Date _____
Fecha

Patient Registration
Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - *Información del Paciente*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Estado Civil *Casada* *Soltera* *Divorciada* *Viuda*

Race/Ethnicity _____
Raza/Etnia

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
Marque Uno *Empleada* *Retirada* *Estudiante Tiempo Completo*

☐ Other _____
Otro

Employer _____
Empleador

Work Phone (_____) _____
Telefono de Trabajo

Home Address _____
Direccion del Hogar

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Email Address _____

Home Phone (_____) _____ Cell Phone (_____) _____
Telefono del Hogar *Telefono Cellular*

I was referred to: _____ by / *por*
Fui recomendado por

☐ Friend _____ ☐ Relative _____
Amigo *Familiar*

☐ Physician _____ ☐ Insurance _____
Médico *Seguro*

☐ Reputation of the LLC's Physicians _____
Reputación de los Médicos del LLC

☐ Existing Patient of the LLC _____
Paciente Existente de la LLC

☐ Other _____
Otro

Insurance Information - *Información del Seguro*

Please provide your insurance card to the receptionist - *Por favor entregue su tarjeta de seguro a la recepcionista*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*

Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Secondary Insurance Information - *Información del Seguro Secundario*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*

Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Emergency Contact - *En Emergencias, contactar a:*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____
Sexo

Home Phone (_____) _____
Telefono del Hogar

Work Phone (_____) _____
Telefono del Trabajo

Pharmacy - *Farmacia*

Pharmacy _____
Farmacia

Pharmacy Phone _____
Numero de telefono de la farmacia

Pharmacy Address _____
Direccion de la farmacia

Spouse / Guarantor / Responsible Party - *Esposo / Persona Responsable*

Social Security # _____
Numero de Seguro Social

Relationship _____
Relación

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*

Daytime Phone (_____) _____
Teléfono durante el dia

Employer _____
Empleo

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Signature Required Please See Reverse Side
Firma Requerida. Por Favor mira al Dorso

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the 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.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compañia 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.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgements up to the minimum amounts pursuant to S.458.320 (5) (g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compañia de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

_____ _____

PATIENT'S / GUARANTOR'S SIGNATURE DATE

8525 SW 92 ST, UNIT D13
Miami, Florida 33156
PH (305) 270-3562 Fax (786)384-5766

Acknowledgment of HIPAA Patient Privacy

I designate the following persons listed below as persons presently involved with my healthcare. I agree that the practice may disclose certain or all aspects of my health information and or billing to listed persons. I understand that I am not required to list anyone and that I may update this at any time in person.

1._____	_____	_____	
Name	Relation to Patient	Telephone	
2._____	_____	_____	
Name	Relation to Patient	Telephone	
3._____	_____	_____	
Name	Relation to Patient	Telephone	

I have been presented with and reviewed the terms of this notice. I understand that I may request a copy of this notice at any time.

_____	_____	_____	_____
Patient Name	DOB	Signature Patient	Date

Dr. G. Lievano, Dr. J. Perez & Associates
OB/GYN
8525 SW 92nd St., Unit D-13
Miami, FL 33156
P# 305-270-3562 F# 786-384-5766

Our goal is to provide each patient with friendly and convenient service during your visit. For your convenience during this visit, our office will collect your blood here in the office and send it to the laboratory for processing.

For this service the office will charge an administrative fee of $20.00 for **annual** gynecologic patients and a one-time fee of $40.00 for obstetric patients that will cover any blood handling and processing throughout your current pregnancy and, if needed, post-partum visits. This service is provided as a courtesy to those patients who do not wish to go to their primary care physician or the lab.

If you choose to take advantage of this service, the administrative fee is due at the time the blood is drawn and is non-refundable. The **lab will bill your insurance company** for the tests that are ordered.

Our office **DOES NOT** verify lab benefits. It is Patient responsibility to be aware of their lab coverage as some of these tests may not be covered or applied to your deductible/coinsurance.

There is also an administrative fee of $20 for administering any type of injection (Rhogam, progesterone, etc.)

There is a charge of $30 for any maternity forms or letters and $10 for any type of GYN letter (per letter)

Please indicate if you would like your blood work done today in our office.

YES _____ NO _____

Patient Signature _____

Print Name _____ Date _____

*Occasionally a test will be ordered that needs special handling or sample tubes that we do not have available. If so, you will be given a requisition to take to the appropriate facility. No fee will be charged.

LIEVANO - PEREZ
OBSTETRICS & GYNECOLOGY OF MIAMI

8525 SW 92 ST, UNIT D13
Miami, Florida 33156
PH (305) 270-3562 Fax (786)384-5766

Patient History Record

Diseases: ___anemia ___asthma ___cancer ___diabetes ___depression ___Cardiac Disease ___hypertension ___problems of kidney /bladder ___pulmonary disease ___thyroid issues ___ gastrointestinal Issues

You smoke: ___Y ___N **Packs per day**:_____

You Drink: ___Y ___N **How many alcoholic beverages do you consume daily**:_____

Allergies:_____
_____
_____
_____
_____

Current Medications:_____
_____
_____

History of Menstrual:
Your menstrual cycle is normal:__Y __N __ If No
Explain:_____
age at which menstruation began:_____ number of days it lasts:_____

History of pregnancy: how many times.....
pregnant:_____ preterm births:_____ deliveries:_____
miscarriages:_____ abortions:_____ living children:_____

LIEVANO - PEREZ
OBSTETRICS & GYNECOLOGY OF MIAMI

8525 SW 92 ST, UNIT D13
Miami, Florida 33156
PH (305) 270-3562 Fax (786)384-5766

Review of Systems

Patient:_____ Date:_____

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

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Integumentary		
Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other_____		

Eyes		
Blurred Vision	Y	N
Double Vision	Y	N

Musculoskeletal		
Joint Pain	Y	N
Extremity Pain	Y	N

Allergy		
Hay Fever	Y	N
Drug Allergies	Y	N
Seasonal Allergies	Y	N

Ears/Nose/Throat/Mouth		
Ear infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Neurological		
Tremors	Y	N
Vertigo/Dizziness	Y	N

Genitourinary		
Urine Retention	Y	N
Painful Urination	Y	N

Endocrine		
Excessive thirst	Y	N
Tired	Y	N
Too hot/cold	Y	N

Respiratory		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of Breath	Y	N

Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Hematologic/Lymphatic		
Swollen glands	Y	N
Blood clotting	Y	N

Cardiovascular		
Chest pain	Y	N
Hypertension	Y	N

Psychiatric		
Depression	Y	N
Anxiety	Y	N

Physician Reviewed:_____

LIEVANO - PEREZ

OBSTETRICS & GYNECOLOGY OF MIAMI

8525 SW 92nd ST, UNIT D13
Miami, Florida 33156
PH (305) 270-3562 Fax (786) 384-5766

PLEASE READ CAREFULLY

Dr. Lievano, Dr. Perez, and/or Dr. Collado have ordered blood work that is medically necessary to evaluate your condition. Our office offers lab services to provide the best care possible for our patients. Your blood work is sent to a lab that participates with your current insurance plan. If you have insurance coverage the laboratory will submit a bill directly to your insurance carrier. This is not billed by our office. Deductible, co-insurance and or copay may apply depending on your type of coverage and plan.

You will be responsible for any bills or claims that you receive from the lab. Any billing questions with regards to lab charges must be addressed directly with the lab. Our office staff does not have access or control of your lab account.

This form acknowledges that you are aware that all blood and pathology tests performed may not be covered by your insurance company and you may be responsible for the bill.

Signature of Patient _____

Print Name _____

Date _____