Boca Raton Family and Family and Pediatric Center
Luis Alvarez, MD (Family Physician) • *Sandra Alvarez, MD (Pediatrician)*
19801 Hampton Drive, Suite C1-2, Boca Raton, FL 33434 • 561-477-2862 • 561-477-2864 (fax)

REGISTRATION AND HISTORY

1 PATIENT INFORMATION

DATE:____________________

____
LAST NAME **FIRST NAME** **MIDDLE**

ADDRESS: ______________________________________

CITY:________________ **STATE**: _______**ZIP:**____________

RESPONSIBLE PARTY (if patient is under 18): ______________________

Sex: ☐ Male ☐ Female

DATE OF BIRTH: ____/_____/_____ **Age**:_______

SOCIAL SECURITY NUMBER: ____________________________

☐ Married ☐ Widowed ☐ Single ☐Minor
☐ Separated ☐ Divorced ☐ Partnered for ___ years

OCCUPATION: ________________________________
EMPLOYER/SCHOOL: ___________________________
SPOUSE'S NAME: _____________________________

WHO MAY WE THANK FOR REFERRING YOU?

☐ Physician______________________ ☐Yellow Pages ☐Insurance
☐ Friend: _________________☐ Internet ☐Other:______________

2 INSURANCE

DO YOU HAVE INSURANCE?
☐ Yes ☐ No – I am self-pay

If yes, please complete below

Who is responsible for this account? _____________________
Relationship to patient:_________________________________
Insurance company: _____________________________________
ID number: ____
Group number: ____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with ____________________and assign directly to Dr. Luis Alvarez and/or Dr. Sandra Alvarez all insurance benefits, and if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits o the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_______________________________ _______________
Signature Date

____________________________ ________________________
PRINT NAME RELATIONSHIP TO PATIENT

3 PHONE NUMBERS

HOME: ____________________________ **CELL:** ____________________ **WORK:**______________________

SPOUSE'S CELL:____________________________ **SPOUSE'S WORK:**____________________________________

IN CASE OF EMERGENCY, CONTACT: ______________________________**PHONE:**___________________________

PHARMACY NAME:____________________________________ **PHARMACY PHONE:**_________________________

4 MEDICATIONS

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION	STRENGTH	HOW MANY TIMES A DAY?

ALLERGIES

PLEASE CHECK ANY ALLERGIES AND/OR FILL IN BELOW

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Sulfa
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa

☐ Other: **PLEASE LIST BELOW**

____
____

-OVER-

5 MEDICAL HISTORY

Have you had any of the following? (Please check)

- ◻ Allergies
- ◻ Anxiety
- ◻ Arthritis
- ◻ Asthma
- ◻ Backaches
- ◻ Bladder
- ◻ Incontinence
- ◻ Cancer
- ◻ Colitis
- ◻ Depression
- ◻ Diabetes
- ◻ Drinking Disorde
- ◻ Eczema
- ◻ Fatigue
- ◻ Frequent Infections
- ◻ Headaches
- ◻ Heart Attack
- ◻ Heart Disease
- ◻ Hernia
- ◻ Hypertension
- ◻ Hypoglycemia
- ◻ Insomnia
- ◻ Irritability
- ◻ Kidney Problems
- ◻ Metal Implants
- ◻ Migraines
- ◻ Nervous Disorders
- ◻ Pacemaker
- ◻ Palpitations
- ◻ Pregnant
- ◻ Rheumatic Fever
- ◻ Seizures
- ◻ Sexual Disinterest
- ◻ Skin Problems
- ◻ Surgeries
- ◻ Tumor
- ◻ Ulcers
- ◻ Weight Fluctuation
- ◻ Weight Problems
- ◻ Other____________________

Do you wear contact lenses? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No

Is there anyone in your family who has died before the age of 40? If yes, who and why did they die?
____

Have you ever had to see a doctor or go to the hospital due to mental or behavioral problems? ________ If yes, when and why?________________
____

6 FLORIDA MEDICAL ASSOCIATION, HIPPA AND FINANCIAL RESPONSIBILITY

THE FLORIDA MEDICAL ASSOCIATION

The current professional liability insurance crisis in Florida affects you and every other patient. Because many physicians are being forced to stop performing certain procedures, retire early or leave to practice in other states where premiums are lower, patients are losing access to their physician. At a time when Florida's population has grown faster than any other state, 63 hospitals have closed in the past 15 years. Patient care is at risk; people have less access. In order to ensure your continued access to physicians in Florida, I am asking you to sign the below notice. If you do not understand this form, you have the right to take it to your attorney to have him or her explain the form to you. YOU MAY CONSULT WITH AN ATTORNEY BEFORE SIGNING THIS FORM. Waiver of the constitutional right provided in article 1, section 21, Florida Constitution. Access to comis – The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay. *I have been advised that signing this waiver releases an important constitutional right; and By signing this waiver I agree that if any controversy arises out of or in any way relating to the current, future or past diagnosis, treatment or care that I have or will receive from the physician or group of physicians listed below, or the physician(s)'s agents or employees, the maximum amount of any non-economic damages that can be awarded in any such action will be $250,000.* This limit applies regardless of the number of claimants or defendants in the proceeding. There is no limit on the amount of economic damages that a jury may award. By signing, I agree to let my case go to arbitration before making a decision.

I have read & understand this notice.

____ _____/_____/_____

Signature Date

HIPPA PRIVACY

This notice describes how medical information about you may be disclosed & how you can get access to it – please review carefully.

Boca Raton Family & Pediatric Clinic provides many types of health related services. BRF&PC is required to protect the information we collect. This information is called "protected health information" or PHI. This Notice of Privacy Practices will tell you how BRF&PC may use or disclose protected health information. BRF&PC May use and disclose information without your authorization for: **TREATMENT** with healthcare providers who are involved with your care. **PAYMENT:** to receive payment or to pay for the health care services you receive. **HEALTH CARE OPERATIONS** in order to manage its programs and activities and review the services you receive. **APPOINTMENTS AND OTHER HEALTH INFORMATION**: to send you reminders for medical care or checkups. **FOR PUBLIC HEALTH ACTIVITIES**: to public health agency that keeps vital records and tracks some diseases, as required by law. **FOR HEALTH OVERSIGHT ACTIVITIES**: to disclose information to inspect or investigate health providers. AS REQUIRED BY LAW: to disclose information when required by federal/state law or court order. **FOR GOVERNMENT PROGRAMS**: to disclose information for public/government benefits. **TO AVOID HARM**: to disclose to law enforcement in order to avoid a serious threat to health/safety. For other situations, BRF&PC will ask you for your written authorization before using or disclosing information. You may cancel this authorization in writing. BRF&PC can't take back and uses or disclosures already made with your authorization. Other Laws protect PHI. Your PHI Privacy rights: right to see and get copies of your records, right to request to correct or update your records, right to get a list of disclosures, right to request limits on uses or disclosures of PHI, right to revoke permission, right to choose how we communicate with you, right to file a complaint, right to get a paper copy of this notice. Please contact Luis A. Alvarez, M.D. or Sandra R. Alvarez, M.D. with any concerns.

GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT UPON REGISTRATION AND FINANCIAL RESPONSIBILITY

I hereby certify that I have not knowingly withheld any information on income or other financial resources and discounts I have disclosed to be true and correct to the best of my knowledge. The undersigned patient and/or responsible person or relative having registered at Boca Raton Family and Pediatric Clinic for the purposes of obtaining health services, do hereby, voluntarily consent to such diagnostic and treatment services, as might be provided by or at the direction of a physician or other health care professional or other qualified member of the staff of the Boca Raton Family and Pediatric Clinic to me according to his/her judgment. I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the center. I recognize that I will be asked to sign a specific consent for surgical and other special procedures including general and/or extensive local anesthesia. I am aware that health services are not based on an exact science, and I acknowledge that no guarantees have been made to me as the results of any treatment services. I hereby authorize payment of health insurance benefits recorded on the registration form to be paid directly to Boca Raton Family and Pediatric Clinic for services provided. I hereby authorize Boca Raton Family and Pediatric Clinic to furnish such information from my medical record pertaining to any and all treatment as requested by either health insurance plans or companies, if applicable to my case. This form has been fully explained to me, and I certify that I understand its contents. I understand that if my insurance plan is accepted that the charges for which I am responsible will reflect the balance due after credit for all appropriate discounts and all collections received by Boca Raton Family and Pediatric Clinic from health insurance benefits for the above named individuals. If my insurance is accepted, I understand my co-pay is due at the time services are provided. I also understand a returned check fee of $25.00 will be charged for any check returned to us for NSF (Non-sufficient funds) if I wish to pay by personal check.

I have read & understand these notices.

____ _____/_____/_____

Signature Date