Roger Estevez, MD P. C

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

PATIENT DEMOGRAPHICS / MEDICAL HISTORY FORM

(The following information is very important to your health. Please take the time to fully and completely fill out both sides. This is important information and we are counting on you.)

Name: _____ **Date of Birth:** _____ Age: ____ Gender: □F □M

Address: _____

Home Phone: Cell Phone: **Social Security: _____**

Race: White ___ Black /African A___ Asian___ American Indian /Alaska Native_____ Filip _____ Latino _____Other _____

Reason for Visit:

_____

Have you ever had any surgery?

_____

Cancer: □YES □NO Type:_____ First diagnosed: _____ Treatment:_____

Prescription and Non-Prescription Medications you are currently taking: (including aspirin, vitamins, birth control, herbs, etc.)

Or attach a list of all prescribed medication that you are taking now

Medication Name Dose How often? Start Date Indication

SOCIAL HISTORY

Do you smoke? ☐**YES** ☐**NO** how many per day? _____ Year when did you start smoking?_____
Quit year? _____

Do you drink alcohol? ☐YES ☐NO ☐ Occasionally ☐ Regularly If yes, how many/week?
_____ month_____

Substance abuse? ☐YES ☐NO What Type?:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Where do you live?
☐House ☐Apartment ☐Other Pets at home? ☐YES ☐NO

For Women Only) Is there any chance of you being Pregnant? ☐YES ☐NO Age of first Period
_____

Pregnancies: _____ # Miscarriages: _____ # Abortions: _____ Last Menst. Period:
_____

Last Mammogram: _____ Last Pap Smear _____

Are you **ALLERGIC** to any CHEMICAL, **FOOD** or MEDICATIONS (ie. Tape, iodine, latex)?
:_____

Have you been exposed to any Toxic Substances, such as asbestos, DES, radiation, chemicals? ☐Yes ☐No

if yes, please explain:

_____

Are you involved in any medical litigation? ☐YES ☐NO Details:

_____

Work Related Injury: ☐ Yes ☐ No Automobile Accident ☐ Yes ☐ NoDate of Injury/Accident:_____

How did you find out about us: ☐TV, ☐Newspaper, ☐ Radio, ☐Friend, ☐Referred from other doctor: _____Other_____

Previous Doctor name: **Phone:**

PHARMACY : **Address:**

Phone:

I Certify that the above information. I have provided to C.R.O.S.N. is accurate and current to the best of my Knowledge.

ROGER ESTEVEZ, MD PATIENT INFORMATION

FAMILY HISTORY: Please check if any of your blood relative had any of the following health problems.

live Dead Diabetes Glaucoma Heart Attack Stroke High blood pressure Cancer Asthma Epilepsy

Father										
Mother										
Sister										
Brother										
Grandparent										

IF DIFFERENT FROM ABOVE – POLICY HOLDER/INSURED INFORMATION – Primary Insurance

Insured Person Name: Phone:

Address:

Primary Insurance: _____ Relationship to Patient_____

Date of Birth: _____Social Security #

Patient's Employer:_____Work Phone_____

Occupation: Retired ☐ Yes ☐ No

E-Mail address: _____

Based on HIPAA requirements I will require that Roger Estevez, MD Professional Corporation contact me regarding appointments, referrals, results or other protected health information (PHI) via the following:

Emergency Contact name: _____ Relationship:_____

Contact #:_____ Alternative **Phone #**_____

(Alternative phone #)

Individuals who I elect to have access to my PHI

_____ _____ _____

NamePhoneRelationship

_____ _____ _____

Name Phone Relationship

Please be advised that failure to provide information as to who CROSN can release your PHI prohibits CROSN and its staff from providing any information to any individual, no exceptions.

I have been presented with a copy of the Notice of Privacy Practices for the office of Roger Estevez, M.D. PC.

Detailing how my information may be used and disclosed as permitted under federal and state law.

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

I Certify that the above information. I have provided to C.R.O.S.N. is accurate and current to the best of my Knowledge.

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 have read and fully understand and accept the terms of this consent.

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 .