Piñero Preventive Medical Care

∇ Rafael E Piñero MD ∇ Giovanni Vélez MD

● Claudia Zuriarrain DNP ● Christine Cernoch APRN

Date:_____

PLEASE PRINT LEGIBLY

PATIENT INFORMATION

Legal Name: Mr. Mrs. Ms._____
(Circle One) (Last) (First) (Middle)

Address:_____
(Street) (Apt. #) (City) (State) (Zip + 4)

Mailing Address:_____
(if different from above) (Street) (Apt. #) (City) (State) (Zip + 4)

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

E-Mail Address: _____

Patient's Occupation:_____ ☐ Patient's Employer or ☐ School:_____

☐ Child ☐ Single ☐ Divorced ☐ Married ☐ Widow Date of Birth:_____ Age:_____ ☐ M ☐ F

Patient's Social Security #: _____ Spouse Parent Guardian (Name):_____
(Circle One) (If Guardian, please provide copy of court order)

Former Primary Care (PCP):_____Address:_____Phone:_____

Referred By:_____

Preferred Language (Mark Only One) ☐ English ☐ Spanish

Race: (Mark Only One) ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Some Other Race ☐ Decline to State

Ethnicity (Mark Only One) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to State

COMPLETE SECTION BELOW IF YOU ARE A PARENT/GUARDIAN OF A MINOR PATIENT

Legal Name: Mr. Mrs. Ms._____ ☐M ☐ F D.O.B._____ SS#: _____
(Check One) (Last) (First) (Middle)

Mailing Address:_____
(Street) (Apt. #) (City) (State) (Zip + 4)

Home Phone: (____)_____ Work Phone: (_____)_____ Relationship to Patient: _____

Employer of Responsible Party: _____Name of Spouse: _____

INSURANCE COMPANY INFORMATION (*Complete and give us your card to copy.)*

Name of Primary Insurance: _____

Primary Insured's Name:_____D.O.B._____ Social Security #: _____

If insurance card is not available, please fill in the following information on your primary insurance:

Claim Address: _____
(Street) (City) (State) (Zip + 4)

Ins. Co. Phone:_____Group Name or No._____I.D. No._____

Name of Secondary Insurance: _____

Primary Insured's Name:_____D.O.B._____ Social Security #: _____

If insurance card is not available, please fill in the following information on your secondary insurance:

Claim Address: _____
(Street) (City) (State) (Zip + 4)

Ins. Co. Phone:_____Group Name or No._____I.D. No._____

Continued on other side

Signature Required in Two Places

PLEASE READ AND FILL OUT COMPLETELY

Please list any family members or significant others that you give your authorization for this practice to discuss any emergency and/or non-emergency medical/billing issues, if you are not readily available. For example, if someone were to call on your behalf, they need to be listed here. ***If none, write "None".***

Name, Relationship To You and Phone Number: _____

You are responsible for notifying this practice of any changes to this list.

FINANCIAL POLICY PLEASE READ

Payment of charges are due at the time service is rendered. This is to include all co-pays, co-insurance, deductible and form fee amounts. PPMC will submit a claim to your insurance company for reimbursement however, financial responsibility remains with the patient. Any amount not covered by the insurance company is due from the patient. Accounts that have balances that are over 90 days past due will be turned over to a collection agency unless previous payment arrangements have been made.

NO SHOW/SAME DAY CANCELATION

All appointments require a **24-hour notice of cancellation**. Patient's will be charged a $25.00 No Show Fee if this notice is not given.

FORMS/MEDICAL CERTIFICATIONS

A $30.00 fee will be charged for forms. (INCLUDING: FMLA, Disability, Certificates of Clearance, etc.)

A $15.00 fee will be charged for an extension of work/school excuse note.

PATIENT RESPONSIBILITY

All patients are responsible for knowing the requirements of their insurance plans, including which labs and radiology facilities they may use, what services are covered, etc. Our staff will assist our patients, but we cannot be responsible for knowing or interpreting the benefits of each individual policy.

PLEASE READ AND SIGN THIS PATIENT CONSENT:

I hereby give my consent for any and all examinations, treatment, therapy, care, anesthetics, ear cleaning, administration of medications, and diagnostic procedure during the course of my care. The risks and complications may include but are not limited to bleeding, infection, damage to adjacent tissues or organs, swelling, pain, anesthesia, or medication reactions.

Signature: _____ **Date**: _____

YOUR SIGNATURE WILL SERVE FOR ANY OR ALL OF THE FOLLOWING:

I hereby give consent to Piñero Preventive Medical Care to provide the necessary treatment the assigned provider and I have discussed.

I am aware that payment is expected at the time service is rendered.

Notice of Office Policies and Privacy Practices: I have received the Notice of Office Policies and Privacy Practices.

Authorization of Medical Release: I authorize any physician examining and/or treating me to release to any third party (such as an insurance company or government agency) any medical information requested for use in determining claim for payment. I also request payment benefits either to myself or to the party who accepts assignment.

Lifetime Signature Authorization for Medicare: I authorize the release of any medical information necessary to process a claim. I also request payment benefits either to myself or to the party who accepts assignment.
Insurance Authorization (applies only as stated above): I authorize payment of medical benefits to the attending physician for services described.

I permit a copy of these authorizations and assignments to be used in place of this original that is on file at the physician's office.

Signature:_____**Date**:

Responsible Party

PATIENT HEALTH/MEDICATION HISTORY

Full Name: _____ Date of Birth: _____ Age: _____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your physician to know that you have carefully reviewed every area of this form.

What is the main reason you are here to see the physician today?

_____

How long have you been experiencing this problem?
___ Hours ___ Days ___ Months ___ Years

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

CURRENT MEDICATIONS
Are you taking ANY kind of medication now? This includes prescription, over-the-counter or herbal medications. ___Yes ___No

Medication Name	Dosage	How Often Taken

Medication Allergies: Are you allergic to any medications ____ Yes ____ No
If yes, please list below:

Medication Name	Type of Reaction (Rash, Swelling, Etc.)

Have You Had:
Influenza Vaccine: ___ Yes ___ No Most Recent **Month** and **Year** Received: _____
Pneumoccal Vaccine: ___Yes ___No Most Recent **Year** Received: _____
Tetanus Booster: ___Yes ___ No Most Recent **Year** Received: _____
Other Vaccines: _____

Do you have an advanced directive/medical living will: ___Yes ___ No If "Yes" please provide a copy to the office.