SURGICAL SOLUTIONS OF MIAMI, LLC.
PATIENT INFORMATION FORM

Welcome to our office. Please complete the following:

Date: _____
Referring Physician: _____
Patient Complaint or Diagnosis_____
How did you hear about our office? _____

Patient Information:
Name: _____
Age: _____**Date of Birth**: _____**SS#**: _____
Sex: □M □F **Marital Status**: □Single □Married □Divorced □Widowed
Race: □White □Hispanic □African American □Asian □Other:_____
Preferred Language: □English □Spanish □Other: _____
Street Address: _____
City/State/Zip: _____ **E-mail Address:** _____
Home Phone _____**Business Phone:** _____**Cell #** _____
Employer: _____
Employers Address: _____
Employer's phone: _____**Occupation:**_____

Insurance Information:
Primary Insurance Co: _____
Subscriber's Name (if other than pt): _____ Subscribers DOB: _____
Relationship to patient:_____
Secondary Insurance Co: _____ Member ID: _____

Background Information:
Family Doctor: _____ **Phone:** _____

I certify that this information is true and correct to the best of my knowledge.

PHYSICIAN RELEASE AND ASSIGNMENT:
I hereby authorize payment directly to SURGICAL SOLUTIONS OF MIAMI, LLC of benefits due to me from my Insurance Company payable to me. I further authorize the release of any medical information required by my Insurance carrier. A copy of this authorization may be used in lieu of the original. I authorize any holder or remedial or other information about me to release to the Social Security Administration or its intermediates or carriers any information needed for this or a related Medicare claim. I request payment of medical Insurance benefits either to myself or to the party who accepts assignments.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE COMPANY.

PATIENT SIGNATURE _____ **DATE:** _____

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PATIENT HEALTH HISTORY

The following information is very important to your health. Please take the time to fully and completely fill out this important information.

Name: _____ **Date**: _____

SSN: _____ **DOB:** _____

Chief Complaint: What is the reason for you visit today? (Please describe problem in detail including history of present illness):

_____
_____
_____

Surgical History: Please list past surgeries with approximate date:

Surgery	Date	Hospital/Surgeon

Medications: Please list any medications you are taking with dose and frequency:

Drug Name	Dose/Frequency	Reason

Please list any over the counter medications, include Herbal, Remedies and/or Vitamins:

_____
_____
_____

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Allergies(*specify reaction***):** _____
Pharmacy Name: _____ **Phone**: _____
Location: _____
Do you accept blood transfusion if needed in the event of a surgery? □YES □NO, REASON: _____

Past Medical History: (Please check if applicable)
□High Blood Pressure □ Diabetes □Cancer □Gastrointestinal □Heart Problems
□Stroke □Epilepsy □Blood Clots □Gynecological Problems □Arthritis □Thyroid
□Glaucoma □Lung Problems □Liver Disease □Depression □Asthma □Fibromyalgia
□Hyperlipidemia □Hypercholesterolemia □Obstructive Sleep Apnea □Obesity □None
□Other: _____

Social History:
Do you drink alcohol? □Yes □No If yes, how much/week? _____
Do you smoke? □ Yes □ No If yes, how many cigarettes/day? _____
Do you consume caffeine? □Yes □No If yes, how many cups/day? _____
Do you use recreational drugs? □Yes □No If yes, what type and frequency? _____
Are you on a special diet? □Yes □No If yes, please describe_____
_____

Family History: *Please list any family member who has/had any of the following conditions:*
□High blood pressure:_____ □Heart Problems:_____ □Cancer, Type/Who: _____
□Stroke:_____ □Multiple Sclerosis:_____ □Kidney disease:_____ □Aneurysm:_____
□Thyroid:_____ □Obesity:_____ □ Psychiatric Disease:_____ □Lung Disease:_____
□Diabetes:_____ □Asthma:_____ □ Epilepsy/Seizures:_____ □Brain Tumor:_____
□Migraine:_____ □ Headaches:_____ □Other: _____

Women only:
Date of last mammogram _____ □Normal □Abnormal:_____
History of pregnancies: _____
_____

Other Comments:
_____
_____
_____

The above information is true and correct to the best of my belief.

_____ _____
Patient's Signature Date

As of January 1, 2010

Notice to my patients:
I regret to have to inform you, it has been impossible for me to obtain affordable malpractice insurance.

I will follow the Florida State Statutes.

"Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law"

Sincerely,

A. Enrique Whittwell, M.D.
Surgical Solutions of Miami, LLC.

Patient Signature:_____Date: _____

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DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act of 1996, you have the right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocations of your copy of this form found at the bottom of the page and returning it to this office.

Patient Name _____ Date of Birth: _____

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information.

Name: _____Telephone _____

Address: _____

What relationship is this person to you? _____

This person is to be afforded all the privileges that would be afforded to me with respect to my protected health information.

I understand that I may revoke this designate on at any time by signing the revocations sections of my copy of this form found below and returning to A. Enrique Whittwell, M.D., 6705 Red Road, #416, Miami, Florida 33143. I further understand that any such revocations does not apply if that person or person's authorized use or disclosure of my protected health information have already taken action on my behalf.

_____ _____
Patient's Signature Date

I HEREBY REVOKE THIS DESIGNATION OF A PERSONAL REPRESENTATIVE.

_____ _____
Patient's Signature Date