Jose Iparraguirre,MD *Spencer Kellogg,MD* Antonio Monzon,MD* LarrySpiegelman,MD*Peter Khamvongsa,MD Elizabeth Updike,MD*Ramon Sanchez-Rauder,MD*Daniel Bolet,MD*Michael Muresan,MD*Cristina Travieso,ARNP

PATIENT INFORMATION

Date____________________
Fecha

Patient Name ________________________________
Nombre del Paciente
Home Address ______________________________
Direccion de Hogar *APT #*
City ______________ **State** _____ **Zip Code** __________
Ciudad *Estado* *Codigo Postal*
Occupation ____________________ **Dept.** ________
Ocupacion del Paciente
Employer ________________________________
Empleo
Work Phone # ____________________**X.**________
Telefono del Trabajo
Drivers License No. (*please present for copying)*
Licensia de Conducir
Referred by ________________________________
Referido Por
Emergency Contact ___________________________
Contacto de Emergencia
Religion__________________________________
Religion
Pharmacy Name:______________________________
Nombre de farmacia
Race (Raza)_________________________________

Home Phone _______________________
Telefono del Hogar
Cell Phone _______________________
Telefono celular
Date of Birth _______________________
Fecha de Nacimiento
Social Security # ____________________
Numero de Seguro Social
Work Address _______________________
Direccion del Trabajo
(Address)__________________________
Direccion del Trabajo (linea 2)
Primary Language____________________
Lengua principal
Marital Status _______________________
Estado Civil
Emerg. Phone _______________________
Telefono de contacto de emergencia
E-mail address_______________________
Correo electronico
Pharm #___________________________
Telefono de farmacia

SPOUSE/PARENT INFORMATION

Name ________________________________
Nombre del Esposo/Pariente
Occupation ___________________________
Ocupacion
Employer _____________________________
Empleo

Date of Birth _______________________
Fecha de Nacimiento
Cell phone______________ **X.**________
Telefono del Trabajo
Other Phone _______________________
Otro teléfono

INSURANCE INFORMATION

INSURANCE CARDS MUST BE SUBMITTED FOR COPYING AT THE TIME OF APPOINTMENT AND MUST INCLUDE THIS INFORMATION: Name of insurance company, address to mail claims, toll free number for claim status, group number, policy number, name of subscriber, date of birth of subscriber, subscriber emloyer____

FEES AND INSURANCE INFORMATION

All office fees are payable at the time that the service is rendered or may be charged to Visa,MasterCard or American Express card. Your medical insurance is a contract between you and your insurance carrier and the terms of the policy vary according to the terms of your policy. **Interest of 1 ½ % per month will accrue on any patient balance still outstanding after 60 days. Any balance over 90 days past due will incur a $20.00 late fee.** Final payments 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 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 servicios deben de ser pagado al recibir el servicio o pueden ser cargados a su tarjeta de Visa, MasterCard, o American Express. Su seguro es un contrato entre usted y esa compania.* ***Un interes de 1 ½% mensual sera cargado al balance de la cuenta del paciente si no es liquidado dentro de 60 dias. Cualquier balance de más de 90 díasde vencida incurrirán en un recargo de $20.00.*** *Pagos por nuestros servicios dependen de los terminos de este contrato que usted tiene con esa compania. El pago final de todos los cargos es responsabilidad del paciente. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable por los gastos incurrido de corte o abogado.*

PHYSICIAN'S RELEASE & ASSIGNMENT

I hereby authorize payment directly to the doctors of all benefits applicable and otherwise payable to me from my insurance carrier, HMO, or any other third party payor, for services. I understand that I am financially responsible for any and all charges which the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for the payment of insurance benefits. *Por la presente autorizo el pago directamente al doctors de los beneficios que a mi me corresponden de mi compania de seguros. Por mi firma doy permiso a transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos incurrido lo cual no pague mi seguro o cargos los cuales no son cubierto bajo mi contrato con mi seguro.*

DATE______________________ **PATIENT'S SIGNATURE** ________________________________

*Jose Iparraguirre,MD*Spencer Kellogg,MD*Antonio Monzon,MD*Larry Spiegelman,MD*
*Peter Khamvongsa,MD*Elizabeth Updike,MD*Michael Muresan,MD*Ramon Sanchez-Rauder,MD*
*Daniel BoletMD*Cristina Travieso,ARNP*

Effective Date: April 14, 2003

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of the Notice of Privacy Practices for the doctors listed on this letterhead, describing how my health information may be used or disclosed under the federal law. Provided that the above-named doctors continue in their good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purposes and the activities permitted under the federal privacy law which are described in the Notice of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (305) 595-4070 or my requesting one at your office.

Patient Name ____________________ Date

Signature of Patient or Personal Representative ____________________ Relationship to Patient

The date that signature was requested ____________________

The reason that the date and signature were not obtained ____________________

*******PLEASE READ AND SIGN BELOW*******

I hereby give permission to discuss my account status or medical history with the office staff with the person(s) named below:

Name of person who can speak to office staff: **Relationship:**

____________________ ____________________

____________________ ____________________

____________________ ____________________

☐ **No information may be given to anyone other than myself**

____
(Patient Signature)

Patient:______________________________ **Date:**________________

Review of Systems

Do you now or in the last month have problems related to the following systems? Please Circle Yes or No.

Constitutional Symptoms:

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other:		

Eyes:

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Do you wear contacts or lenses?	Y	N

Allergic/Immunologic:

Hay Fever	Y	N
Drug Allergies	Y	N

Neurological:

Numbness	Y	N
Tingling	Y	N
Memory Problems	Y	N

Endocrine:

Excessive Thirst	Y	N
Hot Flashes	Y	N
Too Cold	Y	N

Gastrointestinal:

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N

Cardiovascular:

Chest Pain	Y	N
High Blood Pressure	Y	N
Palpitations	Y	N

Integumentary:

Skin Rash	Y	N
Breast Pain	Y	N
Breast Mass	Y	N
Nipple Discharge	Y	N

Musculoskeletal:

Joint Pain	Y	N
Back Pain	Y	N

Ear/Nose/Throat/Mouth:

Ear Pain:	Y	N
Sore Throat	Y	N
Hearing Loss	Y	N

Genitourinary:

Urine Leaking	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Vaginal Discharge	Y	N
Pain with Intercourse	Y	N

Respiratory:

Wheezing	Y	N
Shortness of Breath	Y	N

Hematologic/Lymphatic:

Blood Clotting Problems	Y	N

Psychiatric:

Do you feel depressed?	Y	N
Have you considered suicide?	Y	N
Anxiety	Y	N

Patient Name: ______________________________ Date of Birth: ___________

Last Menstrual Period ______________________

- **Current Medication**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

- **Medical History**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

- **Surgery History**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

- **Allergies**

____________________ ____________________ ____________________

____________________ ____________________ ____________________