Iredell
Tondo Internal Medicine
Lewis J. Tondo, M.D.

***Thank you for choosing our office!***

**In order to serve you properly, we will need the following information. Please print.**

Patient name: Last _____ First _____ M _____

Mailing address: _____

City / State: _____ Zip code: _____

E-Mail address: _____

Please check: ❒ Male ❒ Female | ❒ Employed ❒ Retired ❒ Student

Patient's employer / School name: _____

Home phone #: _____ Cell phone #: _____

Work phone# _____

Date of birth: _____ Social Security #: _____

Please check: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Other

Spouse name / Parent name: _____

Person financially responsible for this account: _____

Emergency contact name: _____ Their phone #: _____

What pharmacy do you use?_____

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I authorize this office to release any information necessary to expedite insurance claims.
I also authorize treatment by Lewis Tondo M.D.

***Signature: _____ Date: _____
(Patient/Parent/Legal Guardian)

# History & Physical

Name: _____

Name _____ SS#_____ Date _____

Address_____ Occupation _____

Phone (home) _____(work)_____ Date of birth_____ Age _____

Chief complaint _____

_____

## DRUG ALLERGIES:

_____

_____

_____

_____

## CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

## FAMILY HISTORY

| | Father | Mother | Father's Parents | Mother's Parents | Siblings | Children |
|---|---|---|---|---|---|---|
| Heart Disease | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| High Blood Pressure | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Stroke | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Cancer | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Glaucoma | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Diabetes | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Epilepsy / Convulsions | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Bleeding Disorder | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Kidney Disease | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Thyroid Disease | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Mental Illness | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |
| Osteoporosis | ❒ | ❒ | ❒ | ❒ | ❒ | ❒ |

## HOSPITALIZATION OR SURGERY:

| Reason | Date | Reason | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## MEDICAL HISTORY:

❒ Hypertension _____
❒ Hyperlipidemia _____
❒ Heart palpitations _____
❒ Heart murmur _____
❒ Arrhythmia _____
❒ Chest pain / Angina _____
❒ MI _____
❒ Stroke / TIAs _____
❒ Claudication _____
❒ Congestive heart failure _____
❒ Congenital heart disease _____
❒ Headache _____
❒ Epilepsy _____

❒ Dizziness/Fainting _____
❒ Anxiety _____
❒ Fatigue _____
❒ Shortness of breath _____
❒ Orthopnea _____
❒ Allergies / Hay fever _____
❒ Asthma _____
❒ COPD _____
❒ Pneumonia _____
❒ Venereal disease _____
❒ Scarlet fever _____
❒ Rheumatic fever _____
❒ Liver disease _____

❒ Ulcer _____
❒ GI Disorder _____
❒ Sexual dysfunction _____
❒ Menstrual dysfunction _____
❒ Incontinence _____
❒ Anemia _____
❒ Arthritis _____
❒ Osteoporosis _____
❒ Gout _____
❒ Diabetes _____
❒ Endocrine disease _____
❒ Other _____
❒ Other _____

## WOMEN ONLY:

Pregnant? ❒ Yes ❒ No Planning pregnancy? ❒ Yes ❒ No

## MEN ONLY:

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? ❒ Yes ❒ No

## HABITS:

❒ Smoke: Packs daily _____
How long?_____
Interested in stopping? _____

❒ Exercise routine: _____
_____
_____

❒ Coffee: Cups daily _____
Other caffeine _____

❒ Alcohol: Type _____
Amount _____

❒ Diet: Salt intake _____
Fat intake _____

❒ Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____

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# Compound Authorization for Release of Information

Name of Patient _____ Date of birth _____

**Tondo Internal Medicine** is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

| **Entity to receive information.**<br>Check each person/entity that you approve to receive information | **Description of information to be released.**<br>Check each person/entity that you approve to receive information. |
|---|---|
| ❒ Voice mail | ❒ Results of lab tests/x-rays<br>❒ Other |
| ❒ Give information to employer<br>❒ Give information to school | ❒ Appointment absentee information |
| ❒ Spouse: _____ | ❒ Family Billing information<br>❒ Financial<br>❒ Medical as follows: _____ |
| ❒ Parent: (Name) _____ | ❒ Family Billing information<br>❒ Financial<br>❒ Medical as follows: _____ |
| ❒ Other: (Name) _____ | ❒ Financial<br>❒ Medical as follows: _____ |
| ❒ Support group: (Name) _____ | ❒ Demographic information |

## Rights of the patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Tondo Internal Medicine.**

I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may not longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

***Signature of patient or personal representative Date

Description of personal representative's authority (attach necessary documentation).

_____

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# Financial Policy

## Patients that have a plan with co-payments only:

Your co-pay must be paid each time you see the doctor, without exception.

## Patients that have a plan with deductibles (including Medicare):

Your plan has a deductible amount that you the patient must pay before the insurance will begin to pay for any medical expenses incurred. All patients are required to pay in full at the time of service until their deductible has been met. Once the deductible has been met, you will be required to pay the percentage that your insurance will not pay.

## Patients that have two insurance plans with no balance:

Patients that have two insurance coverages with no patient balance do not have to pay any money at the time of service.

## Patients with no medical insurance will be given 20% discount:

Patients with no medical insurance are required to pay in full at the time of service. In addition to this, you are required to pay a $100.00 deposit upfront, before being seen. If there is a prior balance, it must be paid in full before being seen. Upon checkout, any other money due must be paid. If you are going to pay by check, you can leave a blank check with the front office and the correct amount can be written in by the patient at time of checkout. If you paid cash and charges are less than $100.00, the difference will be given back to you at checkout.

## Patients with accident related injuries needing medical attention:

if you are here as a result of a work-related injury or accident, it must be prior approved by your employer as a worker's comp case. If this is not done you are required to pay in full today for all medical services rendered. Additionally, payment in full will be required for any future visits.

## Patients with no proof of coverage:

if you are unable to show proof of insurance coverage, you will be required to pay in full at time of service. If you do not meet your financial obligations and make restitution for your patient balances, your account will be placed with an outside collection agency.

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***I understand and fully agree to the financial policies as stated above and agree to pay in full any money due from me for medical services rendered by either cash, check, Visa, MasterCard or bank debit card.***

## Assignment of benefits:

Patient agrees to assign insurance benefits to our office for services rendered.

_____

Print full name of responsible party

_____ _____

***Signature of responsibility party Date

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# Notice of Privacy

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask any questions about our privacy practices.

By signing this form, you agree that you have had the opportunity to read our notice of privacy practices.

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I have received a copy of the notice of privacy practices.

_____ _____

Patient name (please print) Social Security Number

_____ _____

***Signature of patient/representative Date