

112 GVR Medical P.C  
 Dr. Ida Tetro  
 69-60 108 ST, Suite 108  
 Forest Hills, NY 11375  
 Phone: (718) 263-0200  
 Fax: (718) 263-0205

**Patient Intake Form**

Assignment and Release:

I hereby authorize payment of medical benefits to Dr. Ida Tetro. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fee(s) that exceed the payment made by my insurance, if Dr. Ida Tetro's practice does participate with insurance. I agree to pay all copayments, coinsurance, deductibles and out-of-pocket expenses at the time services are rendered.

**PLEASE COMPLETE THE FOLLOWING:**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Email \_\_\_\_\_ SSN (optional) \_\_\_\_-\_\_\_\_-\_\_\_\_

Occupation \_\_\_\_\_ Employer/School \_\_\_\_\_

Employer/ School Address \_\_\_\_\_ Phone \_\_\_\_\_

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_

Emergency Contact/Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

I Consent to Receive Electronic Appointment Reminder via Text Messaging/E-Mail  Yes  No

Insurance:

Primary Insurance \_\_\_\_\_ Member ID \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Member ID \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Please complete to the best of your knowledge, if it doesn't apply you may leave this section blank.

Current Medication(s) \_\_\_\_\_

Current Condition(s)/ Diagnosis \_\_\_\_\_

Allergies \_\_\_\_\_

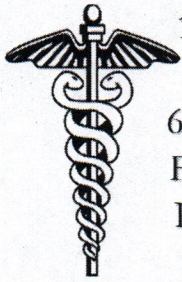
Please Sign Below. Thank you

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If patient is under the age of 18 a parent/guardian must sign on their behalf.

Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient, if other than patient \_\_\_\_\_



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### AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician, person, facility, or entity listed below. I certify that this request is made voluntarily and that the information given below is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. If these records contain any information about, drug/alcohol abuse, cancer diagnosis, HIV/AIDs, or any sexually transmitted diseases (STDs) you are hereby authorized to disclose this information.

**PLEASE COMPLETE THE FOLLOWING:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Last 4 digits of SSN: \_\_\_\_\_ Phone #: \_\_\_\_\_

I hereby authorize the facility listed below to disclose/release my medical records

Provider/Facility/Entity Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Type of Medical Record Requesting (check all applicable):

- All Records
- Office/Progress Notes (Previous 2 yrs.)
- Lab/Pathology Reports (Previous 3 yrs.)
- Other (specify) \_\_\_\_\_
- Medication Records
- Hospital Reports (Previous 2 yrs.)
- Electrocardiograms (EKGs) (Previous 2 yrs.)

Please send these record to:

Provider/Facility/Entity Name: \_\_\_\_\_

Address: \_\_\_\_\_

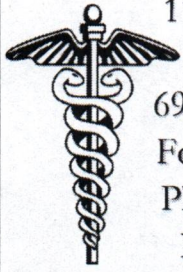
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

*Signature for authorization of release is only valid for 90 days from date signed.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient, if other than patient \_\_\_\_\_



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**Authorization to Release Information and Assignment of Benefits**

I \_\_\_\_\_ the undersigned, hereby authorize and direct my insurance company to pay directly to Dr. Ida Tetro all insurance benefits, if any due to me under my insurance plan. I further agree to pay the balance(s) of the charges not paid by my insurance and understand that it is my responsibility to fulfill these balances within a timely manner. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. I have received the notice of Practice Privacy and I have been provided an opportunity to review it.

***Signature for authorization of release is only valid for 90 days from date signed.***

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient, if other than patient \_\_\_\_\_