



TOVA
Sickle Cell Specialty Treatment Center

WELCOME

PLEASE PRINT THE FOLLOWING INFORMATION. THANK YOU!

TODAY'S DATE: _____

Name: _____ Birth Date (mm/dd/yy) _____

Address: _____

Street

City, State, Zip

Phone #: _____ Can we leave a message? ___YES ___NO

Home

Cell

Social Security Number: _____ Email Address: _____

Race: *circle one* Asian African American Native American Caucasian Other: _____

Ethnicity: _____ Latino or Hispanic _____ Non-Hispanic **Primary Language:** _____

Marital Status: *circle one* ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Emergency Contact:

Name: _____ DOB: _____

Address: _____

Phone #: _____ Relationship to Patient: _____

____ I authorize TOVA to discuss my medical information with the above named person

PATIENT/PATIENT GUARDIAN SIGNATURE: _____ **Date:** _____

DO YOU HAVE HEALTH INSURANCE? _____ YES _____ NO

Name of Insurance Company _____ Insurance Card Number _____

Policy Holder _____ DOB _____ SS# _____

Address _____ Relationship to Patient _____

Secondary Insurance _____ Insurance Card Number _____

PHARMACY: _____ Phone Number: _____

Prescription Plan: _____ ID# _____ Ph# _____

DO YOU HAVE DENTAL INSURANCE? _____ YES _____ NO

Name of Dental Insurance Company _____

Name of Policy Holder _____

Insurance Card Number _____

Are you a smoker? _____

Allergies: _____

Current Medications

Name of Medication	Dosage	How many times a day do you take it?

Medical Conditions

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

Transfusion History

1. # of Transfusions in Lifetime? _____
2. Do you have Red Cell Antibodies? _____
3. Do you have an Indwelling Catheter/Port? _____

Primary Care Provider: _____ Phone # _____

Sickle Cell Provider: _____ Phone # _____

Surgical History

- | | | | |
|----------|------------|----------|------------|
| 1. _____ | Date _____ | 4. _____ | Date _____ |
| 2. _____ | Date _____ | 5. _____ | Date _____ |
| 3. _____ | Date _____ | 6. _____ | Date _____ |

Family Medical History

List any chronic medical conditions, i.e. heart disease, diabetes, cancer, sickle cell etc...

Mother	Father	Grandparents	Siblings	Children

Pharmacy Name _____ Address _____ Telephone _____

MEDICAL AUTHORIZATION FOR TREATMENT AND FINANCIAL DISCLOSURE

I hereby authorize examination, diagnosis and general treatment (including but not limited to use of x-ray and other non-invasive procedures, such as diagnostic tests) to be performed by the medical staff of the medical center. If necessary, I also give my permission for the allied health professionals (social services, nutritionists, nurses, health educators, counselors, etc.) to review my medical record for the purpose of evaluating my overall health needs. I realize that if a medical procedure is required, I will be given additional information.

I hereby authorize the medical center to furnish information from my medical record to any health care provider, which my physician deems necessary to provide for the continuity of my medical care except as follows: (Please list any exceptions or write none)

I also authorize this medical center to furnish information from the medical record to any insurer, compensation carrier, health facility or social services agency that may be providing financial assistance for my care.

I assign and authorize payment to be made directly to this medical center of all insurance benefits and agree to pay, in a timely manner, any unpaid balance that is my responsibility.

Patient/Parent/Guardian Signature

Date

INSURANCE INFORMATION

I request that payment of authorized Medicare benefits be made to the medical center for the services rendered. I authorize the release of needed data to the Centers for Medicare and Medicaid Services and its agents to determine if benefits are payable for these services.

I have read the above and understand and accept these terms. If I should refuse treatment or leave the facility without written consent of the physician, I hereby release the physician and the medical center of all responsibility for my action. I further authorize the medical center personnel to take cultures and use precautions deemed necessary for infectious cases. I am aware of the above contents, but understand that except to the extent that action has been taken based on my authorization, I may withdraw my authorization at any time by written notification to the involved parties.

Patient/Parent/Guardian Signature

Date

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received, read and understand your *Notice of Privacy Practices*. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Parent/Guardian Signature

Date