Drs. Blachar, Brasac & Falquez
Patient Information

PATIENT'S NAME_____ HOME PHONE (____)_____
Nombre del Paciente Last First Middle Initial Telefono del Hogar

CELL PHONE(____) _____ WORK PHONE(____)_____ext._____
Telefono Cellular Telefono del Trabajo

HOME ADDRESS _____ APT. ____ E-MAIL _____
Direccion del Hogar

CITY _____ STATE _____ ZIP _____ DATE OF BIRTH_____
Ciudad Estado Zona Postal Fecha de Nacimeinto

DRIVER'S LICENSE # _____ STATE _____
Numero de licensia de chofer Estado

MARITAL STATUS Single Married Widowed Divorced Separated SOCIAL SECURITY # _____
Estado Civil Numero de Seguro Social

EMPLOYER _____ OCCUPATION_____
Empleo Ocupacion

WORK ADDRESS _____ CITY _____STATE____ ZIP_____
Direccion del Trabajo Ciudad Estado Zona Postal

INSURED NAME & DOB _____RELATION TO PATIENT_____
Nombre del Asegurado y fecha de nacimiento Relacion al Paciente

INSURED WORK PHONE(____)_____ INSURED EMPLOYER _____
Telefono del trabajo del Asegurado Empleo del Asegurado

EMERGENCY CONTACT _____ PHONE (____)_____
Contacto en Caso de Emergencia Telefono

REFERRED HERE BY _____ PRIMARY PHYSICIAN_____
Referido a nuestra oficina por Nombre de su medico primario

NAME OF INSURANCE _____
Nombre de su seguro

PHARMACY NAME_____ PHARMACY NUMBER _____
Nombre de la farmacia Numero de farmacia

Your insurance is a contract between you and your insurance company, whose payments for our services vary according to the terms of your policy. Please familiarize yourself with the details of your insurance benefits.

FINAL PAYMENT OF ALL CHARGES IS THE PATIENT'S RESPONSIBILITY.
ACCOUNTS SENT TO COLLECTION WILL BE CHARGED A 35% COLLECTION FEE.
FAILURE TO CANCEL YOUR APPOINTMENT WITHIN 24 HOURS WILL RESULT IN A $25 CANCELLATION FEE.

I hereby authorize payment directly to Doral Beach OB/GYN, LLC of all benefits applicable and otherwise payable to me from my insurance, PPO, HMO or other 3rd party payer. I understand I am responsible to Doral Beach OB/GYN, LLC for charges not covered by this assignment and for any charges the carrier declines to pay. I authorize the release of my medical records as deemed necessary.

Patient's Signature_____ Date _____

Drs. Blachar, Brasac and Falquez
Obstetrics and Gynecology

Date_____ Name _____ Miami Beach Doral

Birth Date	Age	Race W B O	Marital Status S M W D Sep	Phone (no beepers please) H: Wk:
Total Pregnancies	Full Term	Premature	Abort/Miscarriage	Living

Past Pregnancies

Date Month/Year	Gest. Age (weeks)	Length of Labor	Birth Weight	Vaginal or C - Section	Sex	Place of Delivery	Comments/ Complications

Past Medical History	ONo ✔ Yes		ONo ✔ Yes	**Infectious Disease Screening**	ONo ✔ Yes
High Blood Pressure		Asthma		Are you or your partner at high risk for HIV/AIDS?	
Heart Disease		Urinary Infections		Live with someone with TB?	
MVP or Heart Murmur		History of Abnormal Pap		You or your partner with Herpes? Hepatitis B?	
Rh negative blood type		Anesthetic Complications		If pregnant, have had a virus or rash since last period?	
Diabetes		General or plastic surgery		Current or prior IUD use?	
Nervous Disorders		GYN surgery or Tubal ligation		Chlamydia, gonorrhea, syphillis, HPV?	
Rheumatic Fever		Uterine Abnormalities		Allergies to medications:	
Epilepsy		Infertility			
Hepatitis		DES exposure		Current medications:	
Phlebitis		Tuberculosis			
Thyroid		Alcohol/Drug use			
Accidents		Tobacco Use		**Would you accept a blood transfusion if necessary?**	
Transfusions					

Comments:

_____

_____

_____

_____

_____

_____

_____patient's signature_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	–	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer (male or female)								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic or prostate cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Colon/rectal, uterine/endometrial, ovarian, stomach/gastric, kidney/urinary tract, biliary tract, small bowel, pancreas, brain, and sebaceous adenomas								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

PATIENT_____ DATE:____/_____/_____

Review of System

Do you now or have you had any problems related to the following system? Circle Yes or No.

Constitutional
Have you gained or lost weight recently? Yes No

Eyes
Blurred Vision Yes No

Neurological
Syncope Yes No
Headache Yes No

Musculoskeletal
Joint pain / Back Pain Yes No

Skin / Breast
Rash Yes No
Breast Pain Yes No

Gastrointestinal
Bowel Disorder Yes No
Nausea / Vomiting Yes No

Cardiovascular
Chest pain Yes No
DOE Yes No

Endocrine
Fatigue Yes No

Hot Flashes Yes No

ENT
Sinus Problems Yes No

Genitourinary
Dysuria Yes No
Hematuria Yes No

Respiratory
SOB Yes No
Frequent Cough Yes No

Hematologic / Lymphatic
Anemia Yes No
Phlebitis Yes No

Psychiatric
Anxiety / Depression Yes No

Physician Reviewed: _____

Notice of Privacy Practices
Doral Beach OB-GYN, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

Lissette Morales
4302 Alton Road, Suite 580
Miami Beach, FL 33140
Oficina: (305) 532-1989
Fax: (305) 532-8459

Notice of Privacy Acknowledgement

Doral Beach OB-GYN, 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.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

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

Date: _____ Attempt: _____

Staff Name: _____