TOVBA CARE MEDICAL PC **Date_____**

Patient's Name:_____Date of Birth:_____ Chart #_____

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.

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

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

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)_____

Vital Signs

Blood Pressure:_____/_____

Height:_____Weight:_____

Current Medications

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.

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

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

Medical Record Release Form

Tovba Care Medical PC

Dr. Eduard Fuzaylov

223 Taylors Mills Road Manalapan, NJ 07726

Tel: 732-851-6673Fax: 732-851-6674

TO: _____

_____

_____

_____

I _____ , hereby request and authorize you to send all of my progress notes, labs, x-rays, or other tests and hospital discharge summaries that are in my medical records. Please limit this information to that after_____.

Please send this information to:

_____

_____

_____

Date X_____

Patient's Signature X _____

Print Patient's Name X_____

Patient's Date of Birth X_____

TOVBA CARE MEDICAL PC
EDUARD FUZAYLOV MD
223 TAYLORS MILLS RD
MANALAPAN, NJ 07726

~ OUR FINANCIAL POLICY ~

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All information must be completed before seeing the doctor.

Full payment (co-pays, deductibles, co-insurances, non-covered services, self-pays, etc.) is due at time of service. For your convenience, we accept cash, checks, Visa, and MasterCard. **A fee of $25 will be assessed for returned checks and for any appointment cancelled with less than 24-hour notice.**

~ Regarding Insurance ~

Your insurance policy is a contract between you and your insurance company. If we participate with your insurance company, all co-pays, deductibles, and co-insurances are due at the time of service. Please be aware that some of the services provided (e.g., immunizations, annual physicals, preventive tests and exams) may be non-covered services and not considered reasonable and necessary by your medical insurance company. If your insurance plan deems a service a non-covered one, you will be responsible for the charges.

While we will try our best to bill and collect on your behalf payment for our services from your insurance company, we are not always successful. Payment delays, denials, stalling are common. Therefore, to keep our costs down and to provide you with the best possible service, we require that you provide us with a credit card authorization on file.

~Patient Responsibility/Balance~

We follow **"one-statement"** policy regarding patient responsibility towards copay, co-insurance, deductible and non-covered services. Your credit card on file will be charged for the outstanding balance fifteen days after we send the invoice (if not paid during that time). The receipt of the payment will be sent to you.

~ Outstanding Accounts ~

Any account with an outstanding patient balance over 60 days will be considered delinquent, and **delinquent accounts will be turned over to a collection agency and will be subject to a collection fee of 25% of outstanding balance.**

~ Insurance Commissioner ~

I authorize **Tovba Care Medical, P.C**. to file any appeals and/or complaints to the insurance commissioner on my behalf.

~Assignment of Benefits~

I hereby authorize **Tovba Care Medical, P.C.** to furnish information to my insurance carriers. I request that payment of authorized Medicare and/or other insurance benefits be made to **Tovba Care Medical, P.C**. for any services furnished by her to me, my dependents or the person for which I am claiming responsibility. I understand that I am responsible for any co-payments, deductibles, and payments for non-covered services.

I have read this Financial Policy. I understand and agree to this Financial Policy.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice*.

_____ _____

Patient Name (please print) Date

_____

Patient or Authorized Representative/Responsible Party's Signature

**Note: This acknowledge shall remain valid for a period of five (5) years from the date of signing.*

Practice Name and address

Patient Credit Card Payment Authorization

I authorize **Tovba Care Medical, P.C.** to charge my credit card for outstanding balance on my account towards copay/coinsurance/deductible and non-covered services from Payers.

This money would be charged either at the time of service if its copay/coinsurance or deductible or after insurance adjudication.

This authorization is valid for five years unless I cancel the authorization through written notice to Dr. Fuzaylov. I also agree to inform of any changes in the credit card number or expiry date to ensure that the information provided here is current and valid.

_____ _____

Cardholder signature Date

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip _____

Visa ___ MasterCard ___

Credit Card Number: _____ Expiry Date: _____