Gerald A. Jaworski, M.D. P.C.

Last Name: _____ Middle Int: _____ First Name:_____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Email Address: _____

Marital Status: _____ Social Security Number: _____ Employer: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone number: _____ Preferred Pharmacy: _____

Sex at birth? ___Male ___Female

Insurance Information

Primary Insurance company: _____ Policy Number: _____

Subscriber name: _____ Subscriber DOB: _____

Secondary Insurance company: _____ Policy Number: _____

Subscriber name: _____ Subscriber DOB: _____

The questions below were designed by the US HHS and the Oregon Health Authority in accordance with Section 4302 of the Affordable Care Act (ACA). **We are required to ask but answers are optional.**

Sexual Orientation? __Straight or heterosexual, ___Lesbian, gay or homosexual, ___Bisexual, ___ Do not know, _____Something else (please describe), ___**Decline to answer**

What is your current gender identity? __Male, __Female, __Trans Male, __Trans Woman, ___Gender Queer, _____Additional category (please specify), ___**Decline to answer**

What pronouns do you prefer we use when talking about you? (check all that apply) ___she/her/hers, ___he/him/his, ___they/them/theirs, Other: Please specify_____

Ethnicity: Are you a member of a federally recognized tribe? _____ How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?_____ _____**Decline to answer**

Race: __white, __Black and African American, __Native Hawaiian/Pacific Islander, __Asian, ___Hispanic and Latino, __American Indian or Alaska Native, _____Other, __**Decline to answer**

Language: __English, __Spanish, __German, __Vietnamese, __Russian, _____Other

The undersigned patient or individual acting on behalf of patient agrees as follows: I AUTHORIZE the release of medical information to the above-named insurance company for the purpose of obtaining third party payment on claims for the treatment rendered. I AUTHORIZE the payments by the insurance to be made directly to the attending practitioner for services rendered. I understand that I am solely responsible for sums that are now or may become due for services rendered to me in the event my insurance does not pay or makes partial payment. I understand that a finance fee will be added to overdue balances. I understand that if I fail to make payment and my account is sent to a collection agency, an additional 40% will be added to my balance and I will automatically be discharged from the medical practice. **I give physician full consent to access my medical records, including my Rx history. I give full consent to securely access and exchange my medical records through the Health Information Exchange (HIE).** Recording devices and cell phone use are not permitted in the office. **PLEASE NOTE: WE REQUIRE 24 HOURS NOTICE OF ALL CANCELLATIONS. FAILURE TO PROVIDE 24 HOUR NOTICE WILL RESULT IN A CHARGE OF $125. REPEATEDLY MISSING APPOINTMENTS MAY RESULT IN DISCHARGE FROM THE PRACTICE.**

SIGNATURE: _____DATE:_____

NAME: _____

LIST ALL HOSPITALIZATIONS, INCLUDING MINOR AND MAJOR SURGERIES:

Reason for hospitalization or type of surgery	Date of surgery/ hospitalization	Physician
1.		
2.		
3.		
4.		
5.		
6.		

More: _____

LIST ALL MEDICATIONS TAKEN AND DOSAGES (INCLUDE MEDICINE THAT YOU BUY OVER-THE-COUNTER THAT DOES NOT REQUIRE A PRESCRIPTION (VITAMINS, ASPIRIN, ETC.)

Example: Tylenol 325 milligram, one tablet a day.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

More: _____

LIST ANY KNOWN ALLERGIES (DRUGS, FOOD, HAY FEVER, ASTHMA, INSECT BITE, ETC.)

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

More: _____

_____

_____

LIST ANY MAJOR MEDICAL PROBLEMS THAT YOU HAVE:

Example: Diabetes, high blood pressure, depression, pneumonia, high cholesterol, heart problems, etc.

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

LIST ANY HEALTH PROBLEMS YOU WOULD LIKE ADDRESSED AT YOUR FIRST VISIT:

1. _____ 2. _____
3. _____ 4. _____

More: _____

NAME: _____

SOCIAL HISTORY AND HABITS

Marital status: Single _____ Married _____ Widowed _____ Divorced/Separated _____

Household members: Live alone _____ With spouse _____ With children _____ With another adult _____

Religious affiliation (if any): _____

Do you have a living will? Yes_____ No_____

City and State of birth: _____

Have you used any of the following? (check if answer is yes):

Marijuana _____ Methamphetamines _____ LSD _____ Cocaine _____ Heroin _____

Other _____

Alcohol Consumption:

Do you drink alcohol? Yes _____ No _____ (if no skip this section)

List type(s) of alcohol consumed _____

List average amount consumed per week in ounces, glasses or bottles (if infrequently, approximate number of times per year). _____

For smokers/ex-smokers: (if you have never smoked skip this section):

Amount of cigarettes currently smoking per day_____

The year you first began smoking _____

The average number of cigarettes/packs smoked daily over the years _____

If quit smoking, list date you quit _____

If thinking about quitting, list future date you would like to quit _____

For smokeless tobacco users (chewing tobacco):

List date first began using chewing tobacco _____

Please complete the following family record:

	IF LIVING		IF DECEASED	
	Age	**State of health**	**Age at death**	**Cause of death**
Father	( )	( )	( )	( )
Mother	( )	( )	( )	( )
Brothers	( )	( )	( )	( )
	( )	( )	( )	( )
	( )	( )	( )	( )
	( )	( )	( )	( )
Sisters	( )	( )	( )	( )
	( )	( )	( )	( )
	( )	( )	( )	( )

Your children (list sex, age, state of health, age/cause of death):

1._____ 2._____

3._____ 4._____

5._____ 6._____

NAME: _____

CURRENT OR PREVIOUS PHYSICIAN(S) PROVIDING CARE TO YOURSELF:

Please include address, town, and state for physicians not located in the surrounding Roseburg area)

1. _____
2. _____
3. _____
4. _____
5. _____

DO ANY OF YOUR RELATIVES OR FRIENDS RECEIVE CARE FROM DR. JAWORSKI? (IF YES INDICATE NAME AND RELATIONSHIP TO YOU)

_____

ARE YOU CURRENTLY INVOLVED IN LITIGATION OR AN ON-JOB CLAIM?

No _____ Yes _____

If yes , specify reasons

_____

_____

RECENT TESTING: (Please list approximate date and whether your results were normal or abnormal)

Test	Date	Result (Normal or Abnormal)
1. Chest x-ray		
2. Cholesterol		
3. Thyroid test		
4. Stool occult blood		

ADDITIONAL QUESTIONS FOR WOMEN:

1. Have you ever had or been told that you had: Complications of pregnancy: Yes___ No___
   Menstrual irregularity: Yes___ No___
2. Are you currently pregnant? Yes___ No___ If yes, number of weeks pregnant:_____
3. Date of last menstrual period:_____
4. Date of last Pap Smear: _____ Normal or Abnormal (circle one)
5. Date of last mammogram: _____ Normal or Abnormal (circle one)
6. Contraceptive method: _____
7. Number of pregnancies _____ Number of miscarriages _____ Number of living children _____
   Number of full term deliveries _____ Number of abortions _____ Number of deceased children _____

ADDITIONAL QUESTIONS FOR MEN:

1. Date of last prostate examination _____
2. Date of last prostate blood test _____ Normal or Abnormal (circle one)

Thank you for taking the time to fill out this questionnaire.

Gerry Jaworski, M.D.

Gerald A. Jaworski M.D.
Family Practice

2282 NW Troost Street, Ste 101
Roseburg, OR 9471
Phone: 541-673-0609
Fax: 541-440-9387

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please read all information and instructions before completing and signing the authorization form.

Patient's Name _____ Birth Date _____
(PLEASE PRINT) LAST FIRST MI

Reason for release (i.e. transferring care): _____ Previous Last Name: _____

RECORDS RELEASED FROM:	RECORDS RELEASED TO:
Organization/Person	Organization/Person
Street Address	Street Address
City State Zip	City State Zip
Phone Fax	Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

- ☐ **LAST FULL YEAR OF CHART NOTES FROM DATE OF LAST SERVICE**
- ☐ **LAST FULL YEAR OF LABS/PATHOLOGY FROM DATE OF LAST SERVICE**
- ☐ **LAST FULL 2 YEARS OF IMAGING REPORTS FROM DATE OF LAST SERVICE**
- ☐ **MOST RECENT REPORTS:** ☐ **EKG** ☐ **MAMMOGRAM** ☐ **COLONOSCOPY** ☐ **PAP SMEAR** ☐ **DEXA/BONE DENSITY**
- ☐ **MY HEALTH INFORMATION RELATING ONLY TO THE FOLLOWING TREATMENT OR CONDITION:** _____
- ☐ **MY HEALTH INFORMATION ONLY FOR THE FOLLOWING DATE(S):** _____
- ☐ **OTHER:** _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Mental health information
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment, or referral information.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Written consent is necessary to revoke this request. If you wish to revoke this authorization, provide a written statement to:

Gerald A. Jaworski MD
2282 NW Troost St, Ste 101
Roseburg, OR 97471

I authorize release of my medical records in accordance with the specification listed above. The Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

I have read this authorization and I understand it. Unless specified, this authorization will expire one year from date signed. _____
(Specified Expiration Date)

_____ _____ _____
(Signature of Individual or Personal Representative) **(Date Signed)** **(Description of Personal Representative's Authority)**