TOVA
Primary Specialty Care

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@ Family Medicine Greenhill 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? _____

Sickle Cell Type:

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**

Family Medicine at Greenhill
213 Greenhill Avenue Wilmington, DE 19805
Phone (302) 429-5870 Fax (302) 429-9284

TOVA Primary Specialty Care Clinic

Medical Records Transfer Request Form

Medical Records Transfer Request Form

I, _____ hereby authorize and request that you transfer a copy of all records in your possession concerning any diagnosis, prognosis and recommendation, as well as other data pertinent to your treatment of the patient named below.

Patient Information

Patient Full Name:	
Patient Address:	Date of Birth:
City:	Home Phone:
State: Zip:	

From:	To: Family Medicine at Greenhill
Practice Address:	213 Greenhill Avenue Wilmington, DE 19805
City:	Office Phone 302-429-5870
State: Zip:	

_____

Patient Signature Date

TOVA is fully integrated to improve access to high quality care with Family Medicine at Greenhill

Family Medicine at Greenhill

Tova Community Health, Inc.
Primary Specialty Care
Nina Anderson, DNP Executive Director
James Gill, MD Medical Director

Family Medicine
AT GREENHILL

- Cancel an appointment within **24-48** Hour notice
- Call **(302) 429-5870** to schedule an TOVA appointment
- Arrive **5-10 minutes** before your appointment time
- **Walk-Ins** for simple acute/urgent problems are available Monday through Friday at **4:00pm**
- **Telemedicine** appointments are offered for appropriate requests
- You can leave a secured **message** through the Family Medicine at Greenhill Portal @ fmagreenhill.com

Office Hours:	Monday to Thursday	7am to 7pm
	Friday	7am to 5pm
	Saturday	8am to 1pm

Our mission is to provide high quality of care to persons with complex chronic medical needs regardless of one's finances. If you receive a Bill, we will make sure your medical insurance information is updated in the system. TOVA's program will work with you to meet your financial individual needs. Our aim is to provide the highest quality of care for everyone.

TOVA COMMUNITY HEALTH
#213 Greenhill Ave., Wilmington, DE 19805
302-429-5879 | contact@tovacommunityhealth.org | www.tovacommunityhealth.org

PATIENT HEALTH QUESTIONNAIRE
PHQ-9 - Nine Symptom Checklist

Patient Name: _____ Date: _____

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

3. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

Total # Symptoms: _____ **Total Score:** _____