Dr. Walter L. Bernacki • Dr. Christopher G. Zochowski
300 Polaris Parkway, Suite 2650 • Westerville, OH 43082
Phone (614) 682-5095 • Fax: (614) 891-6533 • office@bernackimd.com

PATIENT INFORMATION

Name _____ Birth Date _____ Age _____
(First, Middle Initial, Last)

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____

E-mail Address _____

Employer/School _____ Occupation _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female Social Security # _____

☐ Spouse or ☐ Parents Name _____

If patient is under 18 years of age: minor lives with ☐ both parents ☐ Mother ☐ Father

Father's Work Phone (____)_____ Mother's Work Phone (____)_____

May we leave a message at your home with other residents? ☐ Yes ☐ No On your answering machine/voice mail? ☐ Yes ☐ No

Referring Doctor _____ Phone (____)_____

Family Doctor _____ Phone (____)_____

Address _____ City _____ State _____ Zip _____

Responsible party for insurance and bills: ☐ Patient ☐ Spouse ☐ Parents ☐ Mother ☐ Father ☐ Other _____

EMERGENCY CONTACT

Relative or Close Friend's Name_____Phone (____)_____

Relationship to patient _____

Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE COMPANY

Name of Insurance _____

Work Comp. Claim # _____

Name on Contract _____ ☐ Self ☐ Other _____
(Please complete the rest of this section if "Other" is checked)

Date of Birth _____ ☐ Male ☐ Female Social Security # _____

SECONDARY INSURANCE COMPANY

Name of Insurance _____

Work Comp. Claim # _____

Name on Contract _____ ☐ Self ☐ Other _____
(Please complete the rest of this section if "Other" is checked)

Date of Birth _____ ☐ Male ☐ Female Social Security # _____

Today's Date: _____

Name *(please print)* _____ Sex: F M
Birthdate: _____ Age: _____
Reason for Today's Visit: _____
Date of Injury: _____

PLEASE FILL OUT COMPLETELY

Please list all:

Surgery	**Diagnosis**	**Year**

Medication	**Dosage**	**Frequency**

Social Habits

Use of alcohol	NEVER	OCCASIONALLY	DAILY
Use of caffeine	NEVER	OCCASIONALLY	DAILY
Use of tobacco	NEVER	OCCASIONALLY	DAILY
Use of illicit drugs	NEVER	OCCASIONALLY	DAILY

Allergies: Medications _____
Reactions _____

PERSONAL HISTORY (Please circle each answer)

Do You have:		
Diabetes	NO	YES
Emphysema/COPD	NO	YES
Asthmas	NO	YES
High Blood Pressure	NO	YES
Heart Disease	NO	YES
Ulcers	NO	YES
Tumors	NO	YES
Cancer	NO	YES
Kidney Disease	NO	YES
Hepatitis	NO	YES
Seizures	NO	YES
Gout	NO	YES
Tuberculosis	NO	YES
Arthritis	NO	YES
Congestive Heart Failure	NO	YES
Colitis or Bowel Disease	NO	YES
Gallbladder or Liver Disease	NO	YES
Polio or Meningitis	NO	YES
AIDS	NO	YES

Allergies:		
Latex	NO	YES
Tape	NO	YES
Iodine	NO	YES
Metal	NO	YES
Are You on Blood Thinners:	NO	YES
Hearing Impaired:	NO	YES
Women Only:		
Painful / irregular periods	NO	YES

Last menstrual period _____
Last pap smear _____
How many pregnancies? _____
How many full term? _____
How many miscarriages? _____
Age at first menstrual period _____
Did you breast feed? _____
Age at first pregnancy _____

FAMILY HISTORY

Medical Issue			**Family Member** (Father, Mother or other Relative)
Hypertension	NO	YES	_____
Stroke	NO	YES	_____
Heart Attack	NO	YES	_____
Other Heart Disease*	NO	YES	_____
Osteoporosis	NO	YES	_____
Diabetes	NO	YES	_____
Caner	NO	YES	_____

Type of Cancer _____
*Please Explain _____
Other Disease _____
Other important Information _____

OHIO PLASTIC SURGERY SPECIALISTS

Walter L. Bernacki, M.D.
Christopher G. Zochowski, M.D.
Board Certified Plastic Surgeons

Dr. Bernacki and Dr. Zochowski are Certified Plastic Surgeons, specializing in cosmetic plastic, and reconstructive surgery. Dr. Bernacki is an investor in the Polaris Surgery Center. Our practice participates with many insurance plans including Medicare, Medicaid, and most commercial HMO and PPO carriers. As a courtesy, we are happy to file health care claims directly to your insurance company. If you are covered by more than one policy, we will file the balance to your secondary payer. In the event your insurance companies do not respond to our request for payment within sixty (60) days form the date of filing, we will submit the bill to you and ask that you pay the remaining balance and follow up with you insurance company for reimbursement.

Many insurance companies require prior authorization for procedures done in the office or in a surgical facility. Prior authorization is NOT a guarantee of insurance payment. In the event your insurance company denies payment, you are responsible for all fees associated with your treatment.

Regretfully, we are unable to advise you of your specific insurance plan benefits. For your protection, we advise you to contact your insurance company prior to seeing the doctor to verify coverage for services.

At each visit our patients are required to provide a current insurance card and./or applicable billing information, co-pay and payment for any outstanding account balance. If you do not have insurance, you will be responsible for payment in full when services are rendered. If Worker's Compensation is responsible for your claim, please bring all related information necessary to bill on your behalf.

Our practice offers payment options thorough CareCredit. This medical line of credit offers low and no-interest payment plans that can help out patients more easily afford treatment. Any outstanding balances over ninety (90) days will be turned over to an outside collection agency for resolution.

We accept cash, Mastercard, Visa, Discover, American Express and CareCredit.

I have read and understand the above policies as witnessed by my signature below.

_____ Date: _____

Patient Signature

OHIO PLASTIC SURGERY SPECIALISTS

I hereby give my consent to Walter L. Bernacki, M.D., and/or Christopher G. Zochowski, M.D., "this practice" to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize this practice, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health professional for care and treatment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to insurance carrier(s) and other payment entities for any and all payment activities further consent to the use for any practice operational needs.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have a right to request how my protected heath information (PHI) has been disclosed. I also have a right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation takes effect when the practice receives it.

SIGN: Patient/ Guardian: _____ Date: _____

Name Printed: _____ If not patient, relationship: _____

Copy of Practice Privacy statement signed or initialed with patient/guardian on: _____

Patient unable to sign privacy statement due to: _____

OHIO PLASTIC SURGERY SPECIALISTS

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS

INTRODUCTION

With consent, medical photographs may be taken before, during, or after a surgical procedure or treatment.

1. **CONSENT TO TAKE PHOTOGRAPHS**
   I hereby authorize Walter L. Bernacki, M.D., Christopher G. Zochowski, M.D. and their associated or licensees to take pre-operative, intra-operative and post-operative photographs.

2. **CONSENT FOR RELEASE OF PHOTOGRAPHS**
   I hereby authorize Walter L. Bernacki, M.D., Christopher G. Zochowski, M.D. and their associated or licensees to use pre-operative, intra-operative and post-operative photographs for professional medical purposes deemed appropriate including but not limited to for purposes of medical education, patient education, lay or exclusive website publication, or during lectures to medical or lay groups.

   I understand that I will not be entitled to monetary payment and/or any other consideration as a result of any use of these images and/or my interview.

   Date _____

   Patient Signature _____

   Witness _____