**Welcome to the practice of Dr. Gina Tobalina**

Thank you for selecting us as your healthcare team. Our goal is to provide the utmost quality of care and satisfaction. In order for our practice to address your healthcare needs, please fill out the following forms as accurately as possible. If you have any questions or concerns please contact our office.

We look forward to meeting you! **Today’s date:**

**Personal Information**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Name: |  | **Nickname:** |  |
| Address: |  | |  |
| Home Number: |  | **Date of Birth:** |  |
| Work Number: |  |  |  |
| Marital Status: |  | **Cell Number:** |  |
| Occupation: |  |  |  |
| Email: |  | **SSN:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency Contact |  |  |  |
| Name: |  | **Phone number:** |  |

**Social History**

Please respond to the following questions

|  |  |  |  |
| --- | --- | --- | --- |
|  | Questions | Responses: |  |
| Tobacco | Do you use tobacco? |  |  |
| Former Smoker? |  |  |
| Current smoker include type and frequency: |  |  |
| Former Smoker note # of years used and quit date: |  |  |
| Drugs | Do you currently use recreational or street drugs? |  |  |
| If yes what kinds? |  |  |
| If you have a history of drug use include details: |  |  |
| ETOH | Do you consume alcohol? |  |  |
| If yes what kinds? |  |  |
| How many drinks per week? |  |  |
| If you have a history of abuse include details: |  |  |
| Caffeine | Do you drink caffeine? |  |  |
| If yes what kinds? |  |  |
| Exercise | Do you exercise? |  |  |
| If yes how often and what types? |  |  |

**Family History**

**us**

Use + symbol to indicate positive history

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Father | Mother | Sisters | Brothers | Sons | Daughters |
| Alcoholism |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |
| Colon or Rectal Cancer |  |  |  |  |  |  |
| Other Cancers |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |
| Hypertension |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |
| Migraines |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |

Indicate (M) Maternal or (P) Paternal for following family members:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Aunts | Uncles | Grandma | Grandpa |
| Alcoholism |  |  |  |  |
| Asthma |  |  |  |  |
| Breast Cancer |  |  |  |  |
| Colon or Rectal Cancer |  |  |  |  |
| Other Cancers |  |  |  |  |
| Diabetes |  |  |  |  |
| Depression |  |  |  |  |
| Hypertension |  |  |  |  |
| Heart Disease |  |  |  |  |
| Heart Attack |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Liver Disease |  |  |  |  |
| Migraines |  |  |  |  |
| Obesity |  |  |  |  |
| Stroke |  |  |  |  |
| Other: |  |  |  |  |

**Medical History**

List past surgeries (include date and description of any complications)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |

**Allergies**

List any known allergies you have to medications, include the type of reaction

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |

**Medication List**

List all current medications; including supplements, over the counter, herbals. Include the name of the medication, the dosage, how often medication is used and by what route. I.e.: oral route. Under pharmacy contact: include the name and address for your preferred pharmacy.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medication |  | |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |
| \* |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacy Contact |  |  |  |
| \* |  |  |  |
| \* |  |  |  |

**Chronic Problems**

List chronic problems, include dates if known

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |
| \* |  |  |  |

**Past Screenings**

Indicate last known date for the following screenings

|  |  |  |
| --- | --- | --- |
| Screenings | Dates: |  |
| Colonoscopy |  |  |
| Cholesterol |  |  |
| Tetanus |  |  |

|  |  |  |
| --- | --- | --- |
| Screenings | Dates: |  |
| Pap Smear |  |  |
| Mammogram |  |  |
| Last Menses |  |  |
| Hysterectomy? |  |  |

**HIPAA Notice of Privacy**

Acknowledgement of Receipt Privacy Officer: Gina Tobalina, MD, INC.

The protection and confidentiality of our patients health information is of extreme importance. By receiving and signing this form, you acknowledge that you have received a copy of this medical practice’s Notice of Privacy. You further acknowledge that a copy of the current notice will be posted in the office, and that a copy of any amended Notice of Privacy will be available at each appointment.

If you would like to receive a copy of any amended Notice of Privacy please include your email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Signed: |
| Date: |
| Telephone: |

If not signed by patient, please indicate relationship (Parent or Guardian of minor patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Gina Tobalina, MD, INC to disclose medical information to whom:

|  |
| --- |
| Name: (Include relationship) |
| Date: |
| Telephone: |

**Financial Policies**

Gina Tobalina, MD, Inc. is loyal to providing you with the best possible health care. The following information outlines financial responsibilities related to payment for professional services. We accept Visa, MasterCard, Cash and Checks.

**Financial Responsibility:** You, the patient are ultimately responsible for all charges associated with your care regardless of insurance coverage. Co-payment and Deductibles are a contrast responsibility between the patient and their insurance. These amounts are non-negotiable.

**Participating Insurances:** Gina Tobalina, MD, Inc. partakes with a variety of insurance plans. It is your responsibility to bring your insurance card and ID to every visit. You must also be prepared to pay your co-pay before each visit. Payment can be made by cash, check, or credit card.

For medical care not covered under insurance, payment will be your full responsibility due at the time of service.

**High Deductible Plans:** If you have a high deductible plan, be prepared to pay for your services in full as you incur them until your deductible has been met.

**Medicare:** Gina Tobalina, MD, Inc. is a participating provider with Medicare. We always file your primary claim. We will file secondary carriers as a courtesy only. If payment from a secondary carrier is not received with 60 days of filling, all charges will become patient responsibility and immediately due and payable.

**Forms:** You will be responsible for the payment for the completion of certain forms.

**Referrals:** An office visit is required for all referrals, and asking to have multiple referrals generated for the same concern will incur an additional fee.

**Additional Charges:** For checks returned for Not Sufficient Funds, a $25 fee will be charged to your account. A fee is assessed for medical records.

**Collection Agency and Bad Debt:** We cannot book any type of appointment for you if your account has been turned over to collections or has a bad debt write-off.

If you have questions about your insurance, our office will help you. However, specific coverage issues should be directed to your insurance company member services department (number is located on insurance card)

**Your signature below indicates that you have read and agree to this Financial Policy.**

|  |
| --- |
| Name: |
| Date: |