WEST KENDALL OBGYN

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 Seugro_____

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**_____

KENDALL
ONE SEVENTEEN PROFESSIONAL ARTS CENTER
8200 SW 117TH AVE, SUITE 304, MIAMI, FL 33183
T: 305.226.5651 F: 305.226.2424

DORAL
3155 NW 82ND AVE, SUITE 202
MIAMI, FL 33122
T: 305.596.6700 F: 305.598.9779

WEST KENDALL
WEST KENDALL BAPTIST MEDICAL ARTS BLDG
15955 SW 96TH ST, SUITE 304, MIAMI, FL 33196
T: 305.226.5651 F: 786.567.4540

WWW.WKOBGYN.COM

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):

- ☐ NONE
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Allergies and Reaction

- ☐ NONE
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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):

- ☐ NONE
- ☐ Cancer _____
- ☐ Breast _____
- ☐ Cervical _____
- ☐ Ovarian _____
- ☐ Colon _____
- ☐ Uterine _____
- ☐ Diabetes_____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Osteoporosis _____
- ☐ Thyroid Disease _____
- ☐ Other _____

Surgical History (Check any that apply):

- ☐ NONE
- ☐ Breast Augmentation
- ☐ Breast Reduction
- ☐ Plastic Surgery
- ☐ Hysterectomy
- ☐ Ovary Removal
- ☐ Tonsillectomy / Adenoids
- ☐ Cholecystectomy
- ☐ Cardiac Surgery
- ☐ Abdominal Surgery
- ☐ Bladder Surgery
- ☐ Colposcopy
- ☐ Dilation and Curettage
- ☐ Endometrial Ablation
- ☐ Tubal Ligation
- ☐ Laparoscopy
- ☐ LEEP

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, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, 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, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, understand that diagnosis or treatment of me by Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, 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, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, is not required to agree to the restrictions that I Request. However, if Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, agree to the restrictions that I have requested, the restriction is binding on Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM.

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, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, 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, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, notice of privacy practices prior to signing this document. The Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Julio Somoano MD , Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, 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, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, duties with respect to my protected information.

Alberto Sirven MD, Julio E. Arronte MD, Patricia Perfetto MD, Julio Somoano MD, Mabel Marotta MD, Frank Cardona Jr. MD, Jhonathan Duarte MD, Frances Perez-Suarez MD, Edilia Pando ARNP, Naviuska Chirino ARNP, Maggier Quinoa ARNP & Maricel Perez Torres ARNP CNM, 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_____

Work Telephone:
__OK to leave message with detailed information
__Leave message with call back number only

Written Communications:
__OK to mail home address
__OK to mail work/office

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 envió.)

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