

# WEST KENDALL OBGYN

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Last Name/APELLIDO \_\_\_\_\_ First Name/NOMBRE \_\_\_\_\_ M.I. \_\_\_\_\_

Social Security Number \_\_\_\_\_ DOB/Fecha de Nacimiento \_\_\_\_\_

Home Address/Dirección \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code/Código Postal \_\_\_\_\_ Email \_\_\_\_\_

Home Phone/Teléfono \_\_\_\_\_ Work/Trabajo \_\_\_\_\_ Mobile \_\_\_\_\_

Marital Status/Estado Civil \_\_\_\_\_ Race/Raza \_\_\_\_\_ Ethnicity/Origen Étnico \_\_\_\_\_

PRIMARY DR. / MEDICO PRIMARIO: \_\_\_\_\_ Phone/Telefono \_\_\_\_\_

Name & Phone Number of an Emergency Contact  
Nombre y Teléfono de un Contacto de Emergencia: \_\_\_\_\_

Pharmacy/Farmacia \_\_\_\_\_ Phone/Telefono \_\_\_\_\_

Pharmacy Location/Dirección de Farmacia \_\_\_\_\_

Primary Insurance/ Seguro Primario \_\_\_\_\_

Member ID/Numero de Membrecía \_\_\_\_\_ Group #/Numero de Grupo \_\_\_\_\_

Insurance Billing Address/Dirección de Seguro \_\_\_\_\_

Insurance Phone Number/Teléfono de Seguro \_\_\_\_\_

Name of Insured/Nombre de Asegurado \_\_\_\_\_ SS# \_\_\_\_\_

DOB/Fecha de Nacimiento \_\_\_\_\_ Relationship to Patient/Relación con el Paciente \_\_\_\_\_

**\*PLEASE READ: ALL charges are due at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claims forms to the office prior to hospitalization.**

I hereby authorize payment of medical benefits billed to my insurance by Florida Woman Care. I hereby accept responsibility for payment of any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if the practice does not participate with my insurance. I agree to pay all co-payments, co-insurance, and deductibles at the time that services are rendered.

Signature/Firma \_\_\_\_\_ Date/Fecha \_\_\_\_\_

# WEST KENDALL OBGYN

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Reason for Visit:**

- Gynecology
- Obstetrics
- Urology
- Infertility

**Past Medical History (Check any that apply):**

- NONE
- Hypertension
- Rheumatology Problem
- Diabetes
- Cholesterol
- Cancer
- Cardiovascular Disease
- Thyroid Disease
- Anemia
- History of Abnormal Pap Smear
- Endocrinology Problems
- Gastroenterology Problems
- Eye Problems
- Urology Problems
- Neurology
- Psychological
- Pulmonary Problems
- Other \_\_\_\_\_

**Gynecological History (Check any that apply):**

- NONE
- First day of last period \_\_\_\_\_
- Age at first Menses \_\_\_\_\_
- Age at first Child \_\_\_\_\_
- Age at Menopause \_\_\_\_\_
- Menstrual Cycle \_\_\_\_\_
- Duration of Menstrual Cycle \_\_\_\_\_
- Birth Control Method \_\_\_\_\_
- Date of Last Pap Smear \_\_\_\_\_
- Date of Last Mammogram \_\_\_\_\_
- Date of Last Bone Density \_\_\_\_\_
- Date of Last Colonoscopy \_\_\_\_\_
- History of Endometriosis \_\_\_\_\_
- History of Fibroids \_\_\_\_\_
- History of Polycystic Ovarian Syndrome \_\_\_\_\_
- History of Sexually Transmitted Disease \_\_\_\_\_

**Obstetrical History**

- NONE
- Total Pregnancies \_\_\_\_\_
- Spontaneous Abortion \_\_\_\_\_
- Full Pregnancies \_\_\_\_\_
- Ectopic Pregnancies \_\_\_\_\_
- Twin Pregnancies \_\_\_\_\_
- Induced Abortions \_\_\_\_\_
- Premature Deliveries \_\_\_\_\_
- Living \_\_\_\_\_

**Past Pregnancies**

Date of Birth	Number of Fetuses	Weeks at Delivery	Birth Weight	Sex	Delivery Type	Anesthesia	Hospital

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## MEDICAL HISTORY

### Current Medication (Name & Dosage):

- |                                |                                |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> NONE  | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

### Allergies and Reaction

- |                                |                                |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> NONE  | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

### Social History

- Smoking Status: \_\_\_ Current \_\_\_ Former \_\_\_ Never
- Illicit Drugs: \_\_\_ Yes \_\_\_ No
- Alcohol Intake: \_\_\_ Occasional \_\_\_ Moderate \_\_\_ Heavy \_\_\_ None
- Caffeine Intake: \_\_\_ Occasional \_\_\_ Moderate \_\_\_ Heavy \_\_\_ None
- Exercise Level: \_\_\_ Occasional \_\_\_ Moderate \_\_\_ Heavy \_\_\_ None
- Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Domestic Partner
- Education: \_\_\_ High School \_\_\_ College \_\_\_ Post-Graduate
- Occupation: \_\_\_\_\_
- Is blood transfusion accepted in case of an emergency?: \_\_\_ Yes \_\_\_ No
- Religion: \_\_\_\_\_

### Family History (Check any that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> NONE           | <input type="checkbox"/> Diabetes _____            |
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Heart Disease _____       |
| <input type="checkbox"/> Breast _____   | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cervical _____ | <input type="checkbox"/> Osteoporosis _____        |
| <input type="checkbox"/> Ovarian _____  | <input type="checkbox"/> Thyroid Disease _____     |
| <input type="checkbox"/> Colon _____    | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Uterine _____  |  |

### Surgical History (Check any that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> NONE                     | <input type="checkbox"/> Endometrial Ablation |
| <input type="checkbox"/> Breast Augmentation      | <input type="checkbox"/> Tubal Ligation       |
| <input type="checkbox"/> Breast Reduction         | <input type="checkbox"/> Laparoscopy          |
| <input type="checkbox"/> Plastic Surgery          | <input type="checkbox"/> LEEP                 |
| <input type="checkbox"/> Hysterectomy             |   |
| <input type="checkbox"/> Ovary Removal            |   |
| <input type="checkbox"/> Tonsillectomy / Adenoids |   |
| <input type="checkbox"/> Cholecystectomy          |   |
| <input type="checkbox"/> Cardiac Surgery          |   |
| <input type="checkbox"/> Abdominal Surgery        |   |
| <input type="checkbox"/> Bladder Surgery          |   |
| <input type="checkbox"/> Colposcopy               |   |
| <input type="checkbox"/> Dilation and Curettage   |   |

# WEST KENDALL OBGYN

Alberto Sirven MD FACOG  
Patricia Perfetto MD FACOG  
Julio Somoano MD FACOG  
Edilia Pando ARNP  
Maggier Quinoa ARNP

Julio E Arronte MD FACOG  
Lorena Tinoco MD FACOG  
Mabel Marotta MD  
Naviuska Chirino ARNP

## CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent the use or disclosure of my protected health information by Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, understand that diagnosis or treatment of me by Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, is not required to agree to the restrictions that I Request. However, if Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, agree to the restrictions that I have requested, the restriction is binding on Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP.

I have the right to revoke this consent, in writing at any time, except to the extent that Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, has taken action in reliance on this consent.

I understand that I have the right to review Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, notice of privacy practices prior to signing this document. The Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, notice of privacy practices has been provided to me. The notice of privacy describes the types of uses and disclosure of my protected health information that will occur in my treatment, payments of my bills or in the performance of health care operations of notices of privacy practices also describes my rights and the Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, duties with respect to my protected information.

Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Lorena Tinoco MD, Julio Somoano MD, Mabel Marotta MD, Edilia Pando ARNP, Naviuska Chirino ARNP & Maggier Quinoa ARNP, reserves the right to change the privacy that is described in the notice of privacy. I may obtain a revised noticed of privacy practice by calling the office and requesting a revised copy be send in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Name of patient or personal representative

\_\_\_\_\_  
Date

## Patient Record of Disclosure

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by means such as sending correspondence to an address other than home.

I wish to be contacted in the following manner (check all that applies):

**Home Telephone:**

- OK to leave message with detailed information
- Leave message with call back number only
- OK to fax to this number \_\_\_\_\_

**Written Communications:**

- OK to mail home address
- OK to mail work/office

**Work Telephone:**

- OK to leave message with detailed information
- Leave message with call back number only

**Other:**

- OK to email to this address: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

**Uses and Disclosures for Lifetime Health Center may be permitted without prior consent in an emergency.**

Healthcare entities must keep records of PHI disclosures. Information provided below will constitute this record. Please list who we may disclose information to such as appointment times, lab results or medication information.

Disclose information to:	Address or Phone #:	Disclose this information:

## Important Notice for ALL Patients

The following services are offered in our office at an **extra charge** as follows:

**Blood services → \$10**

**Injections → \$25**

**Disability Forms → \$20**

**FMLA Forms → \$15**

**WIC Forms → \$15**

**Any VIACORD/CORDBLOOD Collection → \$250**

**Medical Records → \$1 per page for the first 25 pages & \$.25 cents thereafter. (For mailing records there will be a \$20 charge for processing fee & postage.)**

### **Attention: Medicaid Patients ONLY**

Medicaid only covers **one ultrasound** for the entire pregnancy. Any additional **ultrasound(s)** would be the patient's responsibility: **Obstetric Ultrasound cost → \$100 each**

## Aviso Importante para TODOS los Pacientes

Nuestra oficina ofrece los siguientes servicios con **un costo adicional**:

**Servicios de laboratorios → \$10**

**Inyecciones → \$25**

**Formas de Incapacidad → \$20**

**Formas de FMLA → \$15**

**Formas de WIC → \$15**

**Colección de VIACORD/CORDBLOOD → \$250**

**Records Médicos → \$1 por página por las primeras 25 páginas y \$.25 centavos por página adicional. (Si los records requieren ser mandados por correo será un costo adicional de \$20 para el manejo y envío.)**

### **Atención: Pacientes de Medicaid**

Medicaid solamente cubre **un ultrasonido** durante el embarazo. Cualquier **ultrasonido adicional(es)** será responsabilidad del paciente: **Ultrasonido Obstétrico → \$100 c/u**

\_\_\_\_\_  
Patient Name / Nombre del Paciente

\_\_\_\_\_  
Patient Signature / Firma del Paciente

\_\_\_\_\_  
Date / Fecha