HARBOR VIEW MEDICAL CENTER

Dr. Thomas C. Thomas
110 Westwoods Dr.
Liberty, MO 64068
(816)781-6127

Date: ____________

Patient Name: ____

Address : ____________________________ City ______________ State ________ Zip __________

Home Phone #: ________________Work Phone: _______________Mobile Phone: _______________
☐ Widowed ☐ Divorced ☐ Single ☐ Married Sex: M ____ or F _____ Date of Birth: __________________
Social Security #: _______________Employer:________________ Occupation: ____________________

Spouse Name: ________________Spouse SS#: __________________Spouse Date of Birth: ___________
Spouse Employer: ___________________________Spouse Bus. Phone: _________________________
Emergency Contact: Name____________________ Phone ________________ Relationship____________

Where can we contact you to notify you of appointments and test results? _________________________
In accordance with patient confidentiality and privacy laws we will need your written permission to discuss appointments, lab results, test results, medical records and your account with anyone other than yourself. Please list below those family members you give permission to access your information.

__________ NO ONE

____
Name Relationship

___________________________________ _______________________________________
Patient Signature Date Name Relationship

Who is financially responsible for Payment of these services? ☐ Self ☐ Spouse ☐ Parent/Guardian
Name _________________________ Relation ___________________ DOB _____________
Address: ____
City: _____________________________ State: __________ ZIP: ____________________
SS# ________________________ Employer _______________________________________
Home Phone: ______________ Work Phone: _______________ Mobile Phone: _____________

MEDICAL INSURANCE INFORMATION:
We will be happy to file your insurance claim for medical services rendered as long as you provide us with a current insurance card. If you do not have insurance coverage or your insurance is one that we do not participate with, you will be expected to pay for your office visit at the time services are rendered. If perhaps some other arrangement is desired, please speak to the bookkeeper at this time.

Assignment Of Benefits and Authorization To Release Medical Information

I request that payment of authorized benefits, Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished by my physician. I authorize any holder of medical information about me to release it to the listed insurer(s), and/or agents of these companies, and/or the listed responsible person(s) any information needed to determine these benefits or the benefits for other related services.

I request payment of authorized medical benefits be made to Harbor View Medical, and also authorize any holder of medical information about me to release to the above named medigap insurer any information needed or determine benefits payable for services from this provider.

____
Signature Date

I hereby acknowledge that I have been presented with a copy of Harbor View Medical's Notice of Privacy Practice, have read and had an opportunity to discuss it with a staff member. Initial __________

ADULT HEALTH CARE MONITORING

Allergies If none please indicate ☐ NKA	
Medication	Reaction
1)	
2)	
3)	
4)	

SURGERIES PROCEDURES HOSPITALIZATIONS	DATE
1)	
2)	
3)	
4)	
5)	

SOCIAL HISTORY	
ALCOHOL	☐ YES ☐ NO QTY:
DRUG USE	☐ YES ☐ NO QTY:
TOBACCO	☐ YES ☐ NO QTY:
CAFFEINE	☐ YES ☐ NO QTY:
EXERCISE	☐ YES ☐ NO QTY:
OCCUPATION	
MARITAL STATUS	
CHILDREN	

HAS ANY BLOOD RELATIVE EVER HAD:		
	Yes	Who?
Tuberculosis		
Diabetes		
Heart trouble		
High Blood Pressure		
Stroke		
Asthma		
Inherited Disorders		
Cholesterol		
Osteoporosis		
Depression		
Cancer		
Type of cancer:		

LIST ANY MEDICATIONS TAKEN REGULARLY:
1)
2)
3)
4)
5)