Michael S. Lovoi M.D
13725 NW Blvd. Suite 260
Corpus Christi, TX 78410

New Patient Information

These forms need to be completed prior to your appointment.
Please bring in drivers license/picture ID and your insurance card.

Please bring forms and all medications with you to your appointment.

A medical release is provided in this packet.

Payment is due at time of service

Please be aware of your medical benefits.
If you do not know your copay, deductible, or co-insurance, please contact your insurance company.

If you have any questions please contact our office at (361)387-5161

Any appointments not cancelled will be subject to a $25.00 Non-Cancellation fee.

Thank you for your cooperation

Name: _____Appt. Date: _____Time:_____

Patient Signature: _____

Date:_____ Referred by_____

Name:_____D.O.B._____Race _____SS#_____

Address:_____Marital Status: S M W D Sep

City:_____State:_____Zip:_____

Home Phone:_____Cell #:_____Work#_____

Email address_____

Employer Name:_____May we leave message?_____

Address:_____City:_____State:_____Zip:_____

Patient Occupation:_____Contact/Supervisor:_____

Spouse's Name:_____Cell # _____D.O.B._____SS#:_____

Spouse's Employer:_____Telephone #:_____

Address:_____City:_____State:_____Zip:_____

Emergency Contact:_____Relation:_____Phone#:_____

Local Pharmacy:_____Phone#:_____

Mail In Pharmacy:_____Phone#:_____

Primary Insurance:_____Phone#:_____

Mailing Address:_____City:_____State:_____Zip:_____

ID#:_____Group#:_____

Secondary Insurance:_____Phone #:_____

Mailing Address:_____City:_____State:_____Zip:_____

ID#:_____Group#:_____

Medical information Release and Agreement of Benefits

I authorize the release of any medical information necessary to process this claim. I hereby authorize Dr. MICHAEL S. LOVOI, M.D., P.A. and staff to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance be made directly to Dr. MICHAEL S. LOVOI M.D., P.A. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be reviewed by either me or my insurance company at any time in waiting.

Signature:_____Date:_____

PATIENT HISTORY INFORMATION

PLEASE FILL IN AS COMPLETELY TO YOUR KNOWLEDGE AS POSSIBLE

Date:_____ Patient Name:_____ D.O.B._____ Age:_____

Chief Complaint (Why are you here today?)

1. _____

2. _____

3. _____

Surgeries	Y	N	Surgeon	Year	Surgeries	Y	N	Surgeon	Year
Abdominal	___	___	_____	_____	Tonsils	___	___	_____	_____
Gallbladder	___	___	_____	_____	Hysterectomy	___	___	_____	_____
Appendix	___	___	_____	_____	Breast	___	___	_____	_____
Thyroid	___	___	_____	_____	Rectal	___	___	_____	_____
Colonoscopy	___	___	_____	_____	EGD	___	___	_____	_____

Other: _____

Diseases	Yes	No	Dates	Diseases	Yes	No	Dates
Diabetes	___	___	_____	High Cholesterol	___	___	_____
Hypertension	___	___	_____	Respiratory	___	___	_____
Liver Disease	___	___	_____	TB	___	___	_____
Epilepsy	___	___	_____	Cancer	___	___	_____
Heart Disease	___	___	_____	Please List type(s) of cancer: _____			

Other: _____

Lifestyle	Yes	No	Amount	Lifestyle	Yes	No	
Alcohol Use	___	___	_____	Sexually			If yes,
Cigarettes	___	___	_____	Transmitted			please list:
Drug Use	___	___	_____	Disease (STD's)	___	___	_____
Job Stress	___	___	_____	Tattoos	___	___	

Height:_____ Weight:_____

Allergies:_____

VACCINES

Type	Year	Type	Year
Tetanus	_____	Hepatitis	_____
Flu	_____	Pneumonia	_____

Other: _____

Signature:_____ Date:_____

Family History

Father's Health Condition:_____ Age:_____

If Deceased—Cause of Death:_____ Age:_____

Mother's Health Condition:_____ Age:_____

If Deceased—Cause of Death:_____ Age:_____

Diseases (Mother, Father, Brother, and Sister)

	Yes	No	Whom		Yes	No	Whom
Diabetes	___	___	_____	Cancer	___	___	_____
Hypertension	___	___	_____	Respiratory	___	___	_____
TB	___	___	_____	Heart Disease	___	___	_____
Epilepsy	___	___	_____	Bleeding Disorder	___	___	_____

Other: _____

List any and all Medications you are taking, this includes vitamins and supplements:

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED BY

Our office does not prescribe long term narcotics; we do refer to a pain management specialist.

Signature:_____ Date:_____

Michael S. Lovoi, M.D., P.A.
13725 NW Blvd. Suite 260

Corpus Christi, TX 78410

Medical Records Release for Past and Current Physicians

Please include any progress notes, labs, diagnostics, operative notes, and colonoscopies/EGDs/pathologies

I_____hereby request and authorize the release of my Medical Records to: Michael S. Lovoi, M.D., P.A.

13725 Northwest Boulevard Suite 260

Corpus Christi Tx 78410

Phone (361)387-5161 Fax (361)387-4871

From:_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Phone:_____**Fax:**_____

From:_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Phone:_____**Fax:**_____

From:_____

Address:_____**City:**_____**State:**_____**Zip:**_____

Phone:_____**Fax:**_____

Patient printed name:_____

SS#:_____D.O.B._____

Patient Signature:_____Date_____

Witness:_____

Office Employee

Michael S. Lovoi, M.D., P.A.
13725 NW Blvd. Suite 260
Corpus Christi, TX 78410
Phone (361)387-5161; Fax (361)387-4871

Family Medical Records Release

Please list any person who has permission to call and get medical information regarding your health.
If they are not on the list, we cannot release information.

Date:_____

I_____hereby request and authorize the release of my Medical Records to:

Printed Name:_____Relationship_____

Phone:_____Cell:_____

Printed Name:_____Relationship_____

Phone:_____Cell:_____

Printed Name:_____Relationship_____

Phone:_____Cell:_____

Printed Name:_____Relationship_____

Phone:_____Cell:_____

Patient printed name:_____

SS#:_____D.O.B._____

Patient Signature:_____

Witness:_____
Office Employee

Date: _____

Name: _____ Date of birth: _____

13725 NW Blvd. Suite 260 * Corpus Christi, Texas 7840 * 361-387-5161

Notice of Privacy Practices Right

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the HIPAA Privacy Practices by this office, please ask to speak with our HIPAA Compliance Officer.

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim.

I hereby authorize Michael S. Lovoi, M.D., P.A., and staff to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance be made directly to Michael S. Lovoi, M.D., P.A. Our office will accept assignment of your insurance. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter in a dispute with your insurance company over policy limitation or issues. This is your responsibility and obligation. All charges incurred are your responsibility.

You will be responsible for your deductible, co-pay, and co-insurance amounts not paid by your insurance. Payment is requested at time of service.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Appointments

If you have an appointment scheduled which you cannot keep, please contact us 24 hours before your appointment. Any appointment not cancelled will be subject to $25.00 Non-Cancellation Fee. It will be the responsibility of the patient to pay this fee.

Prescriptions

If you need prescription refills, call the pharmacy 24-48 hours before your next refill is due. We respond to pharmacy requests received prior to 3:30 PM by the end of the business day. Requests received after 3:30 PM will be addressed the following business day. For refills during an appointment, let the nurse know as soon as you are taken into the treatment room. For any Narcotic prescriptions, you must call on FRIDAY MORNING BEFORE 11:00 AM SO THAT IT MAY BE AVAILABLE FOR PICK UP ON TUESDAY MORNING.

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice of Michael S. Lovoi, M.D., P.A. I also received a copy of the office policies.

_____

Signature