

TOTAL FAMILY CARE, LLC



Simita Talwar, M.D., Board Certified Family Medicine

1302 Cronson Blvd. Suite E Crofton MD 21114—Phone: (410) 451-1301; Fax: (410) 451-1037

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

REFERRED BY: _____ SEX (M/F): _____ STATUS: S M D W

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY #: ____-____-____

HOME PHONE: (____) ____-____ WORK NUMBER: (____) ____-____

CELLPHONE: (____) ____-____ **E-MAIL:** _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT NUMBER: (____) ____-____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE : _____

INSURED NAME: _____ INSURED NAME: _____

RELATIONSHIP: _____ DOB: _____ RELATIONSHIP: _____ DOB: _____

COPAY AMOUNT: \$ _____ COPAY AMOUNT: \$ _____

POLICY NUMBER: _____ POLICY NUMBER: _____

GROUP NUMBER: _____ GROUP NUMBER: _____

EMPLOYER: _____ EMPLOYER: _____

GUARANTOR INFORMATION

GUARANTOR : _____ ADDRESS: _____

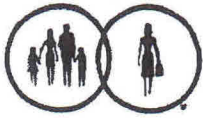
CITY: _____ STATE: _____ ZIPCODE: _____ PHONE: (____) ____-____

PATIENT'S AUTHORIZATION

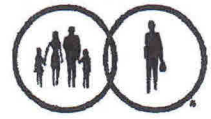
I authorize TOTAL FAMILY CARE, LLC to apply for benefits on my behalf for services rendered by TOTAL FAMILY CARE, LLC. I request payment from my insurance company to be made directly to TOTAL FAMILY CARE, LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims, I permit a copy of this authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. As of January, 2011 most commercial insurances allow the provider to collect the deductible at the time service is rendered. All co-pays and deductibles are due at time service is rendered.

SIGNATURE OF SUBSCRIBER OR BENEFICIARY: _____

DATE: _____



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Name _____ (First, and Last) DOB ____/____/____ DATE ____/____/____ Sex M F

Past Medical History:

List Allergies to Medication or X-Ray Dyes:

List Any Medical Problems: _____

List Any Specialists You Currently See: _____

List Any Medications (include over the counter): _____

List Any Surgeries: _____

Have you ever had any Blood Transfusions? Yes No If yes when? _____

Have you ever had any Problems with Anesthesia? Yes No If yes what? _____

For Women Only: Age of Onset of Period: _____ Number of Pregnancies: _____ Age of Cessation of Periods: _____

How Many Days apart are Periods? _____ Are Periods Regular? Yes No

<u>Family History:</u>	<u>Age</u>	<u>Medical Condition</u>
Father		
Mother		
Brother(s)		
Sister(s)		
Children		

Any other Illnesses in the Family?

Stroke Bleeding Disorders High Blood Pressure Asthma Depression/Psychiatric Illness

Diabetes Heart Disease Cancer, If so what type? _____

Social History:

Marital Status Married Single Divorced Widowed

Occupation: _____

How Many Children: _____ Ages: _____ List everyone In Household: _____

