**Patient Registration Form**



Pedro A. Sevilla, M.D.

Michael J. Hernandez, M.D.

Andres F. Sosa, M.D.

Cristobal F. Risquez, M.D.

*Pulmonary & Critical Care Medicine*

DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

*Fecha*

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

*Nombre del paciente Fecha de Nacimiento*

SOCIAL SECURITY #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ SEX:\_\_\_\_M \_\_\_\_F PRIMARY LANGUAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Seguro Social Sexo Idioma primario*

HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Direccion del hogar Ciudad/Estado/Codio postal*

HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Telefono del hogar Telefono del trabajo Telefono celular*

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_

*Correo electronico Estado civil*

EMPLOYER OR SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Empleador of escuela Tipo de trabajo*

EMERGENCY CONTACT or PARENT OR GUARDIAN (if a minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Contacto en caso de emergencia or padre/guardian si paciente es de menor de edad*

RELATION TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Relacion a paciente Telefono*

I AUTHORIZE TO HAVE RESULTS SENT VIA TEXT MESSAGE TO CELL PHONE AND/OR EMAIL. INITIALS: \_\_\_\_

*Yo autorizo que se me mande mis resultados via texto a mi telefono cellular o por correo elctronico. Sus iniciales son requeridas*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nombre de su medico primario Telefono del doctor*

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

PLEASE LET US KNOW HOW YOU HEARD ABOUT US. PLACE A CHECKMARK (√) IN THE BOX BESIDE THE MOST APPROPRIATE RESPONSE.

*Por favor hagamos saber como supo de nuestro meico. Coloque una marca (√) en la casila junto a la respuesta mas apropiada de las siguientes opciones.*

□ REFERRED BY PCP

 *Referido por su medico primario*

□ REFERRED BY ANOTHER PHYSICIAN. IF SO, WHOM? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Referido por otro medico. ? Quien?*

 *□* REFERRED BY A CURRENT OR FORMER PATIENT. IF SO, WHOM?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Referido por un amigo/familiar. ?Quien?*

□ REFERRED BY A FRIEND/FAMILY MEMBER. IF SO, WHOM? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Referido pro un amigo/familiar. ?Quien?*

□ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Otras*

Miami Pulmonary Specialists

Patient Registration Form

**PRIMARY INSURANCE/Seguro Primario**

INSURANCE CARRIER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Compania de Seguro medico Numero de poliza Numbero de grupo*

INSURED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: self / spouse / child / other

*Nombre de asegurado Relacion al paciente: mi mismo/esposo/hijo(a)/otro*

INSURED SS #: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ INSURED DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE/Seguro Secondario**

 IS PATIENT COVERED BY A SECONDARY INSURANCE? \_\_\_\_ Yes \_\_\_\_ No POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Paciente tiene otro tipo de Seguro? Si No Asegurado*

INSURANCE CARRIER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POLICY ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Compania de seguro medico Numero de poliza Numero de grupo*

**PRIVACY POLICIES/Polica de Privacidad**

THE PRIVACY OF YOUR HEALTH INFORMATION IS OF THE UTMOST IMPORTANCE TO US. TO THAT END, WE HAVE ESTABLISHED AND EMPLEMENTD PRIVACY PRACTICES TO PROTECT YOUR INFORMATION CONSISTENT WITH THE OFFICE OF CIVIL RIGHTS, U.S. DEPARTMENT OF HEALTH AND HUMAN RIGHTS SERVICES. THESE PRACTICES ARE OUTLINED IN THE MIAMI PULMONARY SPECIALISTS PRIVACY POLICIES DOCUMENT. PLEASE INITIAL ON THE LINE BELOW INDICATING YOUR ACKNOWLEDGEMENT AND UNDERDSTANDING OF OUR PRIVACY POLICIES.

*La privacidad de su informacio de salud e sde extrema importancia para nosotros. Por esa razon, nosotros hemos establecido y implementado la Polica de Privacidad para protager su informacion siguiendo lo estalecido por la Oficina de Derechos Civiles y el Dpartamento de Salud y Servicios Humanos de los Estados Unidos. Estas practicas se describen en nuestro document de Polica de Privacidad. Por favor, escribe sus iniciales abajo indicando que usted intiende nuestra policia de privacidad.*

\_\_\_\_\_\_\_ I UNDERSTAND MY HEALTH INFORMATION RIGHTS AS DESCRIBED BY MIAMI PULMONARY SPECIALISTS.

 *Yo entiendo mis derechos relacionado a mi information de salud describe por MIAMI PULMONARY SPECIALISTS.*

**ASSIGNMENT AND RELEASE/Asignacion y autorizacion**

I CERTIFY THAT I, AND/OR MY DEPENDENT(S), HAVE INSURACE COVERAGE WITH THE ABOVE-NAMED INSURANCE(S) AND ASSIGN DIRECTLY TO MIAMI PULMONARY SPECIALISTS ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. MIAMI PULMONARY SPECIALISTS MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE-NAMED INSURANCE(S) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT REATMENT IS COMPLETED.

*Yo certfico que yo, y/o mis dependientes temenos cobertura de Seguro con la anteriormente mecionada compania(s) de seguros y asigno directamente a Miami Pulmonary Specialists todos los beneficios. Yo entiendo que soy completamente responsible por todos los cargos por atencion medica recibida, sea o no pagados por mi seguro. Yo autorizo el uso de mi firma en todos los documentos que se necesiten enviar al seguro. Miami Pulmonary Specialists puede compartir mi informacion de salud con la anteriormente mencionada compania(s) de seguros con el proposito de obtener pagos por servicios recibidos, y determinar beneficios de seguro o beneficios por determinado servicio. Este consantimiento terminara en el momento el actual plan de tratamiento termine.*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_*

SIGNATURE OF PATIENT, PARENT/GUARDIAN OR REPRESENTATIVE DATE/*Fecha*

*Firma del paciente, padre or personal responsible por el paciente*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

PRINT NAME OF PATIENT, PARENT/GUARDIAN OR REPRESENTATIVE RELATIONSHIP TO PATIENT

*Nombre del paciente, padre o personal responsible por el paciente Relacion al paciente*

**Pedro A. Sevilla, MD

Michael J. Hernandez, MD

Andres. F. Sosa, MD

Cristobal F. Risquez, MD

*Pulmonary & Critical Care Medicine*

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Address of Health Care Provider or Facility from which records are being requested:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatment requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail or fax information to: Miami Pulmonary Specialists

 Pedro A. Sevilla, MD

 Michael J. Hernandez, MD

 Andres F. Sosa, MD

 Cristobal F. Risquez, MD

 7000 SW 97 Ave., #120

 Miami, FL 33173

 844-431-6801 (Fax)

I hereby authorize MIAMI PULMONARY SPECIALISTS to obtain the health information indicated below that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses.

|  |  |  |  |
| --- | --- | --- | --- |
|  | All Medical Records |  | Sleep Study Reports |
|  | Physician Office Notes |  | PFT’s (Pulmonary Function Tests) |
|  | Radiology Reports (PET, CT Chest X-Ray) |  | Labs |
|  | Other (Specify): |  |  |

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_

7000 SW 97 Ave., #120

Miami, FL 33173

786-299-5419 (T)

844-431-6801 (F)

**Pedro A. Sevilla, MD

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Cristobal F. Risquez, MD

**Patient Pharmacy Information Update**

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_\_

**PATIENT INFORMATION/informacion del Paciente**

FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MIDDLE: \_\_\_\_\_\_ LAST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nombre: Segundo: Apellido:*

DATE OF BIRTH: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_

*Fecha de Nacimiento:*

**PHARMACY INFORMATION/Informacion de la Farmacia**

NAME OF PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Nombre de la farmacia*

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Direccion*

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Telefono*

FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Numero de fax*

**Pedro A. Sevilla, MD

Michael J. Hernandez, MD

Andres F. Sosa, MD

Cristobal F. Risquez, MD

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record #: \_\_\_\_\_\_\_\_\_

Advanced Directives

Advanced Directives is a written statement about how you want medical decisions to be made should you not be able to make them for yourself.

The three types of advanced directives are:

* A Living Will: It tells your family what kind of medical care you want to receive or not receive. Have you prepared a living will? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_
* A Health Care Surrogate Designation: It is a document where you designate someone to make decisions for you if you are not able to do so for yourself. Have you designated some to make decisions for you? Yes \_\_\_\_ No \_\_\_
* Anatomical Donation: It indicates if you want to donate any organ after death. Have you made a decision about donation of your organs? Yes \_\_\_\_\_ No \_\_\_\_\_

My signature below acknowledges that I have received the information that:

Yes, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, will fill out and return the forms to my doctor.

 *Signature*

No, I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do not wish to fill out the Advanced Directive forms.

 *Signature*

Directiva de Instrucciones Anticipadas a los Medicos, Familiares o Substitutos

Estos son documentos para identificar or autorizar quien puede tomar decisiones medicas en caso que usted este incapacitado.

Hay tres tipos de directivas:

* Testamento en vida: Describe que tratamientos medicos usted desea recibir o que no desea recibir. Tiene usted este tipo de documento? Si \_\_\_\_ No \_\_\_\_
* Nombramiento de Substituto Para Cuidado de Salud. Este documento nombra una persona que haga decisiones por usted. Ha decidido usted quien puede tomar decisiones por usted en caso que usted este incapacitado?

Si \_\_\_\_ No \_\_\_\_

* Formulario Uniforme: Este documento le deja saber a su familia y a su medico si va a donar algun organo despues de su fallacimiento. Tiene usted este tipo documento? Si \_\_\_\_ No \_\_\_\_

Mi firma aqui significa que de recibido la informacion descrita y que:

Si, yo voy a llenar y regresar el formulario a mi doctor. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Firma*

No, you no quiero llenar el formulario. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Firma*

7000 SW 97 Ave., #120, Miami, FL 33173

786-299-5419

844-431-6801