TOVBA CARE MEDICAL PC **Date__________**

Patient's Name:___________________________Date of Birth:____________ Chart #__________ 1

Patient's Gender: __M __F **Marital Status: ___Single ___ Married ___Partnered ___Widowed ___Divorced**

Address:____________________________________City:____________________State____Zip_____________
Telephone: Home:_________________________ Cell:_____________________ Other:___________________

SS #______________________________E Mail Address:_______________________________________

Employer:__________________________________ Employer Tel #____________________________________
Employer Address:__________________________________City______________State____Zip______________

HOW DID YOU HEAR ABOUT OUR PRACTICE?

__Physician __Family Member __Friend ***Name of Referring Person_____________________***
__Internet ___Website __Facebook ***Other_______________________________***

INSURANCE INFORMATION

Primary Insurance: _______________________________________ Are you the Policy Holder? __Yes __No

Is this a managed care Medicare or other Program (HMO) ___Yes ___No

Insured Information:
Subscriber Name: ______________________________ Relationship: ___Self ___Spouse ___Child ___Other
Phone#____________________________Sex __Male __Female DOB ___ /____ / __________
Address: _____________________________________Policy#_________________ Group #__________
Employer:____

Secondary Insurance: _______________________________________ Are you the Policy Holder? __Yes __No

Is this a managed care Medicare or other Program (HMO) ___Yes ___No

Insured Information:
Subscriber Name: ______________________________ Relationship: ___Self ___Spouse ___Child ___Other
Phone#____________________________ Sex __Male __Female DOB ___ /____ / __________
Address: _____________________________________Policy#_________________ Group #__________
Employer:____

What is the Primary Reason for Today's Visit? ____
How Long Has This Been Bothering You? __________ days weeks months years

Please Read and Sign: The above information is correct to the best of my knowledge. I understand that throughout my treatment I am responsible for notifying the physician and/or medical staff of any and all updates to the information related to my health. I authorize payments directly to the physician for surgical and/or medical benefits. In addition, I understand I am responsible for any portion of my bill not covered by my insurance.

_______________________________ _________________________ _________
Signature of patient or representative Print Name Date

Medical History

Please Circle if You Have Had Any of the Following:

AIDS/HIV
Allergy to Anesthetic
Anemia
Angina
Arthritis
Artificial Heart/Valve/Joint
Asthma
Back Problems
Bladder Problems
Bleeding Disorders
Cancer, Type: _______________
Chemical Dependency
Chest Pain
Cholesterol
Chronic Diarrhea
Circulatory Problems
Diabetes, Type: ______________
Ear Problems
Epilepsy

Eye Problem
Fainting
Frequent Infections
Gout
Headaches
Hearing Problems
Heart Disease
Hemophilia
Hepatitis or Jaundice
High Blood Pressure
Immune Disorders
Kidney Problems
Liver Disease
Low Blood Pressure
Neurological
Neuropathy
Phlebitis
Psychiatric Care
Radiation Treatment

Rash
Respiratory Disease
Rheumatic Fever
Shortness of Breath
Sinus Problems
Skin Cancer
Special Diet
Stroke
Swelling in Ankles, Feet
Swollen Neck/Glands
Thyroid
Tired Feet
Tuberculosis
Ulcers - Stomach, Other:__________
Varicose Veins
Venereal Disease
Weight Loss, unexplained
OTHER______________
____

SURGICAL HISTORY

Please Provide Your Surgical History:

Procedure	Date
____	____________
____	____________
____	____________
____	____________
____	____________

By signing at the bottom of this page, you have read and understood the following:
Treatment Consent: I hereby Consent and give my permission to the doctor (and doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

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_________________________________ __________________________ ________
Signature of patient or representative Print Name Date

TOVBA CARE MEDICAL PC - HISTORY AND PHYSICAL - Date__________
Patient's Name:___________________________Date of Birth:____________ Chart #__________

SOCIAL HISTORY:

Do You Smoke ___Yes __No If yes how many packs per day ____ For How Long __________

Alcohol Use ___Yes everyday (5-7 days/week) __Yes Occasionally/socially __No/rarely
Substance Abuse ___Yes, I have a current substance abuse problem.
Please specify: ____
__No, I have never had a substance abuse problem.
Occupation: _____________________________Does it involve mostly __standing __sitting
Exercise: ____ I do not exercise regularly ____Yes, I do the following regular exercise:
____

FAMILY HISTORY: PLEASE INDICATE WHICH FAMILY MEMBER

___Alzheimer's _______________________ ___Depression ___________________________
___Arthritis ________________________ ___Diabetes ___________________________
___Bleeding disorders _________________ ___Emphysema ___________________________
___Blood clot ________________________ ___Heart Disease _________________________
___Cancer ________________________ ___High Blood Pressure _____________________
___Cataracts ________________________ ___Neurological ___________________________
___Circulation Problems ________________ ___Strokes ___________________________
___Other (please specify__________________ ___ Other (please specify) ____________________

Review of Systems: If any of the following apply to you, please check off

Cardiovascular: __fever __fainting __ chest pain/pressure __ leg swelling __ cold hands/feet
__ leg pain while walking __ heart palpitations __ vascular disease __ valve problems __ None

Ears/Nose/Throat: __ sinus problems __ polyps __ deafness __ None

Endocrine: __ diabetes __ thyroid problems __ None

Eyes: __ cataracts __ glaucoma __ blindness __ None

Gastrointestinal: __ abdominal pain __ increased appetite __ heartburn __ vomiting __ blood in stool
__ trouble swallowing __ decreased appetite __ diarrhea __ ulcer __ constipation __None

Genitourinary: __ blood in urine __ hesitancy __ incontinence __ increased urgency
__ decreased frequency __ excessive urination __ kidney disease __ kidney stones __ None

Integumentary: __ nail abnormalities __ athlete's foot __ dry, scaly skin __ itchiness __ keloids __ None

Hematologic: __ lower leg ulcers __ clotting disorders __ blood thinners __ anemia __ sickle cell __ None

Musculoskeletal: __ joint swelling __ muscle weakness __ muscle pain __ back pain __ neck pain
__ joint stiffness __ joint instability __ joint pain __ sciatica __ arthritis __None

Neurological: __ tingling __ weakness __ seizures __ numbness
__ headaches __ tremors __ paralysis __ None

Respiratory: __ chest pain __ wheezing __ COPD __ coughing __ snoring
__ emphysema __ shortness of breath __ None

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_______________________________ ________________________ ________
Signature of patient or representative Print Name Date

TOVBA CARE MEDICAL PC - HISTORY AND PHYSICAL - **Date__________**
Patient's Name:___________________________Date of Birth:____________ Chart #__________

Ethnicity: ______________________________________

I prefer not to answer ______

Preferred language: ____________________________

I prefer not to answer ______

Pharmacy Name: _________________________ **Pharmacy Phone:**_______________
Pharmacy Address:____

Privacy Information Preferences:

Can we call the phone number on file? ______Yes ______No

Can we leave voicemail on machine? ______Yes ______No

Who can we leave message with? ______Wife ______Husband______Other

Name(s)________________________

<u>Vital Signs</u>

Blood Pressure:_______/______

Height:_______Weight:_______

Current Medications

Name:_________________________**Dose:**_______________

Name:_________________________**Dose:**_______________

Name:_________________________**Dose:**_______________

Name:_________________________**Dose:**_______________

Name:_________________________**Dose:**_______________

Name:_________________________**Dose:**_______________

Name:_________________________**Dose:**_______________

Name:_________________________**Dose:**_______________

Allergies

______**No Known Allergies**

Name______________**Reaction:**____________

Name______________**Reaction:**____________

Name______________**Reaction:**____________

Name______________**Reaction:**____________

Name______________**Reaction:**____________

By signing at the bottom of this page, you have read and understood the following:
(Release of Information): I authorize the release of any medical information necessary to process this claim. (HIPPA Privacy): I acknowledge that I received my HIPPA Privacy Practice Notice. (Medication History): I authorize the Doctor's office to retrieve my medical history.

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______________________________ ________________________ ________

Signature of patient or representative Print Name Date