Gina Tobalina, MD, Inc.
1615 Creekside Drive Suite 101, Folsom, CA 95630
Phone: (916) 817-4132 Fax: (916) 817-4148

Welcome to the practice of Dr. Gina Tobalina

Thanks you for selecting us as your healthcare team. Our goal is to provide the utmost quality of care and satisfaction. In order for our practice to address your healthcare needs, please fill out the following forms as accurately as possible. If you have any questions or concerns please contact our office.

Personal Information

Name:	Nickname:
Address:	
City / State:	Zip Code:
Home Number:	Date of Birth:
Work Number:	Race / Ethnicity:
Marital Status:	Cell Number:
Occupation:	Employer:
Email:	Social Security #:

Emergency Contact

Name:	Relationship:	Phone:

Social History

Please respond to the following questions

	Questions:	Responses:
Tobacco	Do you use tobacco?	
	Former Smoker?	
	Current smoker, include type and frequency:	
	Former Smoker note # of years used and quit date:	
Drugs	Do you currently use recreational or street drugs?	
	If yes, what kinds?	
	If you have a history of drug use include details:	

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ETOH	Do you consume alcohol?	
	If yes, what kinds?	
	How many drinks per week?	
	If you have a history of abuse include details:	

Family History

Use + symbol to indicate positive history

	Father	Mother	Sisters	Brothers	Sons	Daughters
Alcoholism						
Asthma						
Breast Cancer						
Colon or Rectal Cancer						
Other Cancer (Specify Type)						
Diabetes						
Depression						
Hypertension						
Heart Disease						
Heart Attack						
Kidney Disease						
Liver Disease						
Migraines						
Obesity						
Stroke						
Other						

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Medical History

List all current medical conditions (include date of onset)

Medical Conditions:	Date of Onset:

Past Surgical History

List past surgeries (include date and description of any complications)

Procedure:	Date:

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Allergies

List any known allergies you have to medications, include the type of reaction

Medication List

List all current medications; including supplements, over the counter, herbals. Include the name of the medication, the dosage, how often medication is used and by what route (ie: oral, topical, etc.)
Under Pharmacy Contact: include the name and address for your preferred pharmacy.

Medications:	**Dosage:**

Pharmacy Contact:

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Financial Policies

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless your services are covered by your insurance carriers with whom we contract. We accept Visa, Mastercard, and checks. **It is your responsibility to be aware of your deductibles and co-pay amounts.** There is an information number on the back of your insurance card.
2. You will need to provide a copy of your current insurance card at the time of each visit along with a photo ID.
3. We do bill and participate in most insurance plans, including Medicare, but keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim. If your insurance company does not pay the practice within 45 days of billing, you will be responsible for payment in full and requesting reimbursement from your insurance. If we later receive a check from your insurer, we will refund any overpayment to you. All non-covered services will be your responsibility and payment is due at the time you receive your statement.
4. There is a fee for Chronic Care Management every month if you have two or more chronic conditions. Fees will also be charged every time the office is contacted for medical advice or for work of some kind to be performed, including completing forms, telephone calls and email or portal requests.
5. Accounts over 90 days past due will be turned over to a collection agency. You will be notified by mail and will have 2 weeks to pay your account. If your account remains unpaid, you will be discharged from the practice.
6. Referrals: An office visit is required for all referrals, and asking to have multiple referrals generated for the same concern will incur an additional fee.
7. Additional Charges: For checks returned for Nonsufficient Funds, a $35 fee will be charged to your account. A fee is assessed for medical records.

Your signature below indicates that you have read and agree to this Financial Policy.

______________________________ ______________________________

Name: Date:

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HIPAA Notice of Privacy

Acknowledgement of Receipt: Privacy Officer: Gina Tobalina, MD, Inc.

The protection and confidentiality of our patients health information is of extreme importance. By receiving and signing this form, you acknowledge that you have received a copy of this medical practice's Notice of Privacy. You further acknowledge that a copy of the current notice will be posted in the office, and that a copy of any amended Notice of Privacy will be available at each appointment.

If you would like to receive a copy of any amended Notice of Privacy please include your email:________________________________

______________________________________ ______________________________
Signature: Date:

____
Phone:

If not signed by patient, please indicate relationship (Parent or Guardian of minor patient):________________________________

I authorize Gina Tobalina, MD, Inc. to disclose medical information to whom:

______________________________________ ______________________________
Name: Relationship:

____
Date:

____
Phone: