CONVIVA
Care Solutions

Provider History Form

Patient Name:_____ **Date Of Birth:**_____

In order for us to best assist you with transitioning your medical care, please complete the information below. List the names of any specialty providers or the names of any specialist's clinics you have visited **within the last two years.** This information may be used to obtain medical records for your provider for treatment, payment, and health care operations as described in the Notice of Privacy Practices.

Provider Name/Practice Name	**Address/Phone Number**	Office Use **Requested?**
Previous Primary Care Physician:		☐ Yes ☐ No
Allergist:		☐ Yes ☐ No
Cardiology/Pulmonology:		☐ Yes ☐ No
Dermatology:		☐ Yes ☐ No
Ear, Nose & Throat (ENT):		☐ Yes ☐ No
Endocrinology:		☐ Yes ☐ No
Gastroenterology:		☐ Yes ☐ No
Nephrology:		☐ Yes ☐ No
Neurology:		☐ Yes ☐ No
Oncology/Hematology:		☐ Yes ☐ No
Ophthalmology:		☐ Yes ☐ No
Pain Management:		☐ Yes ☐ No
Podiatry/Orthopedic:		☐ Yes ☐ No
Rheumatology:		☐ Yes ☐ No
Urology:		☐ Yes ☐ No
Vascular:		☐ Yes ☐ No

Other:		☐ Yes ☐ No
Have you had a recent Er visits or hospitalizations? **Please provide the reason, hospital and dates of admission:**		Office Use **Requested?** ☐ Yes ☐ No

☐ **I do not currently see any specialists.**

Signature of Patient Date

Signature of Parent/Guardian/Personal Representative* Date

Printed Name of Parent/Guardian/Personal Representative* Date

***If you are signing as a personal representative of an individual, describe your authority to act for this individual and provide any corresponding documentation (healthcare power of attorney, healthcare surrogate, guardian, etc.):**

_____

For Office Use Only:

Sign and date this form after checking "Yes" or "No" to whether the records were requested.

Signature of Office Personnel Date

Printed Name of Office Personnel Date