PANAMA CITY GASTROENTEROLOGY
MACIEJ TUMIEL, M.D.
2101 NORTHSIDE DRIVE, SUITE 603
PANAMA CITY, FL 32405
(850) 784-8007 PHONE
(850) 784-1090 FAX

LAST NAME_____FIRST NAME_____ MI_____

ADDRESS_____

CITY AND STATE_____ZIP_____

EMAIL_____DATE OF BIRTH_____

CELL NUMBER_____HOME NUMBER_____

SOCIAL SECURITY NUMBER_____

RACE (PLEASE CIRCLE): ASIAN CAUCASIAN AFRICAN AMERICAN HISPANIC/LATINO

AMERICAN INDIAN OTHER_____

MARITAL STATUS M/ D/ S/ W SPOUSE'S NAME_____

EMPLOYER_____WORK PHONE_____

PRIMARY CARE PHYSICIAN_____REFERRING PHYSICIAN_____

EMERGENCY CONTACT_____PHONE_____

PRIMARY INSURANCE_____

MEMBER ID NUMBER_____GROUP NUMBER_____

SECONDARY INSURANCE_____

MEMBER ID NUMBER_____GROUP NUMBER_____

IF YOU ARE INSURED THROUGH A SPOUSE OR PARENT—PLEASE COMPLETE THE INFORMATION BELOW FOR THE POLICY HOLDER

NAME_____DATE OF BIRTH_____

EMPLOYER_____SOCIAL SECURITY NUMBER_____

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL EXPENSES REGARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION TO MY INSURANCE COMPANY AND/OR REFERRING PHYSICIAN. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER OF SERVICE AND I UNDERSTAND ALL CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. I UNDERSTAND THAT FAILURE TO MAKE TIMELY PAYMENT OR FAILURE TO COMPLY WITH THE PHYSICIAN TREATMENT PLAN MAY RESULT IN MY BEING DISCHARGED FROM THE SERVICE OF PANAMA CITY GASTROENTEROLOGY. I UNDERSTAND THAT I HAVE A RIGHT TO OBTAIN A COPY OF THE PRIVACY PRACTICES OF PANAMA CITY GASTROENTEROLOGY AT ANY TIME DURING MY TREATMENT PERIOD.

SIGNATURE OF PATIENT_____DATE_____

PATIENT NAME_____DOB_____

MEDICAL HISTORY

REASON FOR OFFICE VISIT_____

LIST OTHER ILLNESSES YOU ARE BEING TREATED FOR BY OTHER PHYSICIANS

_____

_____

CURRENT MEDICATIONS: PRESCRIPTIONS AND OTC SUPPLEMENTS (DOSAGE AND FREQUENCY)

_____

_____

_____

_____

LIST ANY KNOWN DRUG ALLERGIES:-

_____

_____

SMOKING—YES/ NO DRINKING—YES/ NO DRUGS—YES/ NO

LIST PAST MEDICAL HISTORY INCLUDING HOSPITALIZATIONS AND SURGERIES:

_____

_____

_____

NAME OF PHYSICIAN AND DATE OF LAST COLONOSCOPY_____

NAME OF PHYSICIAN AND DATE OF LAST ENDOSCOPY_____

**IMMUNIZATIONS:**

HEP B—Y/ N INFLUENZA—Y/ N SHINGLES—Y/ N PNEUMONIA (WITHIN 5 YEARS)—Y/ N

**PLEASE CIRCLE ALL SYMPTOMS THAT APPLY TO YOU**:

REFLUX HEARTBURN DIARRHEA CONSTIPATION ABD PAIN RECTAL BLEEDING
BLOOD IN STOOL NAUSEA VOMITING WEIGHT LOSS COUGH

**IMMEDIATE FAMILY HISTORY: PLEASE CIRCLE**

CANCER:

**COLON** M/F/S/B/CHILD **STOMACH** M/F/S/B/CHILD **LUNG** M/F/S/B/CHILD

**BREAST** M/F/S/B/CHILD **PROSTATE** M/F/S/B/CHILD

OTHER:

**LIVER DISEASE** M/F/S/B/CHILD **HEART DISEASE** M/F/S/B/CHILD

**DIABETES** M/F/S/B/CHILD **STROKE** M/F/S/B/CHILD **HIGH BLOOD PRESSURE** M/F/S/B/CHILD

DR. MACIEJ TUMIEL

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, HEREBY AUTHORIZE THE PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE FACILITY CURRENTLY PROVIDING DIAGNOSIS AND TREATMENT TO ME TO DISCLOSE MY PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING PERSONS. THIS AUTHORIZATION IS EFFECTIVE UNTIL TERMINATED IN WRITING BY ME.

| NAME | RELATIONSHIP TO ME |
|---|---|
| | |
| | |
| | |
| | |

**(PLEASE INITIAL EACH STATEMENT BELOW AND SIGN AT THE BOTTOM)**

_____ I ACKNOWLEDGE AND CONFIRM RECEIPT OF THE FOLLOWING INFORMATION PROVIDED BY PANAMA CITY GASTROENTEROLOGY TO SATISFY THE CURRENT FLORIDA LAW, HIPPA AND MEDICARE REQUIREMENTS.

*IMPORTANT BILL OF RIGHTS
*PRIVACY PRACTICES
*IMPORTANT NOTICE TO MEDICARE BENEFICIARIES

_____ PRESCRIPTIONS ARE **ONLY** REFILLED DURING BUSINESS HOURS, MONDAY THROUGH FRIDAY WITH A 48 HOUR NOTICE.

_____ MISSED APPOINTMENTS, UNLESS CANCELLED WITHIN A 24 HOUR NOTICE, WILL BE CHARGED $25.00

_____ ANY FORMS TO BE FILLED OUT BY NURSE OR PHYSICIAN (EXCEPT RETURN TO WORK NOTES) WILL BE AN ADDITIONAL CHARGE OF $25.00

_____ _____
SIGNATURE OF PATIENT OFFICE STAFF

_____ _____
DATE DATE

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# AUTHORIZATION TO RELEASE MEDICAL RECORD

I HEREBY AUTHORIZE_____

TO RELEASE THE INDICATED INFORMATION FROM THE MEDICAL RECORDS OF:

PATIENT_____ DATE OF BIRTH_____

ADDRESS_____

PHONE_____SSN_____

INFORMATION TO BE RELEASED:

_____OPERATIVE NOTES _____LABS

_____HOSPITAL RECORDS _____XRAYS

_____HISTORY & PHYSICAL _____ALL RECORDS

RELEASE MEDICAL RECORD TO: MACIEJ TUMIEL, M.D.

_____

_____

_____

I HEREBY CERTIFY THAT THIS AUTHORIZATION EXTENDS TO COVER RELEASE OF INFORMATION RELATED TO HIV TESTING, RESULTS OF TESTING, COUNSELING, AND/OR TREATMENT OF AIDS, AIDS RELATED COMPLEX (ARC), OR AIDS RELATED CONDITIONS. I FURTHER CERTIFY THAT THIS AUTHORIZATION EXTENDS TO COVER RELEASE OF INFORMATION RELATED TO PSYCHIATRIC AND/OR DRUG AND ALCOHOL ABUSE TREATMENT.

PATIENT SIGNATURE_____DATE_____

WITNESS_____DATE_____

**WRITTEN TELEPHONE CONSENT**

I AGREE, IN ORDER TO SERVICE MY ACCOUNT OR TO COLLECT MONIES I MAY OWE, PANAMA CITY GASTROENTEROLOGY, AND/OR AGENTS MAY CONTACT ME BY TELEPHONE AT ANY TELEPHONE NUMBER ASSOCIATED WITH MY ACCOUNT. THIS INCLUDES WIRELESS TELEPHONE NUMBERS WHICH COULD RESULT IN CHARGES TO MY CELL PHONE BILL. PANMA CITY GASTROENTEROLOGY AND/OR AGENTS MAY ALSO CONTACT ME BY SENDING TEXT MESSAGES OR EMAIL, USING THE EMAIL ADDRESS I PROVIDE. METHODS OF CONTACT MAY INCLUDE USING PRERECORDED/ARTIFICAL VOICE MESSAGES AND/OR USE OF AUTOMATIC DAILING DEVICE, AS APPLICABLE.

I HAVE READ THIS DISCLOSURE AND AGREE THAT PANAMA CITY GASTROENTEROLOGY, ITS EMPLOYEE AND/OR AGENTS MAY CONTACT ME AS DESCRIBED ABOVE.

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE