



Pedro M. Soler, M.D.

PATIENT INFORMATION (INFORMACION DEL PACIENTE)

PLEASE PRINT ALL INFORMATION CLEARLY (FAVOR DE ESCRIBIR TODA INFORMACION CLARAMENTE)

LEGAL Last Name (Apellido legal) LEGAL First Name (Nombre legal) MI (Inicial)

D.O.B. (Fecha de Nacimiento) Age (Edad) Sex (Sexo) Race (raza)

Social Security # (seguro social del paciente) Marital Status (Estado Marital): Single (Soltero) Married (Casado) Separated (Separado) Divorced (Divorciado) Widowed (Viudo)

Address (Dirección) City (Ciudad)

State (Estado) Zip Code (Codigo Postal) Home # (# de la casa)

Cell Phone (# de celular) Work Phone (# del trabajo)

IF PATIENT IS A CHILD (SIEL PACIENTE ES UN NIÑO):

Mother's Name (Nombre de la Madre) SS # (# de seguro social) DOB (Fecha de Nacimiento)

Father's Name (Nombre del Padre) SS # (# de seguro social) DOB (Fecha de Nacimiento)

MUST BE FILLED OUT!! PERSON OTHER THAN PARENT TO NOTIFY IN CASE OF EMERGENCY (EN CASO DE EMERGENCIA OTRA PERSONA A NOTIFICAR QUE NO SEAN LOS PADRES)

Emergency Contact Name (Nombre en caso de emergencia) Relationship to patient (Relación al paciente) Phone # (Teléfono)

REFERRING PHYSICIAN (MÉDICO QUE REFIERE EL CASO)

PRIMARY CARE PHYSICIAN (DOCTOR PRIMARIO)

Name (Nombre) Address (Dirección)

Name (Nombre) Address (Dirección)

Phone (Teléfono) Fax

Phone (Telefono) Fax

May we provide the above physicians with a copy of Dr. Soler's office note(s): Yes No Si No

If yes, please sign below. Si podemos, porfavor firme abajo.

OFFICE USE ONLY: PRE-OP PHOTOS: POST-OP PHOTOS:

Signature/ (firma) NICKNAME



This Information Is Necessary, Please Complete (Esta Información Es Necesaria, Por Favor llene)

INSURANCE INFORMATION (INFORMACIÓN DEL SEGURO MÉDICO)

Primary Insurance Company _____ Subscriber _____
(Compañía de Seguro Primario) (Subscripción a Nombre de)

Subscriber's SS# _____ Subscriber's Date of Birth _____ Relationship to patient _____
(Seguro Social del Asegurado) (fecha de nacimiento) (Relación al Paciente)

Group#/Name _____ Policy / ID # _____
(Grupo #/Nombre) (# de polisa o de Identificación)

SECONDARY INSURANCE INFORMATION (INFORMACIÓN DEL SEGURO MÉDICO secundario)

Primary Insurance Company _____ Subscriber _____
(Compañía de Seguro Primario) (Subscripción a Nombre de)

Subscriber's SS# _____ Subscriber's Date of Birth _____ Relationship to patient _____
(Seguro Social del Asegurado) (fecha de nacimiento) (Relación al Paciente)

Group#/Name _____ Policy / ID # _____
(Grupo #/Nombre) (# de polisa o de Identificación)

Please answer ALL questions.

What is your reason for today's visit? _____

When did this problem start? _____

Where is this problem located? _____

What makes this problem worse? _____

Are there any other symptoms associated with this problem? Yes No If yes, describe:



WEIGHT _____ HEIGHT _____

Please check all that apply

Cold Sores/Oral Herpes	Yes	No	Bleed Easily	Yes	No	Nose Obstruction	Yes	No
Skin Rashes	Yes	No	Heart Condition	Yes	No	Swelling of Neck	Yes	No
Blurred Vision	Yes	No	Heart Murmur	Yes	No	Headaches	Yes	No
Wear Contacts	Yes	No	Scarlet Fever	Yes	No	Stroke	Yes	No
Glaucoma	Yes	No	Stomach/Ulcer	Yes	No	Asthma	Yes	No
Ear Trouble	Yes	No	Bowel Problems	Yes	No	Paralysis	Yes	No
Deafness	Yes	No	Constipation	Yes	No	Convulsions/Seizures	Yes	No
Dizzy Spells	Yes	No	Hepatitis	Yes	No	Shortness of breath	Yes	No
Sinus Trouble	Yes	No	Low Blood Sugar	Yes	No	Bronchitis	Yes	No
Nose Bleeds	Yes	No	Diabetes	Yes	No	Depression	Yes	No
Emphysema	Yes	No	Arthritis	Yes	No	Pneumonia	Yes	No
Back Pain	Yes	No	Tuberculosis	Yes	No	Fevers	Yes	No
Chest Pain	Yes	No	Anemia	Yes	No	Bleeding Disorder	Yes	No
High Blood Pressure	Yes	No	Heart Attack	Yes	No	Ankles Swell	Yes	No
Cancer	Yes	No	Cancer? When? Year & Type	_____				
Complications from Anesthesia?	YES	NO	Reactions?	_____				

List previous hospitalizations, operations and serious injuries:

Year	Reason for hospitalization	Hospital/Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medications you are currently taking:

<u>DRUG</u>	<u>DOSE</u>	<u>FREQUENCY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate if you are currently taking any of the following. Aspirin or Aspirin products, any Diet pills, St. John's Wart, Ginseng, Ibuprofen, Advil, Motrin, etc. Which one/s? _____



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ALLERGIES

Penicillin: ___ Yes ___ No Effect/s _____
Novocain/Xylocaine: ___ Yes ___ No Effect/s _____
Other Medication/s: _____ Effect/s _____
Allergic to Latex: ___ Yes ___ No Effect/s _____

Past Medical/Family/Social History: (Check all that apply)

Has anyone in your family had Cancer? ___ Yes ___ No Who? _____
Heart problems? ___ Yes ___ No Do you smoke? ___ Yes ___ No
If yes, how many packs per day _____ How many years ___ Do you drink alcohol? ___ Yes ___ No
(If yes- ___ socially or ___ binge on weekends) Do you drink coffee? ___ Yes ___ No Cups per day _____

WOMEN ONLY

Tender Breasts? ___ Yes ___ No Nipple Discharge? ___ Yes ___ No
Lumps or recent change in Breast? ___ Yes ___ No Which breast? ___ left ___ right
Menstrual Problems? ___ Yes ___ No Fibrocystic Disease? ___ Yes ___ No
Birth Control Pills? ___ Yes ___ No Birth Control method: _____
How many Pregnancies: _____ Live Births _____

Patient's Name _____ Date of Birth _____

Patient/Guardian Signature
DATE

Date

PHYSICIAN'S SIGNATURE



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HIPPA Compliance Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
• A means of communication among the health professionals who contribute to my care,
• A source of information for applying my diagnosis and treatment information to my bill,
• A means by which a third-party payer can verify that services billed were actually provided,
• A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the "Notice of Patient Privacy Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "Notice" prior to acknowledging this consent,
• The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
• The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

May discuss treatment, payment or healthcare operation with the following persons:

(Please check all that apply) Spouse Your Children Relatives Other Parents

Please list the names and relationships, if you checked "Relatives" or "Others" above:

- 1. _____ 3. _____
2. _____ 4. _____

Additional: _____

Messages or Appointment Reminders: (Please check all that apply)

May we leave a message on your answering machine at home or at work . Do not leave a message

May we leave a message with someone at your home using the doctor's name or the practice name: Yes No

May we leave a message with someone at your work using the doctor's name or the practice name: Yes No

Messages will be of a non-sensitive nature, such as, Dr's name, appointment time & date.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand and accept the information provided by this consent.

Signature Print name of person signing Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes No

FOR OFFICE USE ONLY

- [] Patient refused to sign the consent form. (Date) _____ Witnessed by: _____
[] Restrictions were added by the patient (see restrictions listed above)
[] "Consent form" received and reviewed by _____ on (date) _____ placed in MR (date) _____