PATIENT REGISTRATION FORM /FORMULARIO DEMOGRAFICO DEL PACIENTE

Today's Date: [fecha]	**Email Address:(correo electronico)**

PATIENT INFORMATION

Patient's last name: Nombre Del Paciente 1. [Last Name] Apellido(s)	First: [First Name] Nombre	Initial:	**Marital status: Estado Civil D/M/P/S/W/LS**
Address: Direccion	Birth date: Fecha De Nacimiento	Age: Edad	**Sexo M___ F___**
Social Security no.: Numero De Seguro Social	Home phone no.: Telefono de Casa	Cell phone no.: Cellular	
Occupation: Empleo	Employer: Empleador	Student/Estudiante:	
Chose clinic because/referred to clinic by (Como Supo De la Oficina) _____			
Other family members seen here: [Algun Familia Viene A la Clinica]			

ADDITIONAL INFORMTION/INFORMACION ADICCIONAL

Preferred Pharmacy/Farmacia Preferida

Pharmacy Name: Nombre de farmacia:		Address/Direcion	phone no.: telefono
Street between/calles cercanas			

Nacionalidad/Nationality **Entidad/Ethnicity** **Race/Raza**

White	Black	Asian	Non-Hispanic	refuse	
Hispanic/Hispano	other				

Language/Lenguaje:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
[nombre del familia o amigo que no viva con usted]	[relacion]	[telefono]	[telefono del trabajo]

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bon Vitas Medical. or insurance company to release any information required to process my claims.

La información anterior es verdadera a mi leal saber y entender. Autorizo que los beneficios de mi seguro se paguen directamente al médico. Entiendo que soy financieramente responsable de cualquier saldo. También autorizo a Bon Vitas Medical o compañía de seguros para divulgar cualquier información requerida para procesar mis reclamos.

Patient/Guardian signature _____ Date _____

Approve by C.Lugo 10/08/2020 HA

Consent and Authorization Agreement

_____ ___/___/_____

Patient Name **Date of Birth**

Please read the "Consent and Authorization and Agreement" form carefully:

I hereby consent and authorize **Bon Vitas Medical** to provide me treatment and certify that no guarantee or agreement has been made asto the results obtained. _____-Initials

Por la presente doy mi consentimiento y autorizo a **Bon Vitas Medical** a proporcionarme tratamiento y certificar que no hay garantía o se ha acuerdo sobre los resultados obtenidos. _____-Iniciales

Agreement to pay for services:

I promise to **Bon Vitas Medical** all undersigned and/or the patient will be responsible for all charges, applicable co-payments and deductibles or charges not paid by my insurance carrier(s). Such payments will be made to **Bon Vitas Medical** upon notification. _____-Initials

Prometo a **Bon Vitas Medical**, todo bajo firma y/o el paciente será responsable de todos los cargos, copagos aplicables y deducibles o cargos no pagados por mi Seguro transportista(s). Dichos pagos se realizarán **a Bon Vitas Medical** tras la notificación. _____-Iniciales

Privacy Notifications:

I acknowledge that I have read **Bon Vitas Medical**, privacy notice. _____initials

Reconozco que he leído **Bon Vitas Medical**, aviso de privacidad. _____ -Iniciales

Authorization:

I authorize **Bon Vitas Medical** to submit a claim to my insurance company on my behalf.

_____Initials

Autorizo a **Bon Vitas Medical** a presentar una reclamación a mi compañía de seguros en mi nombre. _____-Iniciales

NO Solicitation

I certify that I have voluntarily requested the medical services of **Dr. Melissa Ortiz Miranda**. **Dr. Ortiz** nor did employees ask me for their services. _____Initial

Certifico que he solicitado voluntariamente los servicios medicos de la **Dra. Melissa Ortiz Miranda**. La **Dra. Ortiz** ni empleados me solicitaron para sus servicios. _____initials

Telephone and Refill Office Policy

Telephone Messages will have a 48-hour (2 business day) turnaround period. Prescriptions refills should require a 5-business day notice. _____-Initials

Los mensajes telefónicos tendrán un período de respuesta de 48 horas (2 días hábiles). Recargas de recetas debe requerir un aviso de 5 días hábiles. _____-Iniciales

I have read and understand all above information and agree to comply,

He leído y entiendo toda la información anterior y acepto cumplir,

_____

Patient/ Guardian Signature

Health Care Advance Directives

Please read the information below carefully before signing.

The Patient's Right to Decide

Every competent adult has the right to make decision concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decision due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will be respected, the Florida legislature enacted laws pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the decide to make an anatomical donation after death.

By law, hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include SSA-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

hat is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- **e** A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a "living will"?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your healthcare provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a "health care surrogate designation"?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate analternative surrogate.

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives. Forms available upon request.

Yes __ No___ Intubate ___Yes__ NO Resuscitate ____ Refuse

Print patient name:_____ Patient Signature:_____

Date: _____

Approve by C.Lugo 10/08/2020 HA

HIPPA Authorization Form

I, _____ authorize the use or disclosure of my protected health information as described below:

Persons authorized to use and disclose protected health information**. Bon Vitas Medical**. You are authorized to release medical information to:

Name: _____
Relationship: _____
Phone: _____

Name: _____
Relationship: _____
Phone: _____

Authorization

I understand that the information used or disclosed under this authorization form may be subject to redisclosure by individuals at the receiving facility and will no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form. The authorizing person has the right to revoke this authorization in writing at any time. I understand that any action that has been taken based on this authorization cannot be reversed and my revocation will not affect those Actions.

Signed By: _____ Date: _____

Concentration to obtain external prescription history

I, _____ authorize **Bon Vitas Medical**, and their affiliated providers to view my external prescription history through the Rx Hub electronic service or through the website known as E-Force.

I understand that the prescription history of various unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewed by my providers and staff at **Bon Vitas Medical**. This may include multi-year formulary.

I certify that I have read and understood this consent and I authorize access.

_____ _____
Patient Signature Date

BON VITAS MEDICAL

PATIENT HEALTH HISTORY
(Confidential)

If completing form by hand, please print

Name_____ Today's Date_____

☐ Male ☐ Female Age_____ Birthdate_____ Date of last physical examination_____
mm / dd / yyyy

Marital status_____ Occupation_____

What is the reason for your visit today?_____

HEALTH MAINTENANCE *List the most recent date for each of the following:*

WOMEN ONLY (mujer)	BOTH MEN AND WOMEN (Ambos)	MEN ONLY (Hombres)
_____Menstrual period	_____Cholesterol testing _____ Eye Exam	_____PSA (prostate blood test)
_____Mammogram	_____Colonoscopy _____Bone Density (DEXA)	_____Prostate exam
_____Pap smear	_____ Blood Transfusion _____ EKG	

CONDITIONS *Check ☑ conditions you currently have or have had in the past*

☐ AIDS /HIV
☐ Alzheimer
☐ Anemia
☐ Rheumatoid Arthritis
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ B-12 Deficiency
☐ CAD / heart disease
☐ Cancer, type_____
☐ Bulimia
☐ Depression
☐ Diabetes Type I or II
☐ Emphysema/COPD
☐ Epilepsy
☐ Erectile Dysfunction
☐ Fibromyalgia
☐ Gallbladder Stone
☐ GERD (reflux)
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Headaches
☐ Heart Attack
☐ Hepatitis
☐ Herpes
☐ High blood pressure
☐ Heartburn
☐ Kidney Disease
☐ Liver disease
☐ Multiple sclerosis
☐ Pacemaker
☐ Pneumonia
☐ Prostate Problem
☐ Hemorrhoids
☐ Hepatitis A, B, C
☐ High Cholesterol
☐ Hyperthyroidism
☐
☐ Stroke
☐ Back Pain
☐ Thyroid Problem
☐ Tuberculosis
☐ Ulcer(s)
☐ Rectal Bleeding

☐ Other _____

ALLERGIES? *Check ☑ appropriate box below. If yes, please list all known allergies to medications or substances*

☐ No known allergies ☐ Yes, I have the following allergies:

MEDICATIONS *List all medications you are currently taking, including the dose and frequency*

HEALTH HABITS *Check ☑ appropriate boxes below and describe*

Caffeine/ Cafe	☐ None	☐ _____drinks per _____	
Tobacco/Tabaco	☐ None	☐ _____cigarettes per day	☐ Quit smoking around _____
Alcohol	☐ None	☐ _____drinks per _____	
Drugs	☐ None	☐	
Exercise	Describe:		
Sexually Active	Always ☐	Never ☐	Sometimes ☐

(Continued on back)

SURGICAL HISTORY

Year	Hospital / City / State	Type of surgery/ complications if any

PREGNANCY HISTORY

#pregnancies ___ ; # living children

#deliveries: C-sections ; vaginal

Birth Year	M or F	Complications, if any

OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES

Year	Hospital / City / State	Reason for hospitalization, nature of illness or injury

☐ ☐

FAMILY HISTORY

Fill in information about your family below: ***Check if a blood relative has had any of the following:***

Relation	Age, if living	Age at death	Medical conditions/ cause of death	Disease	Relationship to you
Father				☐ Arthritis	
Mother				☐ Asthma	
Brothers				☐ Cancer	
				☐ Diabetes	
				☐ Gout	
				☐ Heart disease	
Sisters				☐ High blood pressure	
				☐ Kidney disease	
				☐ Stroke	
				☐ Other	

ADDITIONAL INFORMATION

What else do you think your doctor should know about your health?

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Certifico que la información de este formulario es correcta según mi conocimiento. No responsabilizaré a mi médico ni a ningún miembro de su personal por ningún error u omisión que pueda haber cometido al completar este formulario.

Patient Signature_____ Reviewed by_____ Date_____