RodriguezMD
Community Care-Cuidado Comunitario

Billing and Registration Form

LASTNAME _____ FIRST NAME_____

DATE OF BIRTH ___/___/____ SOCIAL SECURITY #_____-____-_____ SEX (M / F)MARITAL STATUS_____

MAILING ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE # _____ FORMER NAME(S) _____

EMERGENCY CONTACT & PHONE _____

EMPLOYER INFORMATION:

COMPANY NAME _____ WORK PHONE _____ EXT _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BILLING INFORMATION:

NAME OF RESPONSIBLE PARTY (if other than self) _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

RELATIONSHIP _____ DATE OF BIRTH __/__/_____ PHONE NUMBER _____

INSURANCE INFORMATION/WORKERS COMP INFO:

Please give your card to the receptionist to copy

IS CONDITION RELATED TO EMPLOYMENT?_____ AUTO ACCIDENT?_____ OTHER ACCIDENT?_____

DATE OF INJURY _____ TIME OF INJURY _____

INSURANCE 1 _____ **COPAY AMOUNT** _____

SUBSCRIBER NAME _____ RELATIONSHIP_____

CERTIFICATE # _____ GROUP # _____

INSURANCE 2 _____ **COPAY AMOUNT** _____

SUBSCRIBER NAME _____ RELATIONSHIP _____

CERTIFICATE # _____ GROUP # _____

SUBSCRIBER DATE OF BIRTH (IF DIFFERENT THAN SELF) ___/___/_____ SOCIAL SECURITY #_____-____-_____

I authorize the release of any medical information necessary to process this claim. (REQUIRED) Signature_____Date _____	I authorize payment of medical benefits to my physician for services provided. (REQUIRED) Signature_____Date _____

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Patient History Form for Current Visit

Patient Name_____ Today's Date_____ Date of Birth_____

What medical concerns can we assist with today?

_____

_____

_____

Current Medications:

Medication	Dose (mg/mcg)	Number of times taken daily

Are you allergic to any medications? ☐ Yes ☐ No
If yes, to which medications? _____

Social History

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many packs per day? _____
Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many drinks per week? _____
Do you currently drink coffee, pop, tea, or energy drinks? ☐ Yes ☐ No
Do you exercise daily/weekly? ☐ Yes ☐ No
Do you use seatbelts when driving? ☐ Yes ☐ No
Do you wear a helmet while riding a bike? ☐ Yes ☐ No

Have you have had any of these symptoms recently? (Please circle)

Cough	Change in Vision	Sinus pain	Leg cramps
Bloody nose	Swollen/painful joints	Allergy symptoms	Heartburn
Thoughts of suicide	Headache	Breathing problems	Diarrhea
Eye pain/runny eyes	Dizziness	Chest pain	Vomiting
Decreased hearing	Fainting	Palpitations	Rash
Abdominal pain	Hemorrhoids	Pain with urination	Urinating frequently
Back pain	Foot/ankle pain	Nerve pain	Trouble sleeping/snoring
Sore Throat	Swollen lymph nodes		

Females: Gynecological History

First day of your last menstrual period?_____

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Past Medical History Form

Patient Name_____ Today's Date_____ Date of Birth_____

Have you ever been hospitalized overnight? ☐ Yes ☐ No
Have you been tested or vaccinated for hepatitis A, B, or C? ☐ Yes ☐ No
Last TB screening _____
Last tetanus shot _____

Which of the following conditions are you currently being treated or have been treated for in the past? (please check the box)

☐ Heart disease/murmur/angina	☐ Shortness of breath	☐ Eye disorder/glaucoma
☐ High cholesterol	☐ Asthma	☐ Seizures
☐ Low blood pressure	☐ Lung problems/cough	☐ Stroke
☐ High blood pressure	☐ Sinus problems	☐ Headaches/migraine
☐ Heartburn/ reflux	☐ Seasonal allergies	☐ Neurological problems
☐ Anemia/blood or bleeding problems	☐ Tonsillitis	☐ Depression/anxiety
☐ Swollen ankles/vein problems	☐ Ear Problems	☐ Psychiatric care
☐ Diabetes	☐ Kidney/bladder problem	☐ Liver problem/hepatitis
☐ Arthritis	☐ Cancer	☐ Ulcers/colitis
☐ Thyroid Problem	☐ Sexually transmitted disease	☐ Prostate problems
☐ Corrective lenses/glasses	☐ Hearing loss	☐ Rheumatic fever
☐ Hernia	☐ Kidney stones	☐ Eating disorder

Please describe any current or past medical treatment not listed above

_____

Please list your past surgeries

_____

_____

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	☐ Yes ☐ No	_____	_____
Father	☐ Yes ☐ No	_____	_____
Sisters	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____
Brothers	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____
	☐ Yes ☐ No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____

High blood pressure _____
Mental Illness/depression _____
Stroke _____
Other serious illness _____

Females: Gynecological History

How many times have you been pregnant? _____
Date of last Pap Smear _____
Have you had an abnormal Pap Smear? ☐ Yes ☐ No
Date of last mammogram? _____
Have you ever had a breast biopsy? ☐ Yes ☐ No

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Consent to Use or Disclose Protected Health Information
For Treatment, Payment and Health Care Operations

I consent to allow Rodriguez MD to use or disclose my protected health information for treatment, payment and health care operations.

- ❑ Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.

- ❑ Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.

- ❑ Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Rodriguez MD.

I consent to allow Rodriguez MD to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Rodriguez MD to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Rodriguez MD to disclose protected health information to another covered entity for health care operations activities, provided that Rodriguez MD and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

I acknowledge that I have received a copy of Rodriguez MD's Notice of Privacy.

Name of patient_____Date_____
(Please Print)

_____
Signature of Person Authorizing Consent

_____
Relationship to patient

OFFICE POLICIES AND PROCEDURES

_____**PHONE SYSTEM:** When you call our office, the phone system will be answered by our automated telephone system. Please carefully to the menu so that your call is directed to the appropriate department with little or no waiting time.

_____**SICK VISIT:** If you are sick, please make an appointment as early in the day as possible. We work by appointment only; no walk-ins. Patients arriving later than 20 minutes after the scheduled appointment time will have the option to reschedule or wait for the next available appointment that day. Please be courteous and notify us as soon as possible if you will not be keeping your appointment, so that we may offer the appointment time to another sick person.

_____**NURSE PHONE CALLS:** The nurse line receives a high volume of calls. For your convenience, there is a voice mail system on this line. Please leave your name and phone number and spell your name and date of birth. One of our nurses will return your call as soon as possible. Morning calls are returned by 12:30pm, and afternoon calls by 5pm.

_____**PRESCRIPTION REFILLS:** For medication that cannot be called in, please **notify 48 hours in advance** for picking up a prescription. The nurse will call in other medication refills as quickly as possible.

_____**INSURANCE:** To properly file your insurance claim(s), we must obtain a current copy of your insurance card each time you visit our office. This will help your insurance pay your claims in a timely manner and save you from being billed. In the event you do not provide proof-of-insurance, payment will be expected at the time of service. Further, if you provide us with incorrect insure information, you will be responsible for the bill. If incorrect insurance information is given that requires a claim to be re-filed, there will be a $35 re-filing fee.

- _____It is your responsibility to contact your insurance company and find out whether or not our doctors are participating physicians within your particular insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our doctors may participate in only one of these areas, not in all.

- _____It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on own insurance policy.

- _____**The following circumstance may result in you being billed directly.**

  .We are not participating physicians in your plan; insurance coverage is not in effect because of the date of visit.
  .Non-covered lab work is ordered/performed.
  .Or a non-covered service is performed or denied for the reason “not medically necessary”.

- _____Co-payment is due at the time of service by the person bringing the patient for the visit. If you do not have your co-pay we will bill you for a $15 administrative fee. If someone other than the parent or guardian is bringing the patient, a notice stating approval of the visit must be signed by the parent/guardian and presented at check-in.

_____**REFERRALS:** Referrals may be needed for specialists, emergency room visit, urgent care visit, etc. It is your responsibility to determine if your insurance requires a referral for health care visits outside of our office. If you do need a referral, please contact our office with an appointment date and time. We need 3 working days to obtain a referral from your insurance.

_____**LABS X RAYS, OR OTHER AMBULATORY CARE SERVICES:** If labs, x-ray, or other ambulatory care service are required beyond your office visit, it is your responsibility to know your insurance company covers you to go for these services. Each insurance company contracts with different companies.

I have read and understand the above mentioned policies, and notices.

Print name _____

Signature_____ Date_____