

Robert S. Tomchik, M.D., P.A.

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www.MiramarMedicine.com

Patient Information Sheet

PERSONAL INFORMATION:

Patient Name: _____
Last First Middle Initial

Social Security #: _____ Birth Date: _____ Sex: M F

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email Address: _____

Employed by: _____ Occupation: _____

Marital Status: Single Married Separated Divorced Widowed Minor

Spouse's Name: _____
Last First Middle Initial

Spouse's Birth Date: _____ Employed by: _____

How did you hear of us (optional): _____

If someone other than the patient is responsible for payment, please complete this section:

Name of Responsible Party: _____ Relationship: _____ D.O.B. _____

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Medical Authorization and direction to pay:

I do hereby authorize the doctors/providers of care to furnish you, my insurance company, with the above referred, concerning the examination, diagnosis, treatment, progress, etc., of myself in regard to the accident or illness for which I received treatment. I hereby authorize and direct you, my insurance company, to pay the said doctors/providers of care such sums as may be due and owing them for services rendered to me by reason of this accident or illness. Under no circumstances is this agreement revocable, nor can it be changed unless proof of payment in full of the bill is provided to him/her for services rendered to me. And, I further understand that such payment is not contingent on any insurance policy, settlement, judgment, or verdict by which I may eventually recover said fee. I hereby agree to pay for the services rendered, including attorney's fees, collection charges, and court costs necessary to affect payment of this account. I understand that interest charges of 1-1/2% per month may be charged should my account become delinquent. I will also pay you an additional fee for each dishonored check or similar instrument received by you in payment on this account. A photocopy of this is as valid as the original.

Patient Signature: _____ Date: _____

Patient's Name: _____

It is helpful to gather information about your medical history for the physician to use in your examination. Please complete this form completely for the physician's review

1. CONTITUTIONAL SYMPTOMS

Good general health lately..... No Yes
 Recent weight change..... No Yes
 Fever..... No Yes
 Fatigue..... No Yes
 Headaches..... No Yes

2. INTEGUMENTARY (skin, breast)

Rash of itching..... No Yes
 Change in skin color..... No Yes
 Varicose veins..... No Yes
 Breast pain..... No Yes
 Breast lump..... No Yes
 Breast discharge..... No Yes

3. NEUROLOGICAL

Frequent or recurring headaches No Yes
 Light headed or dizzy..... No Yes
 Convulsions or seizures..... No Yes
 Numbness or tingling sensations..... No Yes
 Tremors..... No Yes
 Paralysis..... No Yes
 Stroke..... No Yes
 Head injury..... No Yes

4. HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts..... No Yes
 Bleeding or bruising tendency..... No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

5. PSYCHIATRIC

Memory loss or confusion..... No Yes
 Nervousness..... No Yes
 Depression..... No Yes
 Insomnia..... No Yes

6. ENDOCRINE

Glandular or hormone problem..... No Yes
 Thyroid disease..... No Yes
 Diabetes (insulin or non insulin – circle one)..... No Yes
 Excessive thirst or urination..... No Yes
 Heat or cold intolerance..... No Yes
 Skin becoming dryer..... No Yes
 Change in hat or glove size..... No Yes

7. Eyes, Ear, Nose, Mouth

Hearing loss or ringing..... No Yes
 Earaches or drainage..... No Yes
 Chronic sinus problem or rhinitis..... No Yes
 Nose bleeds..... No Yes
 Mouth sores..... No Yes
 Bleeding gums..... No Yes
 Sore throat or voice change..... No Yes
 Swollen glands in neck..... No Yes

8. CARDIOVASCULAR

Heart trouble..... No Yes
 Chest pain or angina pectoris..... No Yes
 Palpitation..... No Yes
 Shortness of breath while walking..... No Yes
 Swelling of feet, ankles or hands..... No Yes

9. RESPIRATORY

Chronic or frequent coughs..... No Yes
 Spitting up blood..... No Yes
 Shortness of breath..... No Yes
 Asthma or wheezing..... No Yes

10. MUSCULOSKELETAL

Joint pain..... No Yes
 Joint stiffness or swelling..... No Yes
 Weakness of muscles or joints..... No Yes
 Muscle pain or cramps..... No Yes
 Back pain..... No Yes
 Cold extremities..... No Yes
 Difficulty in walking..... No Yes
 Sports injury..... No Yes

11. GASTROINTESTINAL

Loss of appetite..... No Yes
 Change in bowel movements..... No Yes
 Nausea or vomiting..... No Yes
 Frequent diarrhea..... No Yes
 Constipation..... No Yes
 Rectal bleeding or blood in stool..... No Yes
 Abdominal pain..... No Yes
 Peptic ulcer (stomach or duodenal)..... No Yes

12. GENITOURINARY

Frequent urination..... No Yes
 Burning or painful urination..... No Yes
 Blood in urine..... No Yes
 Incontinence or dribbling..... No Yes
 Kidney stones..... No Yes
 Sexual difficulty..... No Yes
Male – Testicle Pain..... No Yes
Female – Pain with period..... No Yes
 Use douche..... No Yes
 Irregular periods..... No Yes
 Vaginal discharge..... No Yes
 Age at the onset of menstruation..... No Yes
 Number of days menstruation lasts..... No Yes
 Date of last pap smear..... No Yes
 Date of last menstrual period..... No Yes

List all pregnancies with dates, weights, and problems (Please include miscarriages, terminations, and pre-term): _____

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Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing our insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you need to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

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LIVING WILL

This Declaration is made this _____ day of _____, 20_____. I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medicine or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate, as my surrogate to carry out the provision of this declaration:

Name: _____

Address: _____

Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional):

Signed

Witness

Address

Phone

Witness

Address

Phone

Note 1: At least one of the above witnesses is neither a spouse nor a blood relative of the Declarant.

Note 2: It is the responsibility of the Declarant to provide for notification to his attending physician that this Declaration has been made.