PATIENT INFORMATION SHEET

Welcome to Dr. Komorowski's Plastic Surgery Practice! Your time is valuable, and we feel that your being aware of the information found below will help your interactions with our office to be as efficient as possible.

Please arrive 20 minutes early for your first appointment with our office to complete necessary paperwork. Please have your insurance information readily available at check in to allow us to process your information update in a timely manner. Please bring your insurance cards to every visit. Due to federal regulations, all patients will be required to present a photo I.D. upon request. **Payment of co-pays is expected at time of service.**

PHONE CALLS

As a reminder, you will receive a confirmation phone call for upcoming appointments. **Our office requires a 24 hour advance notice for the cancellations or rescheduling of an appointment.** This will allow us to offer that time to another patient. Please be advised, you may be charged a missed appointment fee of $35.00 if advance notice is not given. Repeated failure to keep your scheduled appointments may force us to have your medical care transferred elsewhere.

Phone calls will be returned during the course of the day as the schedule allows. Please remember that the physician and nurses are seeing scheduled patients throughout the day, and it may take some time before a return call can be made. **The office functions with a timely and efficient message system, so it is not necessary to make repeat phone calls to the office during the course of a day.** Calls made after 3 p.m. may not be returned until the following day.

Information updates are required every visit.

MEDICAL RECORDS REQUEST

Please allow 2 weeks to complete requests for medical records. If you do not have a signed release on file, you will be asked to sign one when picking up your records. If you need records to be sent from another medical facility to this office, you will need to send a signed medical release to that office in order for the records to be released to:

Dr. Mark C. Komorowski
610 S. Trumbull St.
Bay City, MI 48708

BILLING

If you have any questions regarding your account balance, please call (989) 797-1400 for assistance. So that we may better serve you, please have your account number from your statement available.

Please complete the following pages and bring them with you to your first appointment. We look forward to helping you!

Dr. Mark Komorowski and Staff

Mark C. Komorowski, M.D., F.A.C.S.

610 S. Trumbull Street

Bay City, MI 48708

Phone: (989) 893-9393 Fax: (989) 893-9975

Patient Name: _____

Appointment Date: _____ **Time:** _____

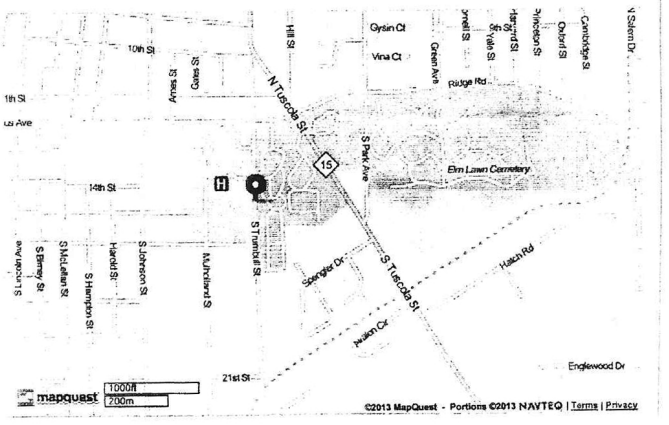
Please Bring to Appointment:

- Photo ID
- Insurance Card(s)
- Insurance Co-Pay (due at time of service)
- Medication List
- If X-rays were performed, obtain a disc and bring it with you
- If Worker's Compensation, a Case Manager **MUST** accompany patient
- If Auto Insurance claim, bring claim # and auto insurance carrier billing and contact info
- Check with your family physician if a Referral Number is required

Due to limited seating in lobby and small exam rooms the patient should be accompanied **by no more than one person.** Small children should not come to the appointment unless he/she is the patient.

If the above documentation is not provided by the patient, the office visit may be cancelled or rescheduled.

Take US-10 or I-75 to the Downtown Bay City Exit 162A, which is a one way street. Stay on the one way and go over Veterans Memorial Bridge and turn right onto Washington. Continue to Columbus Ave and take a left. You will go through 5 stoplights. Just past McLaren Hospital is Trumbull St. Turn right and go past 16th street. We are the 2nd driveway on the right. There is a McLaren sign with Dr. Komorowski's name on it.



We are a red brick building to your right when you pull into the parking lot.

PATIENT REGISTRATION (please print)

Patient's Name _____ Date of Birth _____ Age ____

Address _____

City _____ State _____ Zip _____ Email _____

Phone (H) _____ (W) _____ (C) _____

Sex: Male Female Marital Status Single Married Divorced Widowed

Drug Allergies: _____

How did you hear about us: _____

REASON FOR VISIT: _____

If you are NOT a self-pay patient, please complete the remainder of the form

If Patient Is Under The Age of 18, We Require Responsible Party DOB & SSN

Primary Insurance _____ ID # _____ Group # _____

Insurance Subscriber _____ Subscriber DOB _____

Secondary Insurance _____ ID# _____ Group # _____

Insurance Subscriber _____ Subscriber DOB _____

Employer Name _____

Employer Address _____

Worker's Compensation: Were You Injured On The Job? _____ Date of Injury _____

Worker's Compensation Carrier _____

Address _____

Claim Adjuster Name _____ Phone _____

Claim # _____ Fax # _____

Were You Injured In An Auto Accident? _____ Accident Date _____

THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I HEREBY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS INCLUDING MEDICARE AND PRIVATE INSURANCE AND OTHER PLANS TO MARK C. KOMOROWOSKI, M.D., F.A.C.S. I GIVE AUTHORIZATION TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY THAT I MAY NEED.

Patient's Signature: _____ Date _____

Parent/ Guardian's Signature: _____ Date _____

PATIENT HEALTH HISTORY

Patient Name _____ DOB _____ Sex ____ M ____F

Reason for visit :_____ Pharmacy _____

Date of Injury _____ Work Related _____ Attorney _____

Primary Care Physician Name and Address_____

_____

DRUG ALLERGIES _____

Medications

Are you taking any prescription medications, over the counter medications or herbal medicines? Y N

(Please list ALL medications)

_____

_____

_____

Surgical History (please list all surgeries)

_____

_____

Do you have or did you ever have any of the following?

Cardiovascular Health

High Blood Pressure	Y N
Angina or Heart Attack	Y N
Chest pain on exertion	Y N
Coronary artery blockage or treatment	Y N
Heart valve problem or replacement	Y N
Heart murmur	Y N
Heart disease, problem or treatment	Y N
Rheumatic fever	Y N
Past use of Fen-Phen	Y N
Irregular heart beat or pacemaker	Y N
Difficulty breathing when lying down	Y N
Stroke	Y N
Low blood Pressure	Y N

Respiratory Health

Asthma	Y N
Emphysema or respiratory problems	Y N
Chronis sinus problems	Y N
Tuberculosis or persistent cough	Y N

Endocrine/Blood/Immune Health

Diabetes	Y N
Frequent thirst or frequent urination	Y N
Thyroid problems	Y N
Abnormal bleeding, bruise easily	Y N
Hemophilia	Y N

Muscular-Skeletal/CNS/Mental Health

Joint Replacement	Y N
Arthritis	Y N
Osteoporosis	Y N
Fainting spells or dizziness	Y N
Seizures	Y N
Numbness or muscle weakness	Y N
Multiple Sclerosis	Y N
Mental retardation	Y N
Dementia/Alzheimer's disease	Y N
Anxiety/Nervousness	Y N
Mental health treatment	Y N

Gastro-Intestinal/Genito-Urinary Health

Hepatitis (A, B, C or other)	Y N
Liver disease	Y N
Kidney disease/dialysis	Y N
Stomach trouble/ulcers	Y N
Sexually transmitted disease	Y N

Medication, Allergies and Other Allergies

Penicillin or other antibiotics	Y N
Sulfa Drugs	Y N
Dental antesthetic	Y N
Aspirin	Y N
Codeine/narcotics	Y N
Iodine	Y N

Endocrine/Blood/Immune Health

Anemia/blood disease	Y N
Cancer	Y N
Radiation therapy/chemotherapy	Y N
HIV infection/AIDS	Y N
Cold sores/canker sores	Y N
Organ transplant	Y N
Blood transfusion	Y N

Medication Allergies and Other Allergies

Latex products	Y N
Metals/nickels/jewelry	Y N

Other _____

Females Only

Are you pregnant?	Y N
Are you nursing now?	Y N
Do you take birth control pills?	Y N

How many pregnancies have you had? _____

Vaginal or C-Section _____

Social

Do you use tobacco?	Y N	Quantity _____ Per Day
Do you use alcohol?	Y N	Quantity _____ Per Day _____Per Week
Do you use recreational drugs?	Y N	Quantity _____ Per Day

Do you have any other medical conditions not already listed above?

_____

Signature of PATIENT or GUARDIAN _____ Date _____

I hereby certify that I have read the foregoing and filled out this questionnaire completely. I have advised you of all medical problems of which I am aware of.

FACSIMILIE AND INSURANCE

I hereby authorize Mark C. Komorowski, M.D. to furnish information to another physician, medical facility or insurance carrier concerning my illness and treatments and I hereby assign to Dr. Komorowski payments for medical service rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

(Medicare Patients: I am aware that should Medicare deny payment for services that I am fully responsible for payment.)

Telephone # where you prefer to receive calls about your appointment, results or other health care information (I am fully aware that a cell phone is not a secure line)

_____

Can confidential messages (i.e. Appointments, reminders, requests for you to call for results or insurance questions) be left on your answering machine, voice mail or with a member of your family? No actual results would be left on your machine. YES NO

Can correspondences be mailed to your home? YES NO

Please list family members or other persons, if any, who we may inform about your general medical condition and your diagnosis (treatment, payment and health care options)._____

_____

Patient Name_____ Date of Birth_____

Signature_____ Today's Date _____

Staff Witness Signature_____ Date_____