BASSAM TOMÉ, MD. *PATIENT INFORMATION*

WE ASK THAT PAYMENT BE MADE AT THE TIME OF EACH OFFICE VISIT
WE ACCEPT THE FOLLOWING: CASH OR CHECK

PATIENT NAME_____SEX____ AGE____ BIRTH DATE_____

ADDRESS_____
Number and Street Apt. # City State Zip

HOME PHONE #_____ CELL #_____ SOC. SECURITY # _____

PATIENT'S EMPLOYER_____
Name Work Phone

NAME OF PERSON RESPONSIBLE FOR BILL (IF OTHER THAN PATIENT)_____

ADDRESS & PHONE_____

SPOUSE'S NAME_____ SPOUSE'S EMPLOYER & PHONE_____

NAME AND PHONE # OF NEAREST RELATIVE OR FRIEND_____

NAME OF FAMILY MEMBER PREVIOUSLY SEEN IN OUR OFFICE:_____*DATE*_____

IF PATIENT IS UNDER 18 YEARS OF AGE:

FATHER 'S NAME_____ SOC. SECURITY # _____
EMPLOYER:_____ WORK #_____CELL #_____

MOTHER'S NAME_____ SOC. SECURITY # _____

EMPLOYER:_____ WORK #_____CELL #_____

Who referred you to us? _____

Who is your Previous Primary Care Physician? _____**Phone** _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____POLICY/ ID # _____
Insured's Name_____SOC. SECURITY # _____
Insured's Date of Birth_____Insurance Co. Phone #_____ GROUP # _____
SECONDARY INSURANCE _____POLICY/ ID # _____
Insured's Name _____SOC. SECURITY #_____
Insured's Date of Birth_____Insurance Co. Phone #_____ GROUP # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

1) I authorize Bassam TOMÉ, MD to release to my insurance carriers any information requested concerning my examination or treatment, and I understand that I am responsible for any charges not covered by my insurance.
2) I hereby authorize payment directly to Bassam TOMÉ,MD for medical benefits payable for the services performed.
3) I authorize the administration of any Vaccine & medication) that the doctor advises.
4) I understand that a reasonable fee will be added each month to accounts over 120 days old.
5) My signature below indicates that I am aware of Bassam TOMÉ,MD Privacy Policy and it's availability for my review.
6) I authorize Bassam TOMÉ, MD staff to contact me AND/OR leave a message at: home □ work □
7) Email address _____@_____

_____ _____ _____
SIGNATURE OF PATIENT OR GUARDIAN PRINTED NAME OF GUARDIAN DATE

Name: _____
DOB: _____
Email: _____

Ethnicity: O Non-Hispanic
O Hispanic
O Not specified

Preferred Language: O English
O Other _____
O Not specified

Race:
O African or African American
O Asian or Asian American
O Caucasian or European American
O Native American or Native Alaskan
O Native Hawaiian or Other Pacific Islander
O Other Race or not specified

PLEASE FILL OUT: THIS IS REQUIRED BY THE FEDERAL GOVERNMENT

BASSAM TOMÉ, MD. INTERNAL MEDICINE

Name: _____ Date of Birth_____

Briefly describe reason for visit:_____

_____

_____

Symptoms for how long? _____

Prior treatment &/or testing for this problem: _____

_____

Past Medical History: Have you ever been diagnosed or treated with any of the following: (check all that apply)

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Knee / Hip prosthesis. (circle one)
- ☐ Asthma
- ☐ Bleeding or blood disorder
- ☐ Cancer of_____
- ☐ Diabetes
- ☐ Emphysema / COPD
- ☐ Hepatitis (A B C circle one)
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart murmur/ valve disease
- ☐ Heart attack
- ☐ Heart pacemaker/ defibrillator.
- ☐ Glaucoma
- ☐ Liver disease
- ☐ Rheumatic fever
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid disease
- ☐ _____ other medical condition

Past Surgeries: _____

_____

Family History: _____

Current Medications: (including Aspirin, vitamin, & insulin….) _____

_____

_____

Allergies: (Include allergies to medication, IV contrast or dyes, latex, iodine) _____

_____

Social & Habits:

Smoker? 1) If Yes → Packs per day_____ # of years? _____ 2) Quit_____ What Year? _____
3) No_____ 4) Never smoked _____ 5) Snuff or Chewing Tobacco _____ 6) Cigar or Pipe _____
Alcohol: Yes____ No____ #/Day_____ Drugs: Yes____ No____ Type/ Amount_____

Vaccines: (PLEASE CHECK & INDICATE YEAR GIVEN)

☐ PNEUMONIA_____ ☐ TETANUS_____ ☐HEPATITIS B_____
☐ FLU VACC._____ ☐ SHINGLES_____ ☐ TB_____ ☐OTHER_____

Pharmacy: Name_____ Phone #:_____

_____ _____
Patient or Guardian Signature Date