Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

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

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

***************LIVING WILL: YES [ ] NO [ ] ****************

PATIENT 'S / RESPONSIBLE PARTY INFORMATION

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

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

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

PATIENT'S REFERRAL INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

PHARMACY INFORMATION

Name: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

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

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to PRACTICE NAME, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

PATIENT CONSENT / ACKNOWLEDGEMENT FORM

By signing below, you consent to use and disclosure of your Protected Health Information by Rene A. Reyes, M.D. and/or Dayana Rubio, PA-C and/or Abner E. Sosa, PA-C and/or Mariana Racovita, PA-C, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our "Notice of Privacy Practices". This Notice of Privacy describes your rights and the doctor's duties with respect to your Protected Health Information. You have the right to review our Notice prior to signing this consent. The terms of the Notice may change. If the terms change, you may receive a revised Notice by simply calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of your next appointment.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for diagnosis, treatment, payment and health care operations, although we are not required to agree to these restrictions. However, is we disagree to these restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your Protected Health Information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information.

"Protected Health Information" means health information including demographic information, collected from you, the patient and received by your physician, another health care provider, health plan, employer or healthcare clearinghouse. This Protected Health Information relates to you past, present or future physical or mental health condition.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY. I CONSENT TO THE USE OR DISCLOSURE OF ANY PROTECTED HEALTH INFORMATION BY AURELIO R. REYES, MD AND/OR RENE A REYES, MD FOR THE PURPOSE OF DIAGNOSIS, TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I UNDERSTAND THAT MY DIAGNOSIS AND TREATMENT MAY BE CONDITIONEDUPON MY CONSENT AS EVIDENCED BY MY SIGNATURE ON THIS DOCUMENT. THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR "NOTICE OF PRIVACY" OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

Signature of Patient or Personal Representative: _____ Date: _____

PATIENT CONSENT TO RELEASE CONFIDENTIAL INFORMATION TO RELATIVE

- I, _____ hereby give consent to _____ (Relative's name and relationship to patient), to obtain the following information (circle the information we can release to the above mentioned person)
  Any information pertaining to my: [Lab results][medications][radiology reports][appointment info.][financial info.][mental health][all of the above]

- I, _____ **do not** give consent to any other person but myself to obtain information pertaining to my health.

Signature of Patient: _____ Date: _____

NO-SHOW POLICY

There is a $25 no-show/late-cancellation fee. All appointments must be cancelled by 12 p.m. of the previous day (or by 12 p.m. on Friday for a Monday appointment), to avoid charges for a no-show or late-cancellation. Insurance will not cover charges for no-show/late-cancellation or eligibility fees.

Signature of Patient: _____ Date: _____

R&R
Reyes and Reyes, MD, PA
Better Health Starts Here

Name _____ **Date of Birth** _____

Date _____ **Sex: M F**

Allergies	**Reaction**
1)	
2)	
3)	
4)	
5)	

Medications taken presently	**Dose**	**Times/day**
1)		
2)		
3)		
4)		
5)		

Past Medical History

- ☐ Diabetes
- ☐ Cancer _____
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Other heart trouble
- ☐ Asthma
- ☐ Pneumonia
- ☐ Stroke
- ☐ Epilepsy
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Chicken pox
- ☐ Valley fever
- ☐ Tuberculosis / (+) skin test
- ☐ Depression/anxiety
- ☐ Glaucoma
- ☐ Sexually transmitted disease
- ☐ Fractures _____

_____

- ☐ Headaches
- ☐ Neck problems
- ☐ Back problems
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Esphogeal reflux (GERD)
- ☐ Kidney/bladder disease
- ☐ Hepatitis
- ☐ Peptic ulcer
- ☐ Appendicitis
- ☐ Other stomach/bowel disease

Immunizations:

- ☐ Polio vac (year) _____
- ☐ MMR vac (year) _____
- ☐ DPT vac (year) _____
- ☐ Chicken Pox Vaccine
- ☐ Flu Shot in last 12 months
- ☐ Pneumovax (year) _____
- ☐ Tetanus (year) _____
- ☐ Hep B vac (year) _____

- ☐ Pap (mo./yr.) _____
- ☐ Mammogram (mo./yr.) _____
- ☐ Prostate exam (mo./yr.) _____
- ☐ Colonoscopy (mo./yr.) _____

Specialists (seen regularly)

- ☐ Cardiologist_____
- ☐ Chiropractor_____
- ☐ Allergist_____
- ☐ Other_____
- ☐ Pulmonologist_____
- ☐ Other_____

(Females only) ☐ Menopause

full term pregnacies_____ # premature deliveries_____

C-sections_____

During pregnancy did you have:
- ☐ high blood pressure
- ☐ diabetes
- ☐ pre-eclampsia or eclampsia

vaginal deliveries_____

miscarriages/abortions_____

Surgical History

- ☐ Tonsillectomy
- ☐ Knee / hip surgery
- ☐ Shoulder surgery
- ☐ Heart bypass
- ☐ Back surgery
- ☐ Appendectomy
- ☐ Thyroid surgery
- ☐ Prostate surgery
- ☐ Cataract R(___) L(___)
- ☐ Breast surgery / biopsy
- ☐ Gallbladder surgery
- ☐ Hysterectomy
- ☐ Vasectomy
- ☐ Hernia repair
- ☐ C-section
- ☐ Other _____
- ☐ Other_____
- ☐ Other_____

Family History

Circle major medical problems

Mother	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other_____
Father	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other_____
Brothers	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other_____
Sisters	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other_____
Children	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other_____
Grandmothers	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other_____
Grandfathers	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other_____

Social History

Occupation _____ **Hobbies/Activities** _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Tobacco ☐ never ☐ now ☐ quit
per day_____
Year quit _____
Age started_____

Alcohol use: ☐ never or
☐ Liquor _____ per day / week / month
☐ Beer _____ per day / week / month
☐ Wine _____ per day / week / month

Rec. Drugs: ☐ never ☐ now ☐ in past

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Please specify when was the last time you had the following tests/ exams:

TEST/ EXAM	DATE (MONTH AND YEAR)
Bone Density	
Colonoscopy	
Electrocardiogram (EKG)	
Eye Exam	
Physical Exam	
Mammogram	
Pap Smear	
Rectal Exam	
Prostate-Specific Antigen (PSA)	
Flu Vaccine	
Pneumonia Vaccine	

PHARMACY NAME AND NUMBER: _____

PHARMACY ADDRESS IF KNOWN: _____

PATIENT'S EMAIL ADDRESS: _____

LANGUAGE PREFERENCE: _____

SPECIALISTS SEEN REGULARLY:

SPECIALTY	**Name and Phone Number:**
_____	_____
_____	_____
_____	_____

Patient Signature: _____

Today's Date: _____