

DOUGLAS S. SKURA, M.D.
400 MEDICAL ARTS BUILDING
SUITE 420
KITTANNING, PA 16201
(724) 548-7009

Patient Full Name: Mr/Mrs/Miss/Ms _____

Maiden Name (if applicable): _____

Mother and Father (if patient is a minor): _____

Patient Address: _____

(street)

(city)

(state)

(zip)

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed Separated

Patient Social Security No.: _____

Patient Employer: _____

Family Physician: _____

Were you referred to our practice? _____ If so, by whom? _____

In case of emergency, contact: _____

Telephone number of contact person: _____

Relationship to contact person: _____

INSURANCE INFORMATION:

Circle the following that apply.

Medicare Highmark HMO Worker's Comp Auto Accident Medicaid Other

Name of Policy Owner: _____

Address of Policy Owner: _____

Birthdate of Policy Owner: _____

SS# of Policy Owner: _____

Employer of Policy Owner: _____

Policy Owner's Relationship to Patient: _____

Insurance Company Name: _____

Insurance Company Address: _____

Identification Number: _____

Group Number (if applicable): _____

Date of Accident (if applicable): _____

Claim Number (Compensation and Auto Accident only): _____

Insurance Company Phone Number: _____

This office will file claims with your insurance company. The patient, however, is responsible for all insurance copayments, deductibles, coinsurances and any and all noncovered procedures. Payment for the above is expected at the time of service.

AUTHORIZATION:

I hereby authorize Dr. Douglas Skura to furnish information to my insurance carrier concerning my illness and treatments; and I hereby assign to the physician all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance.

DATE: _____ SIGNATURE: _____

Parent or legal guardian, please sign if patient is under 18 years of age.

Douglas S. Skura, MD
Medical History

Please complete this form to assist your Doctor. The details of your medical history will be helpful in arriving at a more precise diagnosis, to suggest appropriate testing and to evaluate your possible medical risks if surgery is indicated.

Name _____ Age _____ Height _____ Weight _____

Today's Date _____ Birthdate _____

Occupation _____

Job Duties _____

Reason for today's visit _____
_____ Right Left Both

Current symptoms/medical problem _____

List any treatments or medications you have tried for the above problem(s)

Have you had recent x-rays Yes No
If yes, where? _____

List any problem that you have been treated for in the past or being treated for in the present

List all current and/or previous treating physicians _____

List any previous surgeries _____

Name _____

List any injuries (past or present) _____

List all medications you are currently taking: prescription/over the counter/vitamins _____

List allergies to medications, dyes or bee stings and type of reaction _____

Please check yes or no, and list type of problems. Do not leave any blank.

	Yes	No	
Chills	_____	_____	
Fever	_____	_____	
Weight change	_____	_____	Loss or Gain (circle one)
Headaches	_____	_____	
Dizziness	_____	_____	
Epilepsy	_____	_____	
Convulsions	_____	_____	
Paralysis	_____	_____	
Eye problems	_____	_____	
Phlebitis/DVT	_____	_____	
Cancer	_____	_____	
Blood clots	_____	_____	
Shortness of breath	_____	_____	
Asthma	_____	_____	
Emphysema	_____	_____	
Previous pneumonia	_____	_____	
Arthritis	_____	_____	
Stroke	_____	_____	
Hardening of the Arteries/PVD	_____	_____	
Heart attack/MI	_____	_____	
Joint pain	_____	_____	
Fainting	_____	_____	
Rheumatic fever	_____	_____	
Heart problems	_____	_____	
Gallbladder	_____	_____	
Hypertension	_____	_____	

Name _____

	Yes	No
Nausea	_____	_____
Diarrhea	_____	_____
Jaundice	_____	_____
Liver problems	_____	_____
Appetite changes	_____	_____
Heartburn	_____	_____
Ulcer	_____	_____
Bowel problems	_____	_____
Prostrate problems	_____	_____
Urinary tract problems	_____	_____
Diabetes	_____	_____
Kidney stones	_____	_____
Kidney failure	_____	_____
Venereal disease	_____	_____
Hepatitis	_____	_____
Bleeding disorder	_____	_____
Pacemaker	_____	_____

When _____

Type _____

Type _____

How long _____

Type _____

How much caffeine do you consume in one day _____

Coffee Tea Soda pop

Do you use tobacco products? Yes No

Cigarettes Cigar Chewing tobacco

How much per day _____ How long have you used _____

Do you drink alcoholic beverages? Yes No

How much per day _____ Type of beverage _____

Social or intravenous drugs? Past or present

Do you have a high stress level? Yes No

Why _____

Family Medical History

Any known diseases that run in your family _____

Mother _____

Father _____

Sister/Brother _____

Are your parents living?

Mother Yes No

Father Yes No

If not, cause of death _____

Patient Name

Date

Please check yes or no if you are taking any of these medications

OVER-THE-COUNTER PRODUCTS THAT MAY INCREASE RISK OF BLEEDING

Aspirin and Salicylate Containing Products

	Yes	No
Alka-Seltzer with Aspirin	_____	_____
Anacin	_____	_____
Arthritis Foundation Pain Reliever	_____	_____
Arthritis Pain Formula	_____	_____
Arthropan	_____	_____
Ascriptin	_____	_____
Aspirin	_____	_____
Asprimox	_____	_____
Aspergum	_____	_____
Baby Aspirin	_____	_____
Backache Maximum Strength Relief	_____	_____
Bayer	_____	_____
Bufferin	_____	_____
Cama Arthritis Pain Reliever	_____	_____
Easpirin	_____	_____
Ecotrin	_____	_____
Empirin	_____	_____
Excedrin	_____	_____
Extra Strength Adprin-B	_____	_____
Extra Strength Doan's	_____	_____
Genprin	_____	_____
Halfprin	_____	_____
Magnaprin	_____	_____
Momentum Muscular Backache Formula	_____	_____
Nuprin Backache	_____	_____
Norwich Extra Strength	_____	_____
Sodium Salicylate	_____	_____
Vanquish	_____	_____
ZORprin	_____	_____

Non-Steroidal Anti-Inflammatory Medications

Advil	_____	_____
Aleve	_____	_____
Dristan Sinus Tablets	_____	_____
Ibuprofen	_____	_____
Midol	_____	_____
Motrin	_____	_____
Naproxen Sodium	_____	_____

Name _____

Complimentary/Alternative Medicines

	Yes	No
Alfalfa	_____	_____
Angelica	_____	_____
Black Haw	_____	_____
Bogbean	_____	_____
Cat's Claw	_____	_____
Chondroitin	_____	_____
Dong Quai	_____	_____
Fenugreek	_____	_____
Garlic	_____	_____
Ginger	_____	_____
Ginkgo	_____	_____
Guggul	_____	_____
Hesperidin	_____	_____
Horse Chestnut	_____	_____
Irish Moss	_____	_____
Kelp	_____	_____
Kelpware	_____	_____
Khella	_____	_____
Lungwort	_____	_____
Mayapple	_____	_____
Meadowsweet	_____	_____
Motherwort	_____	_____
Parsley	_____	_____
Pau d' arco	_____	_____
Poplar	_____	_____
Prickly Ash	_____	_____
Red Clover	_____	_____
Tonka Bean	_____	_____
Tumeric	_____	_____
Willow	_____	_____
Wintergreen	_____	_____
Yarrow	_____	_____

FOR WOMEN ONLY

Name _____

Check One: _____ Pre-menopausal _____ Post-menopausal

Date of last pap smear _____

Date of last mammogram _____

Do you take a calcium supplement? Yes No

Do you take estrogen replacements? Yes No

Have you been diagnosed with osteoporosis? Yes No

Do you eat cheese? Yes No

Do you drink milk? Yes No

Have you lost height? Yes No

Age at menopause or hysterectomy _____

DOUGLAS S. SKURA, M.D.
Financial Policy

Thank you for choosing Dr. Skura as your health care provider. We are committed to the success of your medical treatment and care.

If you need further information about any of these policies, please ask a staff member or ask to speak with our office manager.

Payment Methods

We accept payment by cash, personal check, debit card, VISA, MasterCard, Discover and American Express. If we receive a returned check for insufficient funds, we will reverse the payment on your account and charge you an additional \$25.00.

Financial Responsibility

Dr. Skura participates with many insurance plans. As a participating provider, we will accept the insurance carrier's allowable amount. Patients are responsible to pay all applicable **co-payments, co-insurances and deductibles**. Payment is due at the time of service. It is also the responsibility of the patient to pay for all services and supplies not normally covered by the insurance carrier.

Please remember that your insurance plan is an agreement between you and your insurance carrier. While we will act on your behalf to obtain payment for our services, the patient is responsible for the balance due.

Our office will make every attempt to communicate with you about your account and will present reasonable options for payment. Our office will send you a monthly statement. If no payment is made on your account after two statements, the account will be sent to a third party for collection. At such time, an additional fee of \$12.50 will be added to your balance to cover administrative costs.

Self-Pay Patients

Patients without health insurance coverage who wish to receive care with us must establish a payment plan with our billing department prior to receiving services or immediately after receiving emergency care.

Disability Insurance Form Completion

Our office will complete your disability insurance forms. We charge \$10.00 for most forms; however, there are exceptions. You will be informed of the fee at the time you present the form. The fee must be paid in advance of completing your form.

I have read, understand and agree to the above Financial Policy.

Patient Signature
(or Parent/Guardian Signature if minor)

Date