# DAMAR MEDICAL CENTER, INC

TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OFBIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MES/DIA /AÑO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FECHA DE NACIMIENTO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOMBRE Y APELLIDO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_S.S. #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIRECCION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CIUDAD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ESTADO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CODIGO POSTAL: \_\_\_\_\_\_\_\_\_\_\_\_\_SOCIAL#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELULAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEFONO DE CASA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTACTO DE EMERGENCIA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEFONO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CORREO ELECTRÓNICO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY OFFICE VISIT OR PROCEDURES RENDERED BY MY DOCTOR, PHYSICIAN ASSISTANT OR NURSE THAT MY INSURANCE COMPANY DEEMS NOT A COVERED SERVICE UNDER MY POLICY.

YO ENTIENDO QUE SOY RESPONSBALE POR EL PAGO A ESTA OFICINA

MEDICA POR LOS SERVICIOS Y PROCEDIMIENTOS REALIZADOS POR EL DOCTOR, ASISTENTE MEDICO O ENFERMERA EN CASO QUE MI SEGURO NO PAGE EL SERVICIO BAJO MI POLIZA DE SEGURO.

DATE: / / SIGNATURE:

AUTHORIZATION RELEASE

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION TO MY INSURANCE COMPANY FOR THE PROCESSING OF MY CLAIMS MADE ON THE BEHALF OF THESE SERVICE.

(YO AUTORIZO LA DIVULGACION DE CUALQUIER INFORMACION A MI COMPAÑIA

DE SEGUROS, PARA LOS RECLAMOS EN NOMBRE DE ESTOS SERVICIOS)

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE MY INSURANCE COMPANY TO ISSUE PAYMENT DIRECTLY TO

DAMAR MEDICAL CENTER INC.

(YO AUTORIZO A MI COMPANIA DE SEGUROS PARA EFECTUAR LOS PAGOS DIRECTAMENTE A DAMAR MEDICAL CENTER INC.)

DATE: / / SIGNATURE:

# DAMAR MEDICAL CENTER, lNC

New Patient Consent for the Use and Disclosure of Health Information.

For Treatment, Payment or Health Operations

**I, understand that as part of my health care Damar Medical Center, Inc. Originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:**

* **A basis for planning my care and treatment**
* **A means of communication among the many health professionals who contribute to my care**
* **A source of information for applying my diagnosis and surgical information to my bill.**
* **A means by which a third-party payer can verify that services billed were actually provided, and**
* **A tool for routine healthcare and reviewing the competence of healthcare professionals.**

**I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:**

* **The right to review the notice prior to signing this consent**
* **The right to object to the use of my health information for directory purpose, and**
* **The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.**

**l understand that Damar Medical Center, lnc. Is not required to agree to the restrictions request. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. l also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.**

**l further understand that Damar Medical Center, Inc. Reserves the right to change their notice and practices and prior to implementation, in accordance with Section**

**164.520 of the Code of Federal Regulations.**

**Should Damar Medical Center, lnc send a copy of my revised notice to the address I’ve provided (whether U.S. Mail or, if I agree, email)**

**I wish to have the following restrictions OR authorization to the use or disclosure of my health information:**

**I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.**

**I fully understand and accept/decline the terms of this consent.**

**Patient’s Signature Date**

Authorization for Release of Information for Purposes Requested by Physician's Office From Another Covered Entity

ATTN:

Name of Covered Entity

Patient Name: D.O.B:

Social Security #

I authorize you to disclose the following protected health information.

(Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

TO: DAMAR MEDICAL CENTER, INC

Dario Altamirano, D.O Fax (305) 820-1943

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Damar Medical Center Inc. in the following manner:

(Describe how protected health information will be used to carry out treatment, payment and/or health care operations purposes).

**Signature of Patient or Personal Representative Print Name of Patient or Representative**

**Date Relationship to patient**

# HEALTH ASSESSMENT

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nombre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fecha de Nacimiento:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity/Race/Language** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pais de Origen /Raza/Lenguaje de Preferencia**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Problems?** YES or NO If yes, please list

**Problemas Médicos?** Si o No, si es si escríbalos.

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

**Active Medication?** YES or No, if yes, please list

**Toma algun medicamento?** Si o No En caso afirmativo escriba el nombre de cada uno.

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

Allergies? YES or No, if yes, please list

Alergias algun medicamento? SI o NO, si es si escríbalos.

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

**Past Medical History?** YES or NO If yes, please list

**Antecedentes Médicos?** Si o No, si es si escríbalos.

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

**Surgical History?** YES or NO If yes, please list and year of surgery.

**Antecedentes Quirurgicos?** Si o No, si es si escríbalos y el ano de la cirugía.

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

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nombre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fecha de Nacimiento:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History?** YES or NO If yes, please indicate the relationship.

**Historia Familiar:** Señale si algún miembro de su familia padece de alguna de las siguientes condiciones

Hypertension: YES or NO Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presión Alta: SI o NO Indique que familiar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: YES or NO Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: SI o NO Indique que familiar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease: YES or NO Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problemas Del Corazón: SI o NO Indique que familiar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer: YES or NO Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer: SI o NO Indique que familiar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid disease: YES or NO Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problemas del Tiroides: SI o NO Indique que familiar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy: YES or NO Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsia: SI o NO Indique que familiar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma YES or NO Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asma SI o NO Indique que familiar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression: YES or NO Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depresión: SI o NO Indique que familiar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preventive Medicine:

Medicina preventiva:

Mammography Yes or No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pap Smear: Yes or No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram Si o No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prueba Cytological Si o No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy Yes o No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Exam: Yes or No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopia Si o No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Examen de los ojos : Si o No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History / Historia Social**

Alcohol use Yes or No Drug use Yes or No

Consume alcohol Si o No Usa Droga Si o No

Tabacco use Yes or No If yes,please fill out the following form

Fomer smoker Yes or No If yes,please fill out the following form

Fuma Si o No si la respuesta es afirmativa, por favor llenar el siguiente formulario

Fumo en el pasado Si o No si la respuesta es afirmativa, por favor llenar el siguiente formulario

 TOBACCO SCREENING FORM

NAME / NOMBRE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE / DIA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigar use / Fuma cigarro if is yes, when started / si fuma,cuando comenzo a fumar \_\_\_\_\_\_\_\_\_

* YesNo

Pipe smoking / Fumador de pipa

* YesNo

Smokeless tobacco use / Mastica Tabaco

* YesNo

Smoking less than 1 pack a day / Fuma menos de una caja al dia

* YesNo

Smoking 1 pack a day /Fuma una caja al dia

* YesNo

Smoking more than 1 pack a day/Fuma mas de una caja al dia

* YesNo

After eating / Fuma despues de comida

* YesNo

Using socially/ Fuma socialmente

* YesNo

Aiding in concentration/ Fuma para concentrarse

* YesNo

When stressed /Fuma cuando esta estresado

* YesNo

When drinking alcohol/Fuma cuando bebe alcohol

* YesNo

Living with a smoker/ Vive con personas que fuma

* YesNo

# Missed Appointment Policy

We are glad you have chosen us to provide your medical care. If you missed your appointments you compromise your care. Annual office visits are required for continuity of care and necessary evaluation of medical care. We want you to be aware of our office policy regarding missed appointments.

A missed appointment is when you fail to show for a schedule appointment without a phone call or prior notification. We strive to be on time for your schedule appointment, as well as respect your time and needs, we ask that you give us the courtesy of a call when you are unable to keep your appointment.

**Routine Office Visits**

We require 24 hour notice for all routine office visits otherwise a $20 missed appointment fee will be charged.

1. First missed follow up appointment: We will call and offer to reschedule your appointment. You will be charged a missed appointment fee of $20
2. Second missed follow up appointment: You will receive written notification of your missed appointment and be charged a fee of $20
3. Third missed follow up appointment: You will be charged an additional missed appointment fee of $20. This may also result in a discharge from the practice.

.

Name:

Signature Date