TOVA Community Health

Primary Specialty Care

WELCOME TO OUR OFFICE

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____

Allergies: _______________________ Are you a **Smoker**? _____________

Current Medications

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

Medical Conditions

1. ________________________________ 4. _____________________________________
2. ________________________________ 5. _____________________________________
3. __________________________________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 # _____________________________
Other: _______________________________________ 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/Medicaid 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