Piñero Preventive Medical Care
Patient Information Form

Patient Name_____ SS#_____

Address_____ DOB____/____/____ ___Male ____ Female

City_____ State_____ ZIP_____Driv Lic#_____State_____

Primary Phone#_____ ___home ____cell Ok to leave messages? Y or N

Secondary Phone#_____ ___home ____cell ____Other Ok to leave messages? Y or N

Email Address_____

Employer's Name_____ Occupation_____

Referred by_____

Marital Status (please circle one) Single Married Significant Other Divorced Widowed

Spouse's/Partner's Name_____

Emergency contact _____Ph #_____Relation to you_____

Person(s) OK to release appointment or medically related information to concerning you.

_____ Relation to you _____

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process claims. I further authorize Piñero Preventive Medical Care PA to apply for benefits on my behalf for covered services rendered by Piñero Preventive Medical Care PA. I request that payment from my insurance company be made directly to Piñero Preventive Medical Care PA.

Patient Signature_____**Date**_____

General Medical Information

Allergies to medications_____

Current Medications_____

_____

Do you take vitamins? Y or N What kind?_____How often?_____ Do you take other supplements? Y or N

Other physicians currently treating you._____

Do you smoke? Y or N or Previously No. of years? _____ How much? _____packs/week When did you quit?_____

Are you interested in stopping smoking? Y or N

Do you regularly drink alcohol? Y or N How many drinks per day?_____ How many drinks per week?_____

Do you regularly drink coffee or other caffeinated beverages? Y or N How many drinks per day?_____

Do you exercise regularly? (not including work related activities) Y or N How many times per week?_____

Immunizations (year last received if known, if never please indicate 'never')

Smallpox _____ Tetanus_____ Typhoid_____ Polio_____ Rubella_____

Hepatitis A_____ Hepatitis B_____ Pneumonia_____ Influenza (Flu Shot)_____ HPV_____

Other_____

Your Health History Checklist

Reviewed by_____

Patient's Name_____**Date form completed**_____

Preventive Tests and Screenings (please indicate the year last done)

- ☐ Physical Exam_____
- ☐ Blood Pressure Screening_____
- ☐ EKG (Electrocardiogram)_____
- ☐ Lipid Panel (Cholesterol Screening) _____
- ☐ Colonoscopy_____
- ☐ Pelvic Exam (women's pap smear)_____
- ☐ Prostate Exam (men)_____
- ☐ Eye Exam_____
- ☐ Cardiac Stress Test_____
- ☐ Skin Cancer Screening_____
- ☐ Upper GI Endoscopy_____
- ☐ Bone Density Test _____
- ☐ Mammogram (women)_____
- ☐ Other_____

Surgeries

- ☐ Abortion
- ☐ Angioplasty
- ☐ Anorectal surgery
- ☐ Arthroscopy
- ☐ Appendectomy
- ☐ Biopsy(any)
- ☐ Brain shunt
- ☐ Breast implants
- ☐ Cataract removal
- ☐ Cardiac Catheter
- ☐ Cholocystectomy
- ☐ Colostomy
- ☐ Coronary Artery Bypass
- ☐ Excisions during colonoscopy Endoscopy or cytoscopy
- ☐ Gastric Bypass
- ☐ Glaucoma surgery
- ☐ Hand or foot surgery
- ☐ Heart valve
- ☐ Hysterectomy
- ☐ Intestinal surgery
- ☐ Laminectomy
- ☐ Other_____
- ☐ Laparotomy
- ☐ Lasik vision surgery
- ☐ Lumpectomy
- ☐ Lung Surgery
- ☐ Mastectomy
- ☐ Other implants,(e.g. screws, joints, etc)
- ☐ Pacemaker
- ☐ Plastic surgery
- ☐ Radiation therapy
- ☐ Skin lesion excisions
- ☐ Skin Grafting
- ☐ Spinal Fusion
- ☐ Tonsillectomy
- ☐ Thyroid
- ☐ Tubal ligation
- ☐ Urinary diversion
- ☐ Uterine myomectomy
- ☐ Vascular surgery
- ☐ Vasectomy

Your Health History Checklist

Reviewed by_____

Chronic Conditions (long term)

Allergy (life threatening)	☐ Food ☐ Medications ☐ Latex ☐ Anesthetics ☐ Anaphylaxis
Blood & Lymphatic	☐ Anemia ☐ Bleeding Disorders ☐ Immune deficiency ☐ Thrombosis ☐ Need for anticoagulants ☐ Sickle Cell ☐ Thalassemia
Cancer	☐ List type and organ _____
Cardiovascular	☐ Hypertension (high blood pressure) ☐ Coronary artery disease ☐ Congestive heart failure ☐ Valvular disease ☐ Atrial fibrillation ☐ Aortic aneurysm ☐ Aortic dissection
Ear/Nose/Throat	☐ Chronic Sinusitis ☐ Hearing Impairment ☐ Tinnitus (ringing in ears) ☐ Vertigo (dizziness) ☐ Upper airway allergies (allergic rhinitis) ☐ Chronic laryngeal conditions
Endocrine	☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism
Eye/Vision	☐ Glaucoma ☐ Cataract ☐ Macular degeneration ☐ Color blindness ☐ Ocular misalignment ☐ Retinal abnormality (e.g. detachment, degeneration) ☐ Amblyopia (lazy eye)
Female Reproductive & Breast	☐ Infertility ☐ Cancer ☐ Endometriosis ☐ Ovarian cysts ☐ Uterine fibroids ☐ Menstrual problems ☐ Amenorrhea (lack of menstruation) ☐ Ectopic pregnancy ☐ Menopause ____ # of pregnancies ____ # of full term ____ # of miscarriages
Gastrointestinal	☐ Peptic ulcer ☐ Reflux esophagitis ☐ Pancreatitis ☐ Crohn's disease ☐ Ulcerative colitis
HIV/AIDS Opportunistic infections	☐ HIV year diagnosed _____ ☐ PCP ☐ MAI ☐ Cytomegalovirus ☐ Toxoplasmosis ☐ Cryptococcus ☐ Other_____
Kidney & Urologic (urinary tract) **Disease**	☐ Anatomic abnormalities ☐ Chronic infections ☐ Kidney stones ☐ Glomerulonepritis ☐ Nephrotic syndrome ☐ Enlarged Prostate ☐ Chronic prostatitis ☐ Ischemic bowel disease
Liver	☐ Cirrhosis ☐ Biliary tract disease ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Gallstones
Male Reproductive	☐ Infertility ☐ Erectile dysfunction

Your Health History Checklist

Reviewed by_____

Chronic Conditions (long term)

Musculoskeletal / Joint	☐ Degenerative arthritis ☐ Rheumatoid arthritis ☐ Lupus ☐ Lyme arthritis ☐ Gout ☐ Osteoporosis
Neurologic	☐ Stroke ☐ Aneurysm ☐ Parkinson's disease ☐ Multiple sclerosis ☐ Headaches ☐ Seizure disorder (epilepsy) ☐ Alzheimer's / dementia ☐ Peripheral neuropathy ☐ Spina bifida
Psychiatric	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Pre-menstrual syndrome (PMS)
Respiratory	☐ Asthma ☐ COPD ☐ Cystic fibrosis ☐ Pulmonary embolus (blood clot to lung) ☐ Pulmonary hypertension ☐ Pulmonary fibrosis ☐ Pleural effusion ☐ Collapsed lung ☐ Tuberculosis
Skin	☐ Dermatitis / Eczema ☐ Psoriasis ☐ Skin cancer(s)
Sleep Disorders	☐ Sleep apnea ☐ Narcolepsy ☐ Chronic insomia ☐ Cataplexy ☐ Somnambulism
Other Chronic Conditions	☐ Chronic Pain ☐ Other_____

Family Health History

(please list pertinent illnesses/diseases)

Mother _____

Father _____

Sister(s)/Brother(s)_____

_____

Grandparents_____

_____

PINERO PREVENTIVE MEDICAL CARE, P.A.

1720 S. Orange Ave, Suite 500, Orlando, FL 32806
T. 407-426-9693 F. 407-426-9694

OUR FINANCIAL POLICY

Thank you for choosing Pinero Preventive Medical Care, PA as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions.

- **We will verify your insurance coverage at every visit. It is your responsibility to supply us with all current insurance information.**
- **We require a 24 hour notice of appointment cancellation. Patients will be charged a $25.00 missed appointment fee if notice is not given.**
- **A $10.00 fee will be assessed to co-payments if not paid at the time of service.**
- **A $5.00 fee will be charged for copies of lost lab orders, referral orders and prescriptions.**
- **A $25.00 fee will be charged for all forms (i.e. FMLA, Medical Certificates of Clearance, FAA Pilot Clearances, etc)**
- **Full payment is due at the time of service unless a prior arrangement has been made with the office.**
- **We accept cash, checks, money orders, Visa, MasterCard and CareCredit Cards ($300 Min.)**
- **A $25 fee will be assessed for returned checks.**
- **When labs or other tests are ordered by our providers, you are responsible to check with your insurance company as to where you are authorized to have these studies done. We will not be responsible for any bill if you have a test done at the wrong laboratory. It will also be your responsibility to check with your insurance and your authorized laboratory if there is any restriction regarding certain tests that may not be covered by your insurance.**

As a courtesy to our patients, we will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit second insurance claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of your services will or will not be covered by your particular plan. The patient is responsible to know the rules of their health plan. I hereby authorize Pinero Preventive Medical Care, PA, to release any medical information required in the course of examination and treatment and permit payment directly to them for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible and non-covered services.

I have read, understood and agree to the Financial Policy (above).

_____ _____

Signature of Patient or Responsible Party Date

FOR OUR MEDICARE PATIENTS — MEDICARE AUTHHORIZATIONS

I request that payment of authorized Medicare benefits be made on my behalf to Pinero Preventive Medical Care, PA, for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap benefits be made on my behalf to Pinero Preventive Medical Care, PA, for any services furnished to me by their providers. I authorize any holder of Medicare information about me to release to my Medigap insurance carrier any information needed to determine these benefits payable for related services.

_____ _____

Signature of Patient or Responsible Party Date

Witness:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS (PHI)

AUTORIZACIÓN PARA DIVULGACIÓN DE INFORMACIÓN MÉDICA

Records Requested (To Be Completed by Office):
Información a ser revelada (Para ser Completado por la Oficina)

- ☐ **Last Office Note and Labs**
  Ultima Visita y Laboratorios
- ☐ **ALL Medical Records**
  Todos los registros médicos
- ☐ **Previous Year Medical Records ONLY**
  Regristros Médicos del Pasado Año **SOLAMENTE**
- ☐ **Records from Admission Date:**
  Regístros Médicos de Admisión / Fecha: _____
- ☐ **Other (Ex. Radiography)**
  Otros (Ej., Radiografías): _____

Name (Nombre):_____ **DOB** (Fecha de nacimiento):_____

Address (Dirección):_____ **Phone** (Teléfono):_____

City/State (Ciudad/Estado):_____ **Zip Code** (Código Postal):_____

At my request, I authorize:
Por mi pedido, Autorizó a:

_____	(____)_____	(____)_____
Physician or Practice Name (Médico ó Practica Médica)	Phone # (Número de Teléfono)	Fax # (Número de Fax)
_____	(____)_____	(____)_____
Physician or Practice Name (Médico ó Practica Médica)	Phone # (Número de Teléfono)	Fax # (Número de Fax)

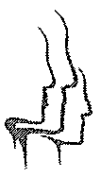
to release my medical records (PHI) to Piñero Preventive Medical Care, PA. For the purposes of continuing care.
a divulgar mis registros médicos a Piñero Preventive Medical Care, PA para continuación de tratamiento médico.

I authorize the release of all information from my medical record. Unless otherwise indicated, my authorization includes the release of the following (Please strike through those you wish to exclude if any):
Autorizó a divulgar información sobre pruebas, diagnósticos y tratamiento incluyendo los siguientes (Favor traze una linea a los que no desee incluir):

Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency. (Consumo de drogas y/o alcohol)
Diagnosis and/or treatment regarding mental health issues. (Trastornos psiquiátricos/de salud mental)
HIV/AIDS test results diagnosis or treatment. (Pruebas y/o diagnósticos de VIH, virus del SIDA)
Genetic test results and/or related issues. (Pruebas Genéticas y/o problemas relacionados)

I understand this authorization shall be in effect for one (1) year from the date signed. However, I understand that this authorization my be revoked at any time by giving oral or written notice to PPMC. If I do revoke the authorization it will not have any effect on actions the PPMC took before the revocation was received. I understand that my treatment or continued treatment by PPMC is in no way conditioned on whether of not I sign this form.
Comprendo que no tengo que firmar esta autorización para obtener beneficios de atención de salud (tratamientos, pagos o inscripciones). Esta autorización sera efectiva por un (1) año desde su fecha de firma. Puedo revocar esta autorización por escrito. Si lo hago, no afectará ninguna medida ya tomada por Pinero Preventive Medical Care, PA basada en esta autorización. No podré revocar esta autorización si el fin de la misma fuera obtener seguro. Para revocar esta autorización, debo escribir una carta al Preventive Medical Care, PA, a la atención de Mike Ames. Esta información estará sujeta a re-divulgación y quizá ya no esté protegida por las leyes de privacidad federales o estatales.

_____ _____
Signature (Firma) **Date (Fecha)**



Piñero Preventive Medical Care
Rafael E. Piñero, M.D.
Board Certified Family Medicine

Please Fax or Send to (Favor enviar a):

Piñero Preventive Medical Care, PA.
1720 S. Orange Ave, Ste 500
Orlando, FL. 32806
Phone: 407-426-9693 / **Fax: 407-426-9694**

Advanced Directives

(In compliance with the Patient Self Determination Act)

An Advance Directive is a written statement about how you want medical decisions made should you not be able to make them yourself.

****ALL PATIENTS ARE STRONGLY ENCOURAGED TO HAVE AN ADVANCE DIRECTIVE****

1. Have you executed an Advance Directive?
- ☐ Yes
- ☐ No

2. If you have an Advance Directive, is the Directive in the form of:
- ☐ A Living Will
- ☐ A Durable Power of Attorney
- ☐ A Health Care Surrogate

3. If you have executed an Advance Directive, have you provided this office with a copy?
- ☐ Yes
- ☐ No

4. If you do not already have an Advance Directive, please ask the receptionist for our packet of information.

Thank You.

Signature: _____

Print Name: _____

Piñero Preventive Medical Care PA
Acknowledgement of Receipt of Notice of HIPAA Privacy Policies

I certify that I have a received a copy of notice of **HIPAA Privacy Policies**. The notice HIPAA Privacy Policies describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of services provided by Piñero Preventive Medical Care PA. The notice of HIPAA Privacy Policies also describes my rights and Piñero Preventive Medical Care's duties with respect to my protected health information.

This is information has been provided in the form of a tri-fold handout, on display in our reception area and is available on our website.

Patient's Printed Name_____

Patient's Signature_____

Responsible Party Signature _____

Please provide the address, if other than your home address, where you would like your billing statements and/or correspondence from our office to be sent.

_____

City:_____ State:_____ Zip:_____

Please print the telephone number, **if other than your home number**, where you want to receive calls about your appointments, bills, results or other health care information. (_____) _____ - _____

Can confidential messages (ie: appointment reminders, message to return our call) be left on your home answering machine or voicemail?

Answer by placing your initials: Yes _____ No _____

Print Patient's Name:_____

Patient's Signature:_____Date:_____

Responsible Party Signature_____ Date_____