

NEW OB PATIENT INFORMATION

PATIENT INFORMATION <i>Informacion del Paciente</i>				
Name (Last, First, MI) <i>Nombre del Paciente</i>		Social Security # <i>Seguro Social</i>	Date of Birth <i>Fecha de Nacimiento</i>	Age <i>Edad</i>
Marital Status <i>Estado Civil</i> <input type="checkbox"/> Single <i>Soltera</i> <input type="checkbox"/> Married <i>Casada</i> <input type="checkbox"/> Divorced <i>Divorciada</i> <input type="checkbox"/> Widowed <i>Viuda</i>		Languages Spoken <i>Idiomas</i>		
Home Address <i>Direccion del Hogar</i>		City <i>Ciudad</i>	State <i>Estado</i>	Zip Code <i>Codigo Postal</i>
Home Phone <i>Telefono del Hogar</i>	Work Phone <i>Telefono del Trabajo</i>	Mobile Phone <i>Telefono Portatil</i>	E-mail Address <i>Direccion de E-mail</i>	
Employer Name & Address <i>Nombre y Direccion del Empleo</i>		Occupation <i>Ocupacion</i>	Work Phone <i>Telefono del Trabajo</i>	
SPOUSE'S INFORMATION <i>Informacion del Esposo</i>				
Spouse's Name <i>Nombre del Esposo</i>		Social Security # <i>Seg. Social</i>	Date of Birth <i>Fecha de Nacimiento</i>	Age <i>Edad</i>
Spouse's Employer Name <i>Nombre del Empleo del Esposo</i>		Work Phone <i>Tele. del Trabajo</i>	Other Phone <i>Otro Telefono</i>	
EMERGENCY CONTACT INFORMATION <i>Contacto de Emergencia</i>				
Name of Emergency Contact <i>Contacto de Emergencia</i>		Relationship to Patient <i>Relacion</i>		Home Phone <i>Telefono del Hogar</i>
Address <i>Direccion</i>	City <i>Ciudad</i>	State <i>Estado</i>	Zip Code <i>Cod. Postal</i>	Work Phone <i>Telefono del Trabajo</i>
WHO MAY WE THANK FOR REFERRING YOU TO US? <i>Quien la referio a nuestra oficina?</i>				
Name <i>Nombre</i>			Phone <i>Telefono</i>	
<input type="checkbox"/> Internet <input type="checkbox"/> Insurance <i>Seguro</i>				
INSURANCE INFORMATION <i>Informacion de Seguro</i>				
Primary Insurance Company <i>Nombre del Seguro</i>		Group # <i># de Grupo</i>		Policy # <i># de Poliza</i>
Subscriber's Name <i>Asegurado</i>	Relationship <i>Relacion</i>	Social Security # <i>Seg. Social</i>	Date of Birth <i>Fecha de Nacimiento</i>	
Secondary Insurance Company <i>Nombre del Seguro</i>		Group # <i># de Grupo</i>		Policy # <i># de Poliza</i>
Subscriber's Name <i>Asegurado</i>	Relationship <i>Relacion</i>	Social Security # <i>Seg. Socia</i>	Date of Birth <i>Fecha de Nacimiento</i>	
FEES AND INSURANCE INFORMATION				
<p>All fees are payable at the time services are rendered. We accept Visa, MasterCard, American Express, and Discover Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.</p> <p><i>Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card, American Express y Discover. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.</i></p>				
PHYSICIAN'S RELEASE AND ASSIGNMENT				
<p>I hereby assign payment directly to Alvarez & Vinueza, MDs, LLC of all payments applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by Alvarez & Vinueza, MDs, LLC. I understand that I am financially responsible to Alvarez & Vinueza, MDs, LLC for any and all charges that the carrier declines to pay (including but not limited to: Not a covered benefit, Disallowed by plan). I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.</p> <p><i>Por la presente autorizo el pago directamente a Alvarez & Vinueza, MDs, LLC todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de recibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.</i></p>				
<p>NOTICE OF PRIVACY ACKNOWLEDGEMENT: I have read and understand the privacy act.</p> <p>Signature of Patient <i>Firma del Paciente:</i> _____ Date <i>Fecha:</i> _____</p>				

MEDICAL HISTORY

Name: _____ Age: _____ Date: _____

Primary Care Doctor: _____

Reason for Visit: Annual Pap Exam Other _____

Date of last visit to OB/GYN: _____

Date of last pap: _____ Results: Normal Abnormal

Date of last mammogram: _____ Results: Normal Abnormal

Do you have a medical/surgical history of:

Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Renal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tumors/Cancers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibrocystic Breasts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HPV	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cervical Dysplasia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menopause	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tubal Ligation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Appendectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hysterectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gallbladder Removal	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do your parents or brothers/sisters have any medical condition or cancer? Yes No

If yes, explain:

Do you have a medical condition that is not listed above? Yes No

If yes, explain:

At what age did your menstrual cycle begin? _____ Are they regular? Yes No

How many days between your cycles? _____

How many days does your cycle last? _____

Do you get menstrual cramps? Yes No

If yes, what do you take? _____

Are you currently experiencing any of the following?

Headaches Dizziness Chest Pain Shortness of breath Heavy Menstrual Bleeding

Burning when you urinate Fever Chills Nausea Vomiting Diarrhea

MEDICAL HISTORY (continued)

When was your last colonoscopy? _____

What is your current method of contraception? _____

Did you ever use an IUD? Yes No

If yes, for how long? _____

Have you ever used contraceptive pills? Yes No

If yes, which one? _____

Have you ever had any STD's? Yes No

If yes, which one? _____

Have you ever had Pelvic Inflammatory Disease? Yes No

If yes, when? _____

Do you Smoke? Yes No

Drink Alcohol? Yes No

Use Illicit Drugs? Yes No

Current Medications:

Name	Dosage	Frequency

Are you allergic to any medications? Yes No

If yes, which ones? _____

Signature of patient

Date

PAST PREGNANCIES (PLEASE LIST ALL PREGNANCIES)

Date of Delivery Mm/dd/year	Type of Delivery (Vaginal, C-section, Miscarriage, Termination)	Total # of Weeks Pregnant	Doctor & Hospital	Length of Labor (in hours)	Single or Multiple Babies	Baby's Birth Weight	Baby's Name and Gender	Complications during pregnancy or Delivery	Comments

PAST SURGERIES (PLEASE LIST ALL SURGERIES)

Date of Surgery	Procedure	Complications/Comments

PRENATAL GENETIC SCREEN

Date ___/___/___ Name _____

Will you be 35 years of age or older by your estimated due date? Yes No

Have you, the baby's father or anyone in either of your families ever had any of the following?

- Down's Syndrome (trisomy 21) Yes No
- Other Chromosomal or Inherited Genetic Disorder Yes No
- Neural tube defect (i.e. Spina Bifida) Yes No
- Hemophilia Yes No
- Muscular Dystrophy Yes No
- Cystic Fibrosis Yes No
- Congenital Heart Defect Yes No
- Sickle Cell Disease of Trait (African) Yes No
- Tay Sachs (Jewish, Cajun, French Canadian) Yes No
- Thalassemia (Italian, Greek, Mediterranean, Asian) Yes No
- Canavan Syndrome Yes No
- Hemophilia or Hematologic Disease Yes No
- Huntington's Chorea Yes No
- Autism Yes No if yes, tested for Fragile X? Yes No
- Mental Retardation Yes No if yes, tested for Fragile X? Yes No

If yes to any of the above, please indicate the relationship of the affected person to you or the baby's father:

Do you or the baby's father have a birth defect? Yes No

If yes, who has the defect and what is it? _____

In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed above?

Yes No

If yes, what was the defect and who had it? _____

Do you, the baby's father, or a close relative in either of your families have a birth defect or chromosomal abnormality not listed above?

Yes No

If yes, indicate the condition and relationship of the affected person to you or to the baby's father: _____

In any previous marriages, have you or the baby's father had a stillborn child or three or more first trimester spontaneous abortions?

Yes No

If yes, have either of you had a chromosomal study? Yes No

If yes, indicate who and the results: _____

If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?

Yes No

If yes, indicate who and the results: _____

Excluding Iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual

period? (Include non-prescription drugs) Yes No

If yes, give the name of the medication and time taken during pregnancy: _____

Signature of patient

Date

NOTICE TO OUR EXPECTANT MOTHERS

Videotaping/photography:

Videotaping or photography are not allowed during the actual delivery. Pictures and videotaping of the baby are permitted after the birth, however they are not permitted at any procedures, such as repair of an episiotomy or closure of a cesarean section surgery.

Deliveries:

Our physicians will make every effort to be there for your delivery. However, at times the situation may arise when your physician may not be available for your delivery. In those cases, our physicians have partnered with a group of physicians for the past several years to help cover each other's patients. This pre-arranged coverage allows us to maintain the highest quality and best possible care for all our patients.

Circumcisions:

Our physicians do not perform circumcisions in the office or in the hospital. You can make arrangements with your pediatrician or the neonatologist at the hospital may be able to perform the circumcision. Please ask your doctor at the time of delivery.

Cesarean Sections:

Although most patients desire and are able to have a vaginal delivery, the medical necessity for a cesarean section may arise prior to or during labor. This will be discussed as needed.

By signing below, I acknowledge that I have read and understand the above notices:

Signature of patient

Printed Name

Date

Signature of Witness

Printed Name of Witness

Date

Notice of Privacy Acknowledgement/ Aviso De Privacidad Reconocimiento Alvarez & Vinueza, MDs, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Entiendo que bajo el Health Insurance Portability and Accountability Act (HIPAA), tengo ciertos derechos a la privacidad con respecto a mi información de salud protegida. Reconozco que han recibido o han tenido la oportunidad de recibir una copia de su aviso de prácticas de privacidad. También entiendo que esta práctica tiene el derecho de cambiar su aviso de prácticas de privacidad y que puedo contactar con la práctica en cualquier momento para obtener una copia actual de la notificación de prácticas de privacidad.

CONTACTS FOR RESULTS/ CONTACTOS PARA OBTENER RESULTADOS:

Patient telephone numbers/ Números de teléfono del paciente:

Home Phone/Teléfono de casa

Work Phone/Teléfono de trabajo

Mobile Phone/Teléfono móvil

I authorize Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza and any members of their staff to fax medical information needed for my treatment to the following fax number (Yo autorizo a Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza y los empleados de la oficina que manden cualquier información necesaria para mi tratamiento medico al siguiente número de fax):

Fax Number/ Número de fax

I authorize Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza and any members of their staff to discuss my medical information including test results with the following individuals (Yo autorizo que el Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza y los empleados de la oficina pueden hablar sobre mi información médica incluyendo resultados de pruebas con las siguientes personas):

Name/Nombre

Relationship to Patient/Relación a paciente

Name/Nombre

Relationship to Patient/Relación a paciente

Name/Nombre

Relationship to Patient/Relación a paciente

Signed/ Firmado:

Patient Name or Legal Guardian (print)/
Nombre del paciente o la Legal de guarda (impresión)

Date/Fecha

Signature/Firma

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

FOR OFFICE USE ONLY



WAIVER REQUESTING LAB TESTS OUTSIDE MY HEALTH INSURANCE COMPANY COVERAGE

I acknowledge that although I may have health insurance which will pay for laboratory tests if I go to the specific local lab designated by my insurance company, I request that **Alvarez & Vinueza M.D's, L.L.C.** perform these tests through this office. My doctor and/or his staff have explained that I may go to the lab with a prescription and have the test(s) done at no charge. However, I request that the test(s) be performed through my Doctor's office despite the cost I shall incur.

This is being done entirely for my convenience and as a courtesy to me.

I agree that today I will pay the \$25.00 administrative fee necessary to perform the specific test through my Doctor's office.

Signature of patient

Date

Signature of witness

Date

I do not wish to have Alvarez & Vinueza, M.D.'s, LLC perform any laboratory tests.

BLOOD TRANSFUSION AND HYSTERECTOMY CONSENT/ CONSENTIMIENTO PARA TRANSFUSION DE SANGRE E HISTERECTOMIA

I, _____, understand that during pregnancy, particularly at the time of delivery, there is an expected amount of blood loss. On certain occasions, this may exceed the average quantity and if there is significant anemia the need for a blood transfusion may arise. All precautions will be taken to minimize the need for transfusion and this option is a last resort to be used only in a life or death situation after all other alternatives are explored. If it becomes necessary under the doctor's discretion that I need a blood transfusion I agree to receive a transfusion.

I am also aware that on very rare occasions if the bleeding cannot be controlled by various other methods, then a hysterectomy may be necessary to save my life in order to prevent further blood loss. This means that I will not be able to have any more children. It would only be an option in a life or death situation and after all other possible alternatives have been attempted under the circumstances.

Yo, _____, entiendo que durante el embarazo, especialmente al momento del parto, voy a tener cierta perdida de sangre. En ciertas ocasiones la perdida de sangre puede exceder la cantidad average causando una anemia significativa requiriendo una transfusion de sangre. Todas precauciones seran tomadas para minimizar la necesidad de una transfusion de sangre explorando otras alternativas. La alternative de la transfusion de sangre sera tomada unicamente ante un eminente riesgo fatal para la paciente. Si se convirtiera necesario y a discrecion del Doctor, yo accedea una transfusion de sangre.

Tambien yo estoy consiente que a veces los sangramientos no se pueden controlar por medio de diferentes metodos pudiendo requerir una hysterectomia para deterner la perdida de sangre. Esto quiere decir que no podre lograr otro embarazo. Esta opcion seria adoptada solamente ante un eminente riesgo de vida o muerte, despues de explorar otras posibles opciones.

Signature of Patient/Firma de Paciente

Printed Name/Nombre de Paciente

Date/Fecha

Signature of Witness/Firma de Testigo

Printed Name/Nombre de Testigo

Date/Fecha



RECEIPT OF NOTICE TO OBSTETRIC PATIENT

I have been furnished information in the form of a Brochure prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), pursuant to Section 766.316, Florida Statutes, by *Alvarez & Vinueza M.D's*, and have been advised that Dr. Wilfredo Alvarez and Dr. Cesar Vinueza are participating physicians in that program, wherein certain limited compensation is available in the event certain types of qualifying neurological injuries may occur during labor, delivery or resuscitation in a hospital. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, Post Office Box 14567, Tallahassee, Florida 32317-4567, (800) 398-2129.

I specifically acknowledge that I have received a copy of the Brochure prepared by NICA.

DATED this ____ day of _____, 20__.

Signature of Patient

Printed Name of Patient

Social Security No: _____

Attest:

Signature of Witness

Date: _____

NOTICE REGARDING INSURANCE/HOSPITAL AFFILIATION

Dear Patient,

Please be advised that there are certain insurances that we accept in our office that may not be accepted at other facilities such as Baptist Hospital. Dr. Alvarez and Dr. Vinueza only have privileges at Baptist Hospital (Main) and MASC (Baptist's Medical Arts Surgical Center). It is your responsibility to verify hospital/facility affiliation with your insurance company. Should you require any service which needs to be provided outside of our offices, it may become necessary to transfer your care to another physician (who has privileges at a facility which is in-network with your insurance). Thank you for your understanding.

I (print name) _____, have read, understand and agree to the above terms.

Patient Signature

Date

Witness Signature

Date

Witness Name (print)

CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS TESTING (HIV)

This is a consent for for a blood test for Human Immunodeficiency Virus (HIV), the virus responsible for AIDS. Tests for HIV detect antibodies to the virus in the blood. Antibodies are proteins produced in response to a foreign body, such as a virus. Testing is done by a test called ELISA If this first test is positive, it is done again in the laboratory. If the second ELISA is also positive, another test, called a Western blot, is done to confirm the results. The same blood sample may be used for all three tests, or you may be called in to give another sample.

There is a time lag between when a person is infected with the virus and when tests for HIV become positive (that is, when antibodies to the virus can be detected in the blood). In most cases, antibodies show up in the test within 6 – 12 weeks, but sometimes it takes longer. This means that if you were infected with HIV soon before having the test, the results today may be negative, even though you are really infected. For this reason you may need to be tested more than once. You may also need to be retested if you continue to be at risk for getting the virus.

Positive results mean that you are infected and can pass the virus on to others, even if you have no signs of illness. You will need to get special health care and take steps to avoid passing the virus to others. Negative results mean that antibodies were not found in your blood. There is a slight chance, though, that the results are falsely negative and that you are really infected with the virus. This could be the case if you were recently infected with the virus. Even if your test results are negative, you still need to protect yourself by changing any behavior that places you at risk.

I understand that the lab that performs this test will send the results to my doctor and that I must return in person to this office to obtain the results, whether they are positive or negative. The results cannot be given out over the phone under any circumstances. I understand that there are treatments available if I do test positive for HIV. If I am pregnant, this treatment may reduce the transmission of HIV to my fetus. I also understand that positive test results will be reported to the county health department. Anonymous and confidential testing for HIV is available at the Dade County Health Department.

PLEASE CHECK ONE:

- I have read the above and I hereby consent to the above testing for HIV.
- I have read the above and I hereby refuse the above testing for HIV.

Signature of patient

Date

Signature of witness

Date

Dear Patient,

The health insurance industry allows physician practices, such as ours, to submit a medical claim on your behalf for the payment of services and treatment provided. Insurance companies often do not notify us of a patient balance until many months after your visit. Because of this, we (like many other physicians, hotels and car rental agencies) request that you provide us with a valid credit card to keep on file to make it easier for you to pay off your balance, if it becomes necessary. This information will be kept confidential. Should you have additional charges or a balance after your insurance company processes our claim, we will send you a statement showing the balance. If, after 30 days from the statement date, we haven't received a payment for the balance, we will then submit the charge through the credit card we have on file for you.

If you request, we can provide an **estimate** for the services rendered. Please understand that this is an **estimate only** and your actual charges and / or responsibility may be more or less than the estimate, depending upon the services performed and coverage actually provided by your insurance company. In some circumstances, additional charges may be incurred after your departure from the office and not included in the estimate. This may occur when a more complete review identifies charges that were missed initially. In addition, the information we initially receive from your insurance company prior to your visit regarding coverage and your responsibility is often different than the information we receive after the claim has been formally submitted.

When making decisions regarding your medical care, we make the best decisions we can given your particular circumstances. However, some insurers will only pay for a limited number of procedures, even if they are considered medically necessary. Insurers allow direct patient billing for uncovered services. If your insurance does not cover a service, you will be responsible for the balance. If you have a question whether you are receiving a covered service, please ask. . . however, we are sometimes unable to get accurate information from insurers prior to the formal submission of a claim, which cannot occur until after the procedures have been performed. Our inability to get valid information from the insurer will not change your obligation for the balance, if one results.

I (name) _____, have read, understand and agree to the above terms.

Patient Signature

Date