Patient Information

Thank you for choosing our office! So that we may better serve you, please complete **all** spaces.
Please print. All information will be confidential.

Patient Name_____ SSN _____

Address_____
Street City State Zip

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (___)_____

Date of Birth _____ Sex: ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Partnered

Race: ___ American Indian ___Asian ___Black ___Caucasian ___Other ___Pacific Islander ___Declined
Ethnicity: ___Hispanic ___ Non-Hispanic ___ Declined
Language: ___English ___Spanish ___Other (please list) _____

Employer_____ Phone_____ ☐ Full-time ☐ Part-time

Pharmacy Name &
Location_____ Ph#_____

Relationship to
Emergency Contact_____ Ph#_____ Patient_____

Email Address _____

Primary Insurance (Must bring insurance cards to appointment)

Insured _____ Date of Birth_____ SSN_____

Relationship to
Employer _____ Patient_____

Insurance Co._____ ID#_____ Grp #_____

Address _____ Phone _____
Street
Referral/
_____ Authorization #_____
City State Zip

Secondary Insurance (Must bring insurance cards to appointment)

Insured _____ Date of Birth _____ SSN_____

Relationship to
Employer _____ Patient_____

Insurance_____ ID# _____ Grp #_____

Address _____ Phone _____
Street
Referral/
_____ Authorization #_____
City State Zip

Authorization and Release: I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____
Signature of patient (or parent, if minor) Date

PATIENT MEDICAL HISTORY

Name: _____ **Birthdate:**_____

Referring physician: _____ **Primary Physician:** _____

Chief complaint: _____

History of present illness: Please describe your symptoms. (**Location, duration, pain level, context, etc**)

_____

_____

Medical history: Please check for each disease.

___Heart disease (list condition below)
___Venereal disease
___Epilepsy
___Migraine headaches
___Tuberculosis
___Diabetes
___Cancer (list condition below)
___High blood pressure
___Asthma

Height _____ **Weight**_____

___AIDS or HIV+
___Stroke
___Hepatitis A____B____C____
___Ulcers
___Kidney disease
___Thyroid disease
___Arthritis
___Rheumatic Fever

Other_____

Surgical history: List all surgeries and dates.

_____ _____
_____ _____
_____ _____
_____

Allergies: Please check and list the reaction you experienced.

___Antibiotics (List below)
___Morphine, Demerol, or other narcotics (List Below)
___Novocain or anesthetics
___Aspirin or Ibuprofen
___Tetanus antitoxin
___Iodine or other antiseptics
___Shellfish

_____

Medications: List all medications
Drug Name/Dose/Frequency

_____
_____
_____
_____
_____
_____

Do you take Insulin? ___YES ___NO
Type._____Dose units_____

Other supplements: check those you use

___Ephedra ___Garlic
___Ginkgo ___Ginseng
___Kona ___Valerian Root
___St Johns Wort ___Echinacea
___Glucosamine/Chondroitin
___Fish Oil

Do you use Steroids? ___YES ___NO
Anabolic_____ total daily use
Prednisone_____ total daily use

Social history: _____married _____single _____divorced _____ widowed?
How many _____ Children ____ Grandchildren ?
Do you use Tobacco use? __Yes __No If yes, _____packs a day for ____years.
Quit date_____
Do you drink alcohol: ___ Yes ____ No If yes, how much? ____daily ____weekly____ monthly.
Do you now or have you ever used illicit drugs? ___yes ___no.
If yes, specify type and frequency. _____
Do you use Marijuana? If yes specify occasional use or chronic/frequent frequent.

___THC	___ CBD
___ Nabilone	___ Dronabinol
___ K2	___ Spice

Family history: **(Please list current age or age at death, health conditions, and/or cause of death).**
Father: ___Alive ___ Deceased(cause)_____
Mother: ___Alive ___ Deceased(cause) _____
Siblings: _____

Review of systems: Please circle all conditions that you have experienced in the past six months.

Constitutional: ___Generalized weakness ___Tires easily ___Weight gain/loss. __ How much?

Eyes: ___Double vision ___Blurred vision ___Glasses ___Contact lens.

HENT: ___Ear pain ___Ringing in ears ___Hearing loss ___Dizziness/vertigo

Cardiovascular: ___Chest pain ___Heart palpitations ___Swollen ankles

Respiratory: ___ Cough ___Shortness of breath ___Wheezing.

Gastrointestinal: ___Nausea ___Vomiting ___ Diarrhea ___Constipation

Genitourinary: ___Frequent urination ___Incontinence ___Urination at night

Musculoskeletal: ___ Neck pain ___Hand pain ___Back pain ___Other_____

Neurologic: ___Headaches ___Numbness/tingling ___Memory loss/confusion.

Integumentary: ___Skin rash ___Easy bleeding ___Easy bruising ___Varicose veins

Endocrine: ___Cold or heat intolerance ___Excessive thirst ___Decreased sexual drive

Psychiatric: ___Depression ___Anxiety ___Insomnia

Radiologic studies:
MRI:_____ Where?_____
CT: _____ Where?_____

To the best of my knowledge, **all** questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my health status.

_____
Patient Signature Date

Ramon Vazquez, M.D.
General and Vascular Surgery

January 1, 2017

To our patients:

Due to dramatically increasing malpractice premiums and a diminishing number of companies willing to write malpractice insurance in Florida, it has become extremely difficult to carry this coverage.

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

Your doctor has decided not to carry medical malpractice insurance.

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.

This notice is provided pursuant to Florida Law.

Ramon Vazquez, M.D.

The undersigned acknowledges receipt of this notice.

Patient Signature: _____

Patient Name: _____

Date of Birth: _____

560 Village Blvd. Suite 200
West Palm Beach, FL 33409
561-694-6911 - 561-625-3239 fax

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this, I acknowledge that I received a copy of the Notice of Privacy Practices for **RAMON VAZQUEZ, JR., MD PA**

The Notice of Privacy Practices is effective January 1, 2017

Patient Signature Date

Please identify below the person(s) with whom your information may be shared and their relationship to you.

My information may be shared with: (Please print)

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

To: _____
(Doctor / Hospital)

Address: _____

City: _____ **State** _____ **Zip** _____

I hereby authorize the release of my medical records, reports, films, xrays, etc. to

RAMON VAZQUEZ, JR., MD PA
RAMON VAZQUEZ, MD
560 Village Blvd, Suite 200
West Palm Beach, FL 33409
561-694-6911 561-625-3239 fax

_____
Print Name of Patient

From: _____ To: _____
Date of Records

_____
Patient's Signature **Date**

Ramon Vazquez, Jr.,M.D.
560 Village Blvd Suite 200
West Palm Beach, FL 33409

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Ramon Vazquez Jr. M.D. as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare.

We ask that you read and sign this form to acknowledge your understanding of the patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care.

We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.

Patients may incur, and are responsible for the payment of additional charges. These charges may include the following:

- Charge for returned checks.
- Charge for extensive phone consultations and/or after hours phone calls requiring diagnosis, treatment, or prescriptions.
- Charge for the copying and distribution of patient medical records.
- Charge for extensive forms completion.
- Any costs associated with collection of patient balances

_____ _____

Patient Printed Named Patient Signature

Date :_____

SIGNATURE ON FILE

Medicare and Medicaid

LIFETIME AUTHORIZATION

Medicare and Medicaid patient certification – patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payments of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

_____ _____

Date Print Patient's Name

_____

Patient's Signature

Medigap (Insurance secondary to Medicare)

MEDICARE BENEFICIARY SIGNATURE AUTHORIZATION

I request that payment of authorized Medigap (secondary to Medicare) benefits be made on my behalf to Ramon Vazquez Jr., MD PA for services furnished to me by Ramon Vazquez, M.D.

I authorize any holder of medical information about me to release to _____ _____ (insurance company) any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Name of Medicare Beneficiary HIC (Medicare Number

_____ _____

Medigap Number Medicare Beneficiary Signature