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: _____

INSURED NAME: _____

RELATIONSHIP: _____ DOB: _____

COPAY AMOUNT: $_____

POLICY NUMBER: _____

GROUP NUMBER: _____

EMPLOYER: _____

SECONDARY INSURANCE :_____

INSURED NAME:_____

RELATIONSHIP: _____ DOB: _____

COPAY AMOUNT: $ _____

POLICY NUMBER: _____

GROUP NUMBER: _____

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

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

Family History:	**Age**	**Medical Condition**
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: _____