PATIENT INFORMATION FORM

DR. VICENTE SILVA

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Birthdate: ____/____/____

Phone: (____) _____ - _____ Please Indicate: Cell ☐ Home ☐

Driver's License #: _____ Social Security #: _____-____-_____

Martial Status: Married ☐ Single ☐ Divorced ☐ Widow ☐

Do You Have a Primary Care Physician?: Yes ☐ No ☐ If So Name: _____

Primary Care Physician Phone: (____) _____ - _____

Primary Language Spoken at Home: _____

**Person Responsible for Bill: _____

_____

Your Occupation: _____ Employer Name: _____

Employer Address: _____

Business Phone: (____) _____ - _____ Please Indicate: Cell ☐ Business ☐

In Case of Emergency Notify: _____ Relationship: _____

Phone: (____) _____ - _____ Please Indicate: Cell ☐ Home ☐

Spouse Name: _____ Spouse Social Security #: _____-____-_____

Spouse Employer Name/Address: _____

Business Phone: (____) _____ - _____ Please Indicate: Cell ☐ Business ☐

INSURANCE INFORMATION

1st Insurance Company Name: _____

Address: _____ Contact/Policy/or ID#: _____

Group Name: _____ Please Indicate: Group ☐ Private ☐

Name of Subscriber: _____ Birthdate: ____/____/____

2nd Insurance Company Name: _____

Address: _____ Contact/Policy/or ID#: _____

Group Name: _____ Please Indicate: Group ☐ Private ☐

Name of Subscriber: _____ Birthdate: ____/____/____

PHYSICIANS RELEASE AND ASSIGNMENT

I HEREBY AUTHORIZE PAYMENT TO DR. VICENTE SILVA, M.D. OF BENEFITS DUE TO ME FROM MY INSURANCE COMPANY OTHERWISE PAYABLE TO ME. SHOULD I FORGO MY INSURANCE AND PAY FOR SERVICES OR USE OUT OF NETWORK BENEFITS I UNDERSTAND THAT MY PHYSICIAN WILL NOT SUBMIT CLAIMS TO THE INSURANCE COMPANY NOW OR IN THE FUTURE. THEREFORE, I WILL BE SOLEY RESPONSIBLE FOR ALL SERVICES. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER(S). A COPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIES ANY INFORMATION NEEDED FOR OR RELATED MEDICARE CLAIM. I REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

Patient Signature: _____ **Date:** _____

PATIENT VISIT INFORMATION

Name: _____ **DOB:** _____ **Date** _____

☐ **I am here today for a Well woman visit**

☐ **I am here with a specific issue I need evaluated, which is** _____

☐ **I am here for both reason**

Update Medical History Since Last Visit

Medical Conditions

_____

_____

_____

Self: ☐ **Thrombo-emboli (Blood clots)** ☐ **Diabetes** ☐ **Heart Disease**

Current Medications

(Name and dosage)

_____

_____

_____

Family Cancer History

Type of Cancer	Family Member

(Type and family member)

Allergies: ☐**None** ☐ Seasonal ☐IV contrast ☐Penicillin ☐Sulfa ☐Surgical tape

☐Iodine ☐Latex ☐**Other**

Other: _____

First day of last period: _____ ☐**MENOPAUSE**

Last Mammogram: _____ ☐ **N/A**

When was your last visit to general/primary doctor? _____

LAB : ☐ **QUEST** ☐ **LAB CORP**

Signature _____

Vicente Silva, MD

COVID-19 Patient Health Survey

For Your Safety and that of others please answer the following questions: Thank you for your cooperation.

- Have you traveled by air or sea to an affected geographic area that is known to be associated with COVID-19?

  Yes_____ NO_____

  If your response is yes, where and when did you travel?

  _____
  _____
  _____

- Have you recently come in close contact with a laboratory-confirmed COVID-19 patient?

  YES_____ NO_____

  If your response is yes, when did you encounter this patient?

  _____
  _____
  _____

- Are you experiencing a fever, chills, cough, sore throat, runny nose, loss of taste or smell and /or having trouble breathing?

  YES_____ NO_____

  If your response is yes, when did these symptoms start?

  _____
  _____
  _____

Patient Signature: _____ Date: _____

VICENTE A. SILVA, M.D., F.A.C.O.G.
DIPLOMATE AMERICAN BOARD OF OBSTECTRICS & GYNECOLOGY

700 N. HIATUS ROAD, SUITE 211
PEMBROKE PINES, FL 33026
(954) 437-3700
FAX: (954) 437-1204

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I consent to medically indicated physical/gynecological examinations which may include, but may not be limited to the following:

A female gynecological exam including a pelvic and/or breast exam.
An ultrasound exam which may include a probe placed in the vagina.
A medically indicated rectal exam.
A testing procedure which may include a probe placed into the vagina and/or rectum during a pelvic support treatment procedure.

This examination will be performed by any provider from Vicente Silva, M.D., LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient

_____

Signature of Patient or Patient's Representative if under 18

_____

Date _____

VICENTE SILVA, M.D., LLC
700 North Hiatus Road., Suite 211
Pembroke Pines, FL 33026

PHARMACY INFORMATION

(Please print)

Pharmacy name: _____

Address: _____

Street City State Zip code

Phone number: _____

☐PRFERRED LOCATION

Pharmacy name: _____

Address: _____

Street City State Zip code

Phone number: _____

Patient Name: _____

Last First M

Date of Birth (MM/DD/YYYY): _____

Patient Signature: _____