TORNIK FAMILY MEDICINE

| DEMOGRAPHIC FORM |

HOW DID YOU HEAR ABOUT US? ________________ REASON FOR TODAY'S VISIT ________________
PATIENT'S FIRST NAME __________________________ MI____ LAST NAME____________________
PREFERRED NAME______________________ SSN ______-______-_______ MARITAL STATUS___________
DOB:______________________________SEX: MALE ___ FEMALE ___
ADDRESS______________________________ CITY__________________ STATE________ ZIP____________
HOME PHONE_______________ MOBILE________________ EMAIL_________________________________
OCCUPATION_________________________ RECEIVE APPOINTMENT REMINDERS ___ YES ____ NO

| EMERGENCY CONTACT |

NAME: ____________________ PHONE NUMBER_________________ RELATIONSHIP________________

| INSURANCE |

INSURANCE COMPANY NAME___________________ SUBSCRIBER FULL NAME____________________
DOB(MM/DD/YYYY)______________________ SSN_____-____-_______ EMPLOYER_________________
RELATIONSHIP TO PATIENT_____________________
SECONDARY INSURANCE INFORMATION____

| RESPONSIBLE PARTY/GUARANTOR |

FIRST NAME:______________________ LAST NAME___________________DOB_____________
RELATIONSHIP TO PATIENT______________________ SSN_____________ OCCUPATION_____________
PHONE NUMBER__________________

RELEASE OF INFORMATION (whom you give us permission to communicate/share your PHI with)

NAME	PHONE NUMBER	RELATIONSHIP

I authorize assignment of any insurance or self-pay benefits due to Tornik Family Medicine:

Patient/Legal Guardian Signature:____ ***Date***____________
Patient/Legal Guardian Printed Name:____

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Patient's Full Name: ______________________ DOB: ____/____/____

Preferred Pharmacy Name: ______________ Pharmacy Address: ______________

|ALLERGIES|

Medication/Food Name	Reaction

Please be sure to list all medication doses and frequencies including supplements and non-prescriptions medications

|CURRENT MEDICATIONS|

Medication	Dose	Frequency	Medication	Dose	Frequency

FAMILY HEALTH HISTORY: *(Immediate family)* ______________________

____

CURRENT ONGOING MEDICAL CONDITIONS: ______________________

____

PAST MEDICAL HISTORY: *(Include any surgeries)* ______________________

____

SOCIAL HISTORY:

Tobacco Use ☐ Yes ☐ No ☐ Former — If yes, how frequently? ☐ Daily ☐ Weekly ☐ Monthly ☐ ________
☐ Cigarette ☐ Chewing ☐ Cigar ☐ Other ______

Alcohol Use ☐ Yes ☐ No ☐ Former — If yes, how frequently? ☐ Daily ☐ Weekly ☐ Monthly ☐ ________
☐Beer ☐ Liquor ☐ Wine ☐ Other ______

Illicit Drug Use ☐ Yes ☐ No ☐ Former — If yes, how frequently? ☐ Daily ☐ Weekly ☐ Monthly ☐ ________
Type ________

I have read all the information contained in this form. I certify that I have answered all the questions true and correct to the best of my knowledge. I will not hold Tornik Family Medicine responsible for any errors or omissions. I have made completion of this form. I will notify you of any changes in my health.

Patient/Legal Guardian Signature: ______________________ Date: ____________

TORNIK FAMILY MEDICINE

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PHONE (614)-873-6700 FAX (614)-873-6790

At TORNIK FAMILY MEDICINE, we are committed to providing our community with excellent quality medical care. An essential part of this commitment is our dedication to protecting the privacy and confidentiality of your medical information. Thank you for selecting TORNIK FAMILY MEDICINE and remember that we appreciate referrals sent to us by our patients and friends.

We do our best to make prompt appointments for you when you call. If you cannot keep an appointment, kindly give us at least a 24 hour notice prior so that we can give the appointment time to someone on our waiting list. We generally cannot accept walk-in patients.

We will see patients under 18 years of age when they are accompanied by a parent or legal guardian.

Prescriptions will be considered for refill only by evaluation here in the office. We will not refill prescriptions by telephone order without examination. Please plan ahead and make an appointment before your prescriptions expire.

We encourage you to consider using out DISCOUNTED PAY AT TIME OF SERVICE PROGRAM if you do not have health insurance. We provide a significant discount in return for paying directly at time of service. If you do not pay at the time of service, you will receive a bill for the non-discounted price of the office visit.

Insurance coverage is a contract between a patient and the insurance company. Deductibles and copays will be due at the time of service. Any amount remaining unpaid after 60 days will be immediately due and payable, whether your insurance company has made a payment or not.

Thank you for your assistance, consideration, and cooperation.