

Jose Iparraguirre,MD * Antonio Monzon,MD* Larry Spiegelman,MD* Elizabeth Updike MD* Ramon Sanchez-Rauder MD*
Gabriel Valverde-Tavarez MD*Michael Muresan MD*Nicole Cruz MD*Cristina Travieso,ARNP, Yalenis Perez, ARNP

PATIENT INFORMATION

Date _____
Fecha

Patient Name _____

Nombre de/ Paciente

Home Address _____

HomePhone _____

Telefono de/ Hagar

CellPhone _____

Direccion de Hagar _____ *APT#* _____

City _____ **State** _____ **Zip Code** _____

Telefono celular

Date of Birth _____

Ciudad _____ *Estado* _____ *Codigo Postal* _____

Occupation _____ **Dept.** _____

Ocupacion de/ Paciente

Employer _____

Empleo

Work Phone# _____

Telefono de/ Trabajo

Drivers License No. *(please present/or copying) Licencia*

de Conducir

Referred by _____

Referido Por

Emergency Contact _____

Contacto de Emergencia

Religion _____

Religion

Pharmacy Name: _____

Nombre defarmacia

Race (Raza) _____

Fecha de Nacimiento

Social Security# _____

Numero de Seguro Social

Work Address _____

Direccion de/ Trabajo

(Address), _____

Direccion de/ 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 de/ Esposo/Pariente

Occupation _____

Ocupacion

Employer _____

Empleo

Date of Birth _____

Fecha de Nacimiento

Cell phone. _____

Telefono de/ Trabajo

Other Phone _____

Otro telefono

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 employer. _____

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 pagados 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 compañía. Un interés de 1½% mensual será cargado al balance de la cuenta de/ paciente si no es liquidado dentro de 60 días. Cualquier balance de más de 90 días de vencida incurrirá en mi recargo de \$20.00. Pagos por nuestros servicios dependen de los términos de este contrato que usted tiene con esa compañía. El pago final de todos los cargos es responsabilidad de/ paciente. Si es necesario tomar acción legal para cobrar esta deuda, usted es responsable por los gastos incurridos 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 doctor de los beneficios que a mi me corresponden de mi compañía de seguros. Por mi firma doy permiso a transferir documentos relacionados a mi tratamiento médico a mi compañía de seguro para procesar mi reclamación. Yo entiendo que soy responsable por todos los cargos incurridos lo cual no pague mi seguro o cargos los cuales no son cubiertos bajo mi contrato con mi seguro.*

Jose Iparraguirre,MD Antonio Monzon,MD*Larry Spiegelman,MD *Elizabeth
Updike,MD*Michael Muresan,MD *Ramon Sanchez-Rauder MD* Gabriel Valverde-Tavarez MD
Nicole Cruz MD*Cristina Travieso ARNP*Yalenis Perez ARNP*

**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:		

integumentary:

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

Eyes:

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

Musculoskeletal:

Joint Pain	y	N
Back Pain	y	N

Allergic [immunologic:

Hay Fever	y	N
Drug Allergies	y	N

Ear [Nose [Throat [Mouth:

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

Neurological:

Numbness	y	N
Tingling	y	N
Memory Problems	y	N

Genitourinary:

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

Endocrine:

Excessive Thirst	y	N
Hot Flashes	y	N
Too Cold	y	N

Respiratory:

Wheezing	y	N
Shortness of Breath	y	N

Gastrointestinal:

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

Hematologic [Lymphatic:

Blood Clotting Problems	y	N
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Cardiovascular:

Chest Pain	y	N
High Blood Pressure	y	N
Palpitations	y	N

Psychiatric:

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

PatientName: _____

DateofBirth: _____

Last Menstrual Period _____

Current Medication

_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgery History

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

_____	_____	_____
_____	_____	_____