PATIENT INFORMATION

PATIENTS NAME: Nombre del Paciente:		
PERMANENT ADDRESS: Direccion Permanente:		
CITY: Ciudad:	STATE: Estado:	ZIP CODE: Zona Postal:
E-MAIL ADDRESS: Correo Electronico:		
HOME PHONE: Telefono:	CELL PHONE: Telefono:	
DATE OF BIRTH: Fecha de Nacimiento:	AGE: Edad:	SEX: Sexo:
RESPONSIBLE PARTY OR SPOUSE: Persona Responsable o Esposo/a:		

OCCUPATION: Ocupacion:	SOCIAL SECURITY: Seguro Social:
EMPLOYED BY: Empleo:	BUSINESS PHONE: Telefono del Trabajo:
BUSINESS ADDRESS: Direccion del Trabajo:	

PRIMARY INSURANCE: Seguro Primario:	
POLICY NUMBER: Numero de Poliza:	GROUP NUMBER: Numero de Grupo:
NAME OF SUBSCRIBER: Nombre del Asegurado:	
RELATION TO PATIENT: Relacion al Paciente:	

REFERRED BY: Referido por:	
NEAREST RELATIVE: Familiar Cercano:	PHONE: Telefono:
PRIMARY PHYSICIAN: Medico Primario:	

MARITAL STATUS Estado Civil	PREFERRED LANGUAGE Idioma Preferido	RACE Raza	ETHNICITY Etnicidad
□ ANNULLED	□ ENGLISH	□ AMERICAN INDIAN OR ALASKA NATIVE	□ HISPANIC/LATINO
□ DIVORCED	□ SPANISH	□ ASIAN	□ NOT HISPANIC/LATINO
□ SEPARATED	□ OTHER	□ BLACK/AFRICAN AMERICAN	□ OTHER
□ MARRIED	□ DECLINED	□ NATIVE HAWAIIN OR OTHER PACIFIC ISLAND	□ DECLINED
□ NEVER MARRIED		□ WHITE	
□ DOMESTIC PARTNER		□ OTHER	
□ WIDOWED		□ DECLINED	

PETE GARCIA, M.D.
BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

NAME: ______________________________ TODAY'S DATE: ______________

AGE: _____________ DATE OF BIRTH: ____________________SEX: _______

CHIEF COMPLAINT

SYMPTOM

____

LOCATION

____

DURATION

____

REVIEW OF SYSTEMS CHECK ONLY THE ONES YOU NOW HAVE OR HAVE HAD RECENTLY

GENERAL	SKIN	HEAD/NECK	BREASTS
CHILLS	BRUISE EASILY	BLEEDING GUMS	DISCHARGE
WEAKNESS	ITCHING	BLURRED VISION	LUMP/MASS
FATIGUE	CHANGE IN MOLES	DIFFICULTY SWALLOWING	PAIN
WEIGHT LOSS	RASH	DOUBLE VISION	BLEEDING
FAINTING	SORES	HOARSENESS	NIPPLE CHANGE
NIGHT SWEATS	SCARS	NOSEBLEEDS	SKIN CHANGE
SWOLLEN NODES	DRYNESS	PERSISTENT COUGH	BLOATEDNESS
ANEMIA		LUMP/MASS	
		PAIN	

LUNGS	HEART	GASTROINTESTINAL	
COUGH	MURMUR	PAIN	GAS
BLOOD	PALPITATIONS	NAUSEA	BELCHING
SHORT OF BREATH	CHEST PAIN/PRESSURE	VOMITING	HEARTBURN
WHEEZING	IRREGULAR HEARTBEAT	POOR APPETITE	HEMORRHOIDS
PAIN	HIGH BLOOD PRESSURE	BLOATING	HERNIAS
CONGESTION	LOW BLOOD PRESSURE	IRREGULAR BOWEL HABITS	INDIGESTION
INHALANT EXPOSURE		CONSTIPATION	RECTAL BLEEDING
PHLEGM		DIARRHEA	FOOD INTOLERANCE

GENITOURINARY		VASCULAR	
URGENCY	DISCHARGE	VARICOSE VEINS	HEAVINESS/TIRED LEGS
INCONTINENCE	SORES	SWELLING/EDEMA	LIMB HAIR LOSS
STRAINING	ERECTION DIFFICULTIES	ACHES	TROPHIC NAILS
STONES	LUMP/MASS	ITCHING	PARASTHESIA
BURNING	SMALL STREAM	CHANGE IN COLOR	BURNING SENSATION
BLOODY URINE		DERMATITIS/ECZEMA	LEG PAIN WHILE WALKING
		ULCERATION	LEG PAIN AT REST
		SUPERFICIAL PHLEBITIS	CRAMPS
		DEEP THROMBOPHLEBITIS	

NEUROLOGICAL		PSYCHIATRIC	
SEIZURES	WEAK GRIP	DEPRESSION	TIMID
VERTIGO	PARALYSIS	IRRITABLE	SUICIDAL THOUGHTS
TREMBLING	DIFFICULTY OF SPEECH	ANXIOUSNESS	EXTREME WORRY
INCOORDINATION	TINGLING/NUMBNESS	HALLUCINATIONS	SEXUAL PROBLEMS
DIZZINESS	LOSS OF MEMORY	INSECURITY	TROUBLED SLEEP

NAME: ____________________________ DOB: ___________ DATE: ________

GYNECOLOGICAL		
SPOTTING	CONTRACEPTION/TYPE	MENSTRUAL FLOW
MENSTRUAL CRAMPS	AGE AT FIRST PERIOD	HEAVY MODERATE LIGHT
DISCHARGE	AGE AT MENOPAUSE	
ITCHING	DURATION OF CYCLE	LAST PERIOD _____/_____/_____
PAINFUL INTERCOURSE	DURATION OF FLOW	
IRREGULAR PERIODS	# OF PREGNANCIES	LAST PAP SMEAR _____/_____/_____
HOT FLASHES	# OF BIRTHS	
PAIN BETWEEN PERIODS	# OF MISCARRIAGES	LAST MAMMOGRAM _____/_____/_____
	# OF ABORTIONS	

PAST MEDICAL HISTORY

CHECK ONLY THE ONES YOU HAVE HAD IN THE PAST

PAST GENERAL HEALTH: EXCELLENT GOOD FAIR POOR				
HAY FEVER	SINUSITIS	ANGINA/CHEST PAIN	COLITIS	ARTHRITIS
MUMPS	THYROID PROBLEMS	HEART MURMUR	CROHN'S DISEASE	GOUT
MEASLES	BREAST TROUBLE	HEART PROBLEMS	POLYPS	MIGRANES
RHEUMATIC FEVER	ASTHMA	HIGH CHOLESTEROL	KIDNEY INFECTION	EPILEPSY/SEIZURES
ALLERGIES	BRONCHITIS	STROKE	KIDNEY STONES	PARALYSIS
ANEMIA	PLEURISY	ULCERS	BLADDER PROBLEMS	POLIO
CANCER	PNEUMONIA	JAUNDICE	DIABETES	MENTAL ILLNESS
TUMOR	TUBERCULOSIS	GALLSTONES	SYPHILIS	ALCOHOLISM
BLOOD DISEASE	EMPHYSEMA	PANCREATITIS	GONORRHEA	DEPRESSION
LEUKEMIA	PULMONARY EMBOLISM	LIVER PROBLEMS	HIV/AIDS	NERVOUS BREAKDOWN
SKIN PROBLEMS	PHLEBITIS/THROMBOPHLEBITIS	HEPATITIS	SEXUAL PROBLEMS	OTHERS
CATARACTS	VARICOSE VEINS	PARASITES	PROSTATE PROBLEMS	
TONSILITIS	HYPERTENSION	DYSENTERY	HEMORRHOIDS	

PAST SURGICAL HISTORY			
ABDOMINAL ANEURYSM	CARDIAC STENTS	HEART VALVE REPLACEMENT	NECK SURGERY
ABDOMINAL HERNIA	CATARACT SURGERY	HEMOFFHOIDECTOMY	OVARIAN SURGERY
ADRENALECTOMY	CHOLECYSTECTOMY	HIP REPLACEMENT	PACEMAKER/DEFIBRILLATOR
ANAL FISSURE/ULCER	COLECTOMY	HYSTERECTOMY	PROSTATE SURGERY
APPENDECTOMY	CORONARY ARTERY BYPASS	INGUINAL HERNIA	RECTAL ABSCESS
ARTERIAL BYPASS-LEG	DIALYSIS ACCESS	KNEE SURGERY	THYROIDECTOMY
ARTERIAL STENTS-LEG	DILATION & CURETTAGE (D&C)	LITHOTRIPSY	TONSILLECTOMY
BACK SURGERY	BOWEL SURGERY	LUNG RESECTION	TUBAL LIGATION
CARDIAC CATHERIZATION	GASTRIC SURGERY	MASTECTOMY	UMBILICAL HERNIA

HOSPITALIZATIONS	DATE	HOSPITAL

IMMUNIZATIONS/VACCINATIONS		BLOOD TYPE	BLOOD TRANSFUSIONS
DPT	MEASLES	A+ A-	# OF TRANSFUSIONS
MUMPS	PNEUMOCOCCAL	B+ B-	DATE(S)
SMALLPOX	INFLUENZA	AB+ AB-	___/____/____
TYPHOID	POLIO	O+ O-	___/____/____
TETANUS	MMR		___/____/____

NAME: ____________________________ DOB: ___________ DATE: ________

FAMILY HISTORY

LIST ANY OF THE DISEASES IN THE SECTION ABOVE WHICH RUN IN THE FAMILY

BLOOD RELATIVES ONLY	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	STATE OF HEALTH	ILLNESSES
FATHER					
MOTHER					
BROTHER(S)					
SISTER(S)					
MATERNAL GRANDFATHER					
MATERNAL GRANDMOTHER					
PATERNAL GRANDFATHER					
PATERNAL GRANDMOTHER					

SOCIAL HISTORY

CHECK THE BOXES AND FILL IN

WEIGHT	MENTAL WORK	PHYSICAL WORK	EXERCISE	EDUCATION LEVEL
CURRENT	HEAVY	HEAVY	HEAVY	HIGH SCHOOL
USUAL	MODERATE	MODERATE	MODERATE	VOCATIONAL
MAXIMUM	LIGHT	LIGHT	LIGHT	COLLEGE
MINIMUM	# HOURS / DAY	# HOURS / DAY	# HOURS / WEEK	MASTERS/DOCTORATE

SMOKING	ALCOHOL	CAFFEINE (COFFEE,TEA,COLA)	NUTRITION # OF PORTIONS/WEEK	
NEVER	BEER AMOUNT/WEEK	CUPS PER DAY	MILK	CHICKEN
FORMER	LIQUOR AMOUNT/WEEK	# OF YEARS	MILK PRODUCTS	CEREAL
CURRENT	WINE AMOUNT/WEEK		EGGS	FISH
# PACKS/DAY	SEXUAL ACTIVITY	RECREATIONAL DRUGS	VEGETABLES	SWEETS
# OF YEARS	ACTIVE	# PER DAY	FRUITS	BEEF
	INACTIVE	# OF YEARS	BREADS	PORK

MEDICATIONS

LIST ALL CURRENT PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

NAME	DOSE	HOW OFTEN DO YOU TAKE?	REASON FOR MEDICATION?

ALLERGIES

LIST ALL ALLERGIES AND REACTIONS TO ANY MEDICATIONS

MEDICATION	REACTION
DO YOU HAVE A LATEX ALLERGY? ☐ YES ☐ NO	

PETE GARCIA, M.D.
BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I ____this ___________________
(NAME) (DATE)

do hereby authorize ____
(DOCTOR)

to release my medical information to Dr. Pete Garcia, and any information required regarding my case history, operative notes, office follow-up notes, x-ray films/reports, lab reports, and/or any information pertinent to the disposition of my case.

____
SIGNATURE OF PATIENT

____
WITNESS

PETE GARCIA, M.D.
BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

MEDICAL MALPRACTICE INSURANCE DISCLOSURE STATEMENT INSTRUCTIONS

UNDER RECENT CHANGES TO SECTION 458.320 OF THE FLORIDA STATUTES, PHYSICIANS WHO SELF-INSURE ARE REQUIRED TO POST THE NOTICE BELOW IN THE FORM OF A SIGN PROMINENTLY DISPLAYED IN THE RECEPTION AREA OF THEIR OFFICE AND CLEARLY NOTICEABLE TO ALL OF THEIR PATIENTS THAT THEY DO NOT CARRY MALPRACTICE INSURANCE.

IN ADDITION, PHYSICIANS ARE NOW ALSO REQUIRED TO PROVIDE A WRITTEN STATEMENT TO EACH OF THEIR PATIENTS TO SIGN, ACKNOWLEDGING RECEIPT THEREOF, AND ARE TO MAINTAIN THIS ACKNOWLEDGMENT IN THE PATIENT'S FILE. IF THE PATIENT REFUSES OR IS UNABLE TO SIGN THE WRITTEN STATEMENT, THE PHYSICIAN IS REQUIRED TO NOTE THAT ON THE FORM.

"UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** THIS IS PERMITTED UNDER FLORIDA LAW SUBJECT TO CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENALTIES AGAINST NON-INSURED PHYSICIANS WHO FAIL TO SATISFY ADVERSE JUDGMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE. THIS NOTICE IS PROVIDED PURSUANT TO FLORIDA LAW."

BY MY SIGNITURE, I CONFIRM THAT I HAVE READ AND UNDERSTAND THE ABOVE NOTICE.

"BAJO LAS LEYES DE LA FLORIDA, SE REQUIRE GENERALMENTE QUE LOS MEDICOS TENGAN SEGURO DE MALAPRACTICA MEDICA O SINO DEMONSTRAR RESPONSABILIDAD FINANCIER PARA CUBRIR POSSIBLE RECLAMACIONES POR MALAPRACTICA MEDICA. **SU MEDICO HA DECIDIDO NO TENER SEGURO DE MALAPRACTICA MEDICA**. ESTO SE PERMITE POR LAS LEYES DE LA FLORIDA SUJETO A CIERTAS CONDICIONES. LAS LEYES DE LA FLORIDA IMPONEN MULTAS A LOS MEDICOS NO ASEGURADOS QUE NO SATISFAGAN JUICIOS ADVERSOS DERIVADOS DE RECLAMACIONES DE MALAPRACTICA MEDICA. ESTE AVISO HA SIDO PROVISTO SIGUIENDO LAS LEYES DE LA FLORIDA.

CON MI FIRMA, YO CONFIRMO QUE HE LEIDO Y ENTIENDO ESTE AVISO.

_______________________________________ ________________

PATIENT'S SIGNATURE DATE
FIRMA DEL PACIENTE FECHA

PETE GARCIA, M.D.

BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

PATIENT CONTACT AUTHORIZATION

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 is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: ______________________________________
_________ OK to leave detailed message
_________ Leave message with call back number only

Work Telephone: ______________________________________
_________ OK to leave detailed message
_________ Leave message with call back number only

Cell Telephone: ______________________________________
_________ OK to leave detailed message
_________ Leave message with call back number only

E-Mail: ____
_________ OK to leave detailed message
_________ Leave message with call back number only

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____

[ ] Child(ren) ____

[ ] Other ____

[ ] Information is not to be released to anyone

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 requested by the individual. Healthcare entities must keep records of PHI disclosures. To assist us with this requirement, our office will only release information with a written request signed by the patient or legal guardian of said patient. This includes requests made by other physicians and their office(s). Our office will supply the proper form. **Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency. All authorizations will be in effect until revoked in writing by the patient.**

___________________________________ ___________________________
Patient/Parent/Guardian Signature Date

____
Printed Name

PETE GARCIA, M.D.
BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

ASSIGNMENT OF BENEFITS

INSURANCE

I hereby authorize Pete Garcia MD, PA to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original. **Either my insurance carrier or I may revoke this authorization at any time in writing**.

______
Initials

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Pete Garcia MD, PA for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. **I understand and agree that I am financially responsible for charges not paid by my insurance company.**

______
Initials

PAYMENT POLICY

Payment for services is due at the time services are rendered. All returned checks are subject to a ***$50 returned check fee***. If it becomes necessary to refer my account to an outside collection agency, I agree to pay 33% interest on the debt.

______
Initials

____ ____________
Patient Name Date

____
Patient Signature

PETE GARCIA, M.D.
BOARD CERTIFIED
GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the materials, please sign in the space provided below.

PATIENT RIGHTS

As a patient, you have a right to inspect, copy, amend, request a restriction or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of any accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. You may request that we communicate with you only in a specific manner (i.e. "only communicate with me at my work telephone number").

PROVIDER RIGHTS

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

____ _______________
Patient (or Guardian) Signature **Date**

____ _______________
Patient Name (Printed) **Date of Birth**

Written acknowledgement was not obtained for the following reasons:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgment
Other ____

____ _______________
Staff Signature **Date**

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GENERAL, VASCULAR, AND LAPAROSCOPIC SURGERY

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that Pete Garcia MD, PA may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Pete Garcia MD, PA to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

______________________________ ____________
Patient Name Date

____
Patient Signature