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MINIMALLY INVASIVE SURGERY OBSTETRICS + GYNECOLOGY

NEW PATIENT INFORMATION

PATIENT INFORMATION *Informacion del Paciente*

Name (Last, First, MI) *Nombre del Paciente*	**Social Security #** *Seguro Social*	**Date of Birth** *Fecha de Nacimiento*	**Age** *Edad*
Marital Status *Estado Civil* □ **Single** *Soltera* □**Married** *Casada* □**Divorced** *Divorciada* □**Widowed** *Viuda*	**Languages Spoken** *Idiomas*		
Home Address *Direccion del Hogar*	**City** *Ciudad*	**State** *Estado*	**Zip Code** *Codigo Postal*
Home Phone *Telefono del Hogar* / **Work Phone** *Telefono del Trabajo*	**Mobile Phone** *Telefono Portatil*	**E-mail Address** *Direccion de E-mail*	
Employer Name & Address *Nombre y Direccion del Empleo*	**Occupation** *Ocupacion*	**Work Phone** *Telefono del Trabajo*	

SPOUSE'S INFORMATION *Informacion del Esposo*

Spouse's Name *Nombre del Esposo*	**Social Security #** *Seg. Social*	**Date of Birth***Fecha de Nacimiento*	**Age** *Edad*
Spouse's Employer Name *Nombre del Empleo del Esposo*	**Work Phone** *Tele. del Trabajo*	**Other Phone** *Otro Telefono*	

EMERGENCY CONTACT INFORMATION *Contacto de Emergencia*

Name of Emergency Contact *Contacto de Emergencia*		**Relationship to Patient** *Relacion*		**Home Phone** *Telefono del Hogar*
Address *Direccion*	**City** *Ciudad*	**State** *Estado*	**Zip Code***Cod. Postal*	**Work Phone** *Telefono del Trabajo*

WHO MAY WE THANK FOR REFERRING YOU TO US? *Quien la referio a nuestra oficina?*

Name *Nombre* □ **Internet** □ **Insurance** *Seguro*	**Phone** *Telefono*

INSURANCE INFORMATION *Informacion de Seguro*

Primary Insurance Company *Nombre del Seguro*	**Group #** *# de Grupo*		**Policy #** *# de Poliza*
Subscriber's Name *Asegurado*	**Relationship** *Relacion*	**Social Security #** *Seg. Social*	**Date of Birth***Fecha de Nacimiento*
Secondary Insurance Company *Nombre del Seguro*	**Group #** *# de Grupo*		**Policy #** *# de Poliza*
Subscriber's Name *Asegurado*	**Relationship** *Relacion*	**Social Security #** *Seg. Socia*	**Date of Birth***Fecha de Nacimiento*

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, MasterCard, American Express, and Discover Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card, American Express y Discover. Su segurdo medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta dueda, usted es responsible de los gastos legales.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby assign payment directly to Alvarez & Vinueza, MDs, LLC of all payments applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by Alvarez & Vinueza, MDs, LLC. I understand that I am financially responsible to Alvarez & Vinueza, MDs, LLC for any and all charges that the carrier declines to pay (including but not limited to: Not a covered benefit, Disallowed by plan). I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a Alvarez & Vinueza, MDs, LLC todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de recibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi seguro medico.

NOTICE OF PRIVACY ACKNOWLEDGEMENT: I have read and understand the privacy act.

Signature of Patient *Firma del Paciente*: **Date** *Fecha*:

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MEDICAL HISTORY

Name: _____ **Age:**_____ **Date:** _____

Primary Care Doctor:_____

Reason for Visit: ☐ Annual Pap Exam ☐ Other _____
Date of last visit to OB/GYN:_____
Date of last pap: _____ Results: ☐ Normal ☐ Abnormal
Date of last mammogram: _____ Results: ☐ Normal ☐ Abnormal

Do you have a medical/surgical history of:

Heart Disease	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Urinary Infections	☐ Yes	☐ No
Renal Disease	☐ Yes	☐ No	Blood Transfusions	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
Psychiatric Disorders	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Tumors/Cancers	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Fibrocystic Breasts	☐ Yes	☐ No	HPV	☐ Yes	☐ No
Cervical Dysplasia	☐ Yes	☐ No	Menopause	☐ Yes	☐ No
Tubal Ligation	☐ Yes	☐ No	Appendectomy	☐ Yes	☐ No
Hysterectomy	☐ Yes	☐ No	Gallbladder Removal	☐ Yes	☐ No

Do your parents or brothers/sisters have any medical condition or cancer? ☐ Yes ☐ No
If yes,explain:

Do you have a medical condition that is not listed above? ☐ Yes ☐ No
If yes, explain:

At what age did your menstrual cycle begin? _____ Are they regular? ☐ Yes ☐ No
How many days between your cycles? _____
How many days does your cycle last? _____
Do you get menstrual cramps? ☐ Yes ☐ No
If yes, what do you take? _____

Are you currently experiencing any of the following?

☐ Headaches ☐ Dizziness ☐ Chest Pain ☐ Shortness of breath ☐Heavy Menstrual Bleeding

☐ Burning when you urinate ☐ Fever ☐ Chills ☐ Nausea ☐ Vomiting ☐ Diarrhea

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MEDICAL HISTORY (continued)

When was your last colonoscopy?_____

What is your current method of contraception? _____
Did you ever use an IUD? ☐ Yes ☐ No
If yes, for how long? _____

Have you ever used contraceptive pills? ☐ Yes ☐ No
If yes, which one? _____

Have you ever had any STD's? ☐ Yes ☐ No
If yes, which one? _____

Have you ever had Pelvic Inflammatory Disease? ☐ Yes ☐ No
If yes, when? _____

Do you Smoke? ☐ Yes ☐ No
Drink Alcohol? ☐ Yes ☐ No
Use Illicit Drugs? ☐ Yes ☐ No

Current Medications:

Name	Dosage	Frequency

Are you allergic to any medications? ☐ Yes ☐ No
If yes, which ones? _____

_____ _____
Signature of patient Date

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PAST PREGNANCIES (PLEASE LIST ALL PREGNANCIES)

Date of Delivery Mm/dd/year	Type of Delivery (Vaginal, C-section, Miscarriage, Termination)	Total # of Weeks Pregnant	Doctor & Hospital	Length of Labor (in hours)	Single or Multiple Babies	Baby's Birth Weight	Baby's Name and Gender	Complications during pregnancy or Delivery	Comments

PAST SURGERIES (PLEASE LIST ALL SURGERIES)

Date of Surgery	Procedure	Complications/Comments

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Notice of Privacy Acknowledgement/ Aviso De Privacidad Reconocimiento

Alvarez & Vinueza, MDs, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Entiendo que bajo el Health Insurance Portability and Accountability Act (HIPAA), tengo ciertos derechos a la privacidad con respecto a mi información de salud protegida. Reconozco que han recibido o han tenido la oportunidad de recibir una copia de su aviso de prácticas de privacidad. También entiendo que esta práctica tiene el derecho de cambiar su aviso de prácticas de privacidad y que puedo contactar con la práctica en cualquier momento para obtener una copia actual de la notificación de prácticas de privacidad.

CONTACTS FOR RESULTS/ CONTACTOS PARA OBTENER RESULTADOS:

Patient telephone numbers/ Números de teléfono del paciente:

_____ _____ _____
Home Phone/*Teléfono de casa* Work Phone/*Teléfono de trabajo* Mobile Phone/*Teléfono móvil*

I authorize Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza and any members of their staff to fax medical information needed for my treatment to the following fax number (*Yo autorizo a Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza y los empleados de la oficina que manden cualquier información necesaria para mi tratamiento medico al siguiente número de fax)*:

_____
Fax Number/ *Número de fax*

I authorize Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza and any members of their staff to discuss my medical information including test results with the following individuals (*Yo autorizo que el Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza y los empleados de la oficina pueden hablar sobre mi información médica incluyendo resultados de pruebas con las siguientes personas)*:

_____ _____
Name/*Nombre* Relationship to Patient/*Relación a paciente*

_____ _____
Name/*Nombre* Relationship to Patient/*Relación a paciente*

_____ _____
Name/*Nombre* Relationship to Patient/*Relación a paciente*

Signed/ *Firmado*:

_____ _____
Patient Name or Legal Guardian (print)/ Date/*Fecha*
Nombre del paciente o la Legal de guarda (impresión)

_____
Signature/*Firma*

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____ **FOR OFFICE USE ONLY**

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WAIVER REQUESTING LAB TESTS OUTSIDE MY HEALTH INSURANCE COMPANY COVERAGE

I acknowledge that although I may have health insurance which will pay for laboratory tests if I go to the specific local lab designated by my insurance company, I request that **Alvarez & Vinueza M.D's, L.L.C.** perform these tests through this office. My doctor and/or his staff have explained that I may go to the lab with a prescription and have the test(s) done at no charge. However, I request that the test(s) be performed through my Doctor's office despite the cost I shall incur.

This is being done entirely for my convenience and as a courtesy to me.

☐ **I agree that today I will pay the $25.00 administrative fee necessary to perform the specific test through my Doctor's office.**

_____ _____
Signature of patient Date

_____ _____
Signature of witness Date

☐ **I do not wish to have Alvarez & Vinueza, M.D.'s, LLC perform any laboratory tests.**

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NOTICE REGARDING INSURANCE/HOSPITAL AFFILIATION

Dear Patient,

Please be advised that there are certain insurances that we accept in our office that may not be accepted at other facilities such as Baptist Hospital. Dr. Alvarez and Dr. Vinueza only have privileges at Baptist Hospital (Main) and MASC (Baptist's Medical Arts Surgical Center). It is your responsibility to verify hospital/facility affiliation with your insurance company. Should you require any service which needs to be provided outside of our offices, it may become necessary to transfer your care to another physician (who has privileges at a facility which is in-network with your insurance). Thank you for your understanding.

I (print name) _____, have read, understand and agree to the above terms.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____
Witness Name (print)

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Dear Patient,

The health insurance industry allows physician practices, such as ours, to submit a medical claim on your behalf for the payment of services and treatment provided. Insurance companies often do not notify us of a patient balance until many months after your visit. Because of this, we (like many other physicians, hotels and car rental agencies) request that you provide us with a valid credit card to keep on file to make it easier for you to pay off your balance, if it becomes necessary. This information will be kept confidential. Should you have additional charges or a balance after your insurance company processes our claim, we will send you a statement showing the balance. If, after 30 days from the statement date, we haven't received a payment for the balance, we will then submit the charge through the credit card we have on file for you.

If you request, we can provide an **estimate** for the services rendered. Please understand that this is an **estimate only** and your actual charges and / or responsibility may be more or less than the estimate, depending upon the services performed and coverage actually provided by your insurance company. In some circumstances, additional charges may be incurred after your departure from the office and not included in the estimate. This may occur when a more complete review identifies charges that were missed initially. In addition, the information we initially receive from your insurance company prior to your visit regarding coverage and your responsibility is often different than the information we receive after the claim has been formally submitted.

When making decisions regarding your medical care, we make the best decisions we can given your particular circumstances. However, some insurers will only pay for a limited number of procedures, even if they are considered medically necessary. Insurers allow direct patient billing for uncovered services. If your insurance does not cover a service, you will be responsible for the balance. If you have a question whether you are receiving a covered service, please ask. . . however, we are sometimes unable to get accurate information from insurers prior to the formal submission of a claim, which cannot occur until after the procedures have been performed. Our inability to get valid information from the insurer will not change your obligation for the balance, if one results.

I (print name) _____, have read, understand and agree to the above terms.

_____ _____

Patient Signature Date