Roger Estevez, MD Professional Corporation

4020 Pecos McLeod Rd   Las Vegas, Nevada 89121   Phone: (702) 570-6107

Demografico / Historia Medica

(La siguiente informacion es muy importante para tu salud, Por favor toma el tiempo de completar ambos lados de esta forma.Esto es Imporatante para Nosotros contamos con ustedes.)

Nombre: ___________________________________ **Fecha de Nacimiento**: ______________ **Edad:** ______
Genero: □F □M

Direccion: ____

Telef: ________________________ Cellular: _______________________ **Seguro social**:__________________________

Raza: Blanco___ Negro/Afric___ Asian___ American Indian /Alaska Native_____ Filip _____ Latino ______Other _______

Razon de la visita:
____

Has tenido alguna Cirugia o has estado Hospitalizado?
____

Nombre del su medico anterior: Telefono:

Cancer □Si □NO Tipo:_________________________ Diagnosticado: _________________
Tratamiento:______________

Lista de todos los medicamentos que estas tomando actualmente .

Nombre del Medicamento Dosis Frecuencia? Fecha de Comienzo Indicacion

HISTORIA SOCIAL

Fumas? □Si □NO Cuantos por Dia? _____ Ano que Comenzastes a fumar?______________ Cuando dejastes de fumar? ___________

Tomas Alcohol? □YES □NO □ Occasional □ Regularmente Si, Cuantos por Semana? ___________ Mes ___________

Abuso de Sustancias? □Si □NO Que Tipo?:____________

Estado Marital: □Soltero □Casado □Viudo Donde vives? □Casa □Apartamento □Otro
Animales en casa cual?________

(<u>Solo para Mujeres</u>) **Podrias salir embarazada?** □Si □NO # Embarazos: _______ # abortos: ______

Ultimo Periodo: ____________ Ultimo Mamograma: _________________ Last Pap Smear ___________________

Eres **ALLERGICO a algun Quimico** , **Comida** or **Medicamento?**(ie. Tape, iodine, latex)?
____

Has estado expuesto a sustancias toxicas como Asbestos, quimicos, radiacion, DES? □Si □NO

Explique: ____

Work Related Injury: □ Yes □ NoAutomobile Accident □ Yes □ NoDate of Injury/Accident:

Estas involucrado en algun litigio medico? □Si □NO Detalles:
____

Como supo de nosotros: □TV, □Periodico, □ Radio, □Amigo, □Referido por otro doctor:
________________Other_________

Farmacia que usa habitualmente: Telefono:

Certifico que toda la informacion Proveida a CROSN. Es correcta y actualizada en mi mejor conocimiento.

ROGER ESTEVEZ, MD PATIENT INFORMATION

FAMILY HISTORY: por favor seleccione si alguno de sus familiars cercanos han padecido alguna de estas enfermedades

RelacionVivo Muerto Diabetes Presion Alta Accidente

Cerebrovascular Cancer

Asthma

SI ES UNA PERSONA DIFERENTE AL PACIENTE – POLICY HOLDER/INSURED INFORMATION

Nombre de la persona asegurada: _____Phone:

Direccion:

Date of Birth: _Social Security #___Relacion con el paciente_________

Empleador del paciente: Ocupacion:

Work Phone Retirado: □Si □NO

Primary Insurance: Phone Number

Basado en los requerimientos de HIPAA Es requerido que Roger Estevez, MD Professional Corporation me contacte respecto a citas, referencias, resultados o cualquier otra información de salud protegida (PHI) por el siguiente medio:

Contacto de Emergency: ______________________ Relacion:________________ Telefono :__________________

Email: ____________________________ _____ Teléfono # ________________________

(correo electrónico) (# de preferencia)

Personas / Individuos que yo elijo tengan acceso a mi PHI:

______________________________ ______________________________ ______________________________

Nombre Teléfono Relación

______________________________ ______________________________ ______________________________

Nombre Teléfono Relación

Tenga en cuenta que la falta de información en cuanto a quién CROSN puede liberar su PHI prohíbe a CROSN y su personal suministrar cualquier información a cualquier persona, sin excepciones.

Al firmar abajo yo reconozco que he recibido aviso de las prácticas de privacidad de: Roger Estevez, MD PC

Si no es firmado por el paciente indique la relacion con el paciente y el nombre del paciente

Certifico que toda la informacion Proveida a CROSN. Es correcta y actualizada en mi mejor conocimiento.

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____________________________________, understand that as part of my health care, Roger Estevez,MD.PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination 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 operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been offered a copy of the Notice of Privacy Policies 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 purposes, 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.

I understand that Roger Estevez, MD. PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that 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.

I further understand that Roger Estevez, MD. PC reserves the right to change their notices and practices and prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations. Should Roger Estevez, MD. PC

Change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree email).

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 those permitted uses, including disclosures via fax.

I fully understand and accept ________.

CONSENT TO CONTACT BY PHONE / TEXT / EMAIL

I authorize Roger Estevez MD Professional Corporation and a third party business associate (including a collection agency) to use any email address or cellular telephone number that I provide on my account, for receiving information relating to my financial obligations; including, but not limited to, appointment confirmations, payment reminders and delinquent notifications. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing service or text messages.

COVER MY MEDS CONSENT

CoverMy med is online tool that may require the input of certain patient health information , to properly generate and submit prior authorization or other coverage determination inquiries, included but not limited to the patient’s name, DOB, address and contact information, diagnosis and/or medical condition, treatment/medical history (including prescription medications), health insurance information, and/or financial or other relevant information to enable the determination of drug coverage, by signing below you consent and give permission to Roger Estevez, MD, PC, to share or transmit information that included identifiable protected health information .