Rodolfo D. Farhy, MD

PATIENT HISTORY FORM (Please Print)

Patient Name: _____ **Date of Birth**: _____

Social Security Number: _____ **Driver's License Number:** _____

Marital Status: Married Single Divorced Widowed **Gender:** Male Female

Home Address: _____
Street Apt. Number

_____
City State Zip code

Telephone #'s Home: ( ) _____ Work: ( ) _____

Cell: ( ) _____ Email: _____

Emergency Contact: (Name/Relationship/Phone): _____

Family Physician: _____

How did you hear about Dr. Farhy? (Friend/relative, radio, internet, etc.): _____

INSURANCE INFORMATION

Primary Insurance Company _____ Subscriber Social Security # _____

Subscriber Name _____ Subscriber Date of Birth _____

Contract Number _____ Group Number _____

Secondary Insurance Company _____ Subscriber Social Security # _____

Subscriber Name _____ Subscriber Date of Birth _____

Contract Number _____ Group Number _____

Do you have any history of :

High Blood Pressure Y or N

Asthma/Emphysema Y or N

By-Pass Surgery (CABG) Y or N When: _____

Previous Heart Attack Y or N When: _____

Diabetes Y or N

High Cholesterol Y or N

Angioplasty or Stent Y or N When: _____

Congestive Heart Failure Y or N

Atrial Fibrillation Y or N

Do You Smoke Y or N How much: _____

Family history of heart disease Y or N

Current Height: _____

Current Weight: _____

Current medications/strength/dose: _____

Allergies to any medications: _____

Pharmacy: _____

HIPAA POLICY AGREEMENT

By signing below you are authorizing Rodolfo D. Farhy, MD to disclose information about you for:

- ✓ Ordering laboratory tests and procedures, plus calling to give you the results over the phone.
- ✓ Authorizing the office to release prescription information to pharmacies over the telephone.
- ✓ Use of your information to fulfill standard health operations such as billing your insurance carrier(s).
- ✓ Appointment Reminders via telephone.

Revocation of Consent: You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices: Rodolfo D. Farhy, MD reserves the right to modify the privacy practices. I understand that Rodolfo D. Farhy, MD will notify me of these changes upon my next appointment.

Signature: I have reviewed this consent form and give my permission to Rodolfo D. Farhy, MD to use and disclose my health information in accordance with this consent ("Notice of Privacy Policies and Practices" available upon request.)

1.) _____

Signature of Patient (or Legal Guardian) Date

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign to **Rodolfo D. Farhy, MD** any insurance or other third-party benefits available for health care services provided to me. I understand that **Rodolfo D Farhy, MD** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Rodolfo D. Farhy, MD**, I agree to forward **Rodolfo D Farhy, MD** all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I also authorize, **Rodolfo D. Farhy, MD** to release any medical information requested by my insurance company to process a claim.

2.) _____

Signature of Patient (or Legal Guardian) Date

PAYMENT POLICY

The information I've provided is accurate and true to the best of my knowledge.
I understand that the verification of my insurance benefits is a courtesy and the estimated out-of-pocket expenses are not a written agreement or guarantee of the actual amounts that may be owed.
I understand that I am responsible to pay all deductibles, co-payments, etc. according to my insurance provider for the services rendered to me.

3.) _____

Signature of Patient (or Legal Guardian) Date