

_____

_____

For Physician's Use Only — Notes and Comments

Patient Consent Form/HIPPA

My Notice of Privacy Practice provides information about how I may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of my Notice may change. If I change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that I restrict how protected health information about you is used or disclosed for treatment, payment of health care operations. I am not required to agree to this restriction, but if I do, I shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing signed by you. However, such revocation shall not affect any disclosures I have already made in reliance on your prior consent. My practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at anytime and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

DISCLOSURE TO FAMILY/FRIENDS

I authorize Gregory Pokrywka, MD to disclose medical or financial information to the following individual(s):

_____ _____
(name) (telephone number)

_____ _____
(name) (telephone number)

I authorize Gregory Pokrywka, MD to leave messages on my answering machine YES or NO

This consent was signed by: _____ _____
Printed Name -Patient or Representative Date

_____ _____
Signature of Patient **Date**

Insurance Coverage Waiver

I understand that my eligibility for coverage by my insurance company cannot be confirmed at this time. Or that I am here as a self pay basis. I wish to receive medical service from Dr. Pokrywka. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Patient/Legal Guardian:_____

Date:_____

PATIENT ELECTRONIC MEDICAL RECORDS UPDATE

- Your name_____
- Black or African American, White, American Indian or Alaska Native, Asian, Hispanic, Hawaiian or other Pacific Islander (circle one)
- Smoker, former smoker, never smoked (circle one)
- Email address _____
- Referring physician and address_____
- Would you like a copy of your electronic medical visit today, and/or access with a PIN number to your medical record profile? (please allow 30 days for visit summaries and/or your medical profile to be ready for you to read).
- Your preferred language?
- Your ethnicity? Hispanic/Latino or Non Hispanic/Latino (circle one)
- Please verify your address_____
- What is your preferred method of communication? Cell phone, email, or home phone. (circle one)
- Cell phone number?
- We will also add your gender to your electronic record.
- Do you have any drug allergies that we need to know about?