Stephen A. Pokowicz, D.C.
543 Easton Tpke, Suite 102
Lake Ariel, PA 18436
(570) 689-5757 phone
(570) 689-5758 fax

Name:______________________________ **Date:**____/____/__________

Address:____

City:______________________ **State:**____________ **Zip:**____________

Date of Birth:____________________ **Best Phone:**____________________

Email:_________________________

Medical Doctor: ______________________ Phone:____________________

Last Medical Visit:____________________ Last Blood Test:________________

Any recent x-ray or MRI: No Yes: (date & facility)____________________________

How did you hear about our office:______________________________________

Single Married Divorced Widowed

Spouse:__________________ DOB:________________

Race: American Indian/Alaskan Native Asian African American Hawaiian/Pacific Island

White Mixed 2 or more races Choose not to Identify

Ethnicity: Hispanic/ Latino non-Hispanic Choose not to Identify

Tobacco History: Current Smoker Former Smoker Never Smoked

Surgeries: ____

____

Allergies to Medication: ____

Allergies: ____

Medications:(List?)____

____

Past Medical History: Asthma Diabetes Thyroid High Blood Pressure HIV Hepatitis

Heart/MI Cancer__________ Stroke/TIA Seizure Disorder Prostate Gynecological

Other:____

Chief Complaint (s): ______________________________ Pain Scale:1 2 3 4 5 6 7 8 9 10

____ Pain Scale:1 2 3 4 5 6 7 8 9 10

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How did it happen?____

Aggravated by?____

Relieved by?____

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PATIENT RELEASE OF INFORMATION CONSENT FORM

I have read and fully understand Dr. Stephen Pokowicz's Notice of Privacy Practices. I understand that Dr. Pokowicz may use or disclose my personal health information for the purpose or carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that Dr. Pokowicz will consider requests for restrictions on a case-by- case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purpose noted in Dr. Pokowicz's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the company in writing at any time.

______________________ ______________________ __________

Patient Name Signature Date

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby Authorize one or all of the designated parties (anyone OTHER THAN your physician, insurance company, Workman Compensation Carrier or Employer) listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

AUTHORIZED DESIGNEES:

Name:______________________ Relationship: ______________

Name:______________________ Relationship: ______________

______________________ ______________________ __________

Patient Name Signature Date