RONOEL PENALVER MDPA33333
FAMILY MEDICINE
1490 PALM AVENUE
PEMBROKE PINES, FLORIDA 33025
PHONE: 954-852-5485 I FAX: 954-842-3332
EMAIL: DRPENALVERMDPA@GMAIL.COM

PATIENT DEMOGRAPHIC (DATOS DEL PACIENTE)

PATIENT NAME: _____ AGE: _____

DOB: ___/ ___/ ____ EMAIL: _____ LANGUAGE PREFERENCE
☐ENGLISH☐SPANISH

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ ALTERNATIVE PHONE_____ WORK PHONE: _____

MARITAL STATUS:

☐SINGLE ☐MARRIED ☐WIDOW ☐SEPARATED

OCCUPATION: _____

EMPLOYEE BY: _____

EMERGENCY CONTACTS

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE NO.: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE NO.: _____

PHARMACY:

NAME: _____ PHONE NO.: _____

ADDRESS: _____

ANY ALLERGIES: _____ _____

_____ _____

_____ _____

INSURANCE (SEGURO MEDICO)

NAME OF INSURANCE COMPANY: _____

POLICY OR ID NUMBER: _____ GROUP NUMBER: _____

NAME OF SUSCRIBER: _____ RELATIONSHIP: _____

Authorization: I hereby authorize the physician office to furnish information to the insurance carriers concerning this illness/accident, and herby irrevocably assig to the doctor all payments for medical service referred. I understand that i am financially responsible for all charges whether or not covered by insurance.

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PATIENT SIGNATURE: _____ DATE: ___/___/ ____

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MEDICAL HISTORY (ANTECEDENTES PERSONALES)

HAVE YOU EVER HAD THE FOLLOWING; ¿HA TENIDO USTED ALGUNA DE LAS SIGUIENTES?

MEASLES (SARAMPION)	☐	MUMPS (PAPERAS)	☐
EPILEPSY (EPILEPSIA)	☐	Asthma (Asma)	☐
Kidney Disease(Enf de Riñones)	☐	HEPATITIS	☐
Ulcers (Ulceras)	☐	Gallstones (Piedras en la vesícula)	☐
Thyroid Issues (Probl de Tiriode)	☐	Surgery history (cirugías)	☐
CHIKENPOX (VARICELA)	☐	WHOOPING COUGH (TOSFERINA)	☐
SCARLET FEVER (SCARLATINA)	☐	DIPHTERIA(DIFTERIA)	☐
SMALLPOX (VIRUELA)	☐	POLIO	☐
ARTHRITIS (ARTRITIS)	☐	HERNIA	☐
BLOOD (TRANSFUIONES)	☐	TUBERCULOSIS	☐
PNEUMONIA (NEUMONÍA)	☐	HIGH BLOOD PRESSURE (PRESION ALTA)	☐
LOW BLOOD PRESSURE (PRESION BAJA)	☐	SEXUAL TRANSMITID DISEASE (ENF. TRANSMISION SEXUAL)	☐
DIABETES	☐	MIGRAINE(MIGRANA)	☐
HEADACHE (DOLOR DE CABEZA)	☐	ANEMIA	☐
CANCER	☐	HEART DISEASES (ENFERMEDAD CARDIACA)	☐
GLAUCOMA	☐	BACK ISSUES (PROBLEMA DE ESPALDA)	☐
RHEUMATIC FEVER (FIEBRE REUMÁTICA)	☐		

FAMILY HISTORY (ANTECEDENTES FAMILIARES)

DIABETES	☐ YES ☐ NO	WHO /QUIEN? _____
CANCER	☐ YES ☐ NO	WHO /QUIEN? _____
HEART DISEASE (ENF. CARDIACA)	☐ YES ☐ NO	WHO /QUIEN? _____
HIGH CHOLESTEROL/COLESTEROL ALTO	☐ YES ☐ NO	WHO /QUIEN? _____
HIGH BLOOD PRESSURE PRESIÓN ALTA)	☐ YES ☐ NO	WHO /QUIEN? _____

HABITS (HABITOS)

PATIENT SMOKING STATUS:

☐FORMER SMOKER (EX FUMADOR) ☐SMOKER (FUMADOR)

HOW MUCH (CUANTO FUMA):_____

DO YOU DRINK ALCOHOL? (TOMA BEBIDAS ALCOHOLICAS?)

☐NO ☐YES

DRINKS PER WEEK (BEBIDAS POR SEMANA).: _____

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MECICATIONS/MEDICAMENTOS QUE TOMA

MEDICATIONS/MEDICINA	DOSAGE/DOSIS	HOW OFTEN/FRECUENCIA

TEST/EXAMENES	DATE MONTH/YEAR (FECHA MES/AÑO)
BONE DENSITY (EXAMEN OSEO)	
Colonoscopy (Colonoscopia)	
EKG (ELECTROCARDIOGRAMA)	
EYE EXAM (EXAMEN DE LA VISTA)	
PRFOSTATE EXAM(EXAMEN PROSTATA)	
MAMOGRAM (MAMOGRAFIA)	
PAP SMEAR (PAPANICOLAO)	
PSA (ANTIGENO PROSTATICO DE SUPERFICIE)	
FLU VACCINE (VACUNA DE LA GRIPE)	
PNEUMONIA VACCINE (VACUNA DE NEUMONIA)	
SHINGLES VACCINE (VACUNA DEL HERPE)	
COVID VACCINE (VACUNA DEL COVID)	
STD TESTING	

SPECIALIST SEEN REGULARY (ESPECIALISTAS QUE VISITA CON REGULARIDAD)

SPECIALITY/ESPECIALIDAD	NAME	PHONE NUMBER

PATIENT SIGNATURE (FIRMA): _____ **DATE (FECHA) :** ___/___/___

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MEDICAL INFORMATION RELEASE FORM HIPAA RELEASE

PATIENT NAME (NOMBRE): _____ **DOB:** ___/___/___

I UNDERSTAND THAT RONOEL PENALVER MDPA, MAINTAIN MY PERSONAL RECORDS, MEDICAL HISTORY, SYMPTOMS, EXAMINATIONS, AND TEST RESULT AS PART OF MY HEALTHCARE. THIS INFORMATION IS NOT TO BE GIVEN TO ANY OTHER PERSON WITHOUT MY PERMISSION. THEREFORE, THIS IS WRITTEN CONSENT TO AUTHORIZE RELEASE OF MY MEDICAL INFORMATION.

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING DIAGNOSIS, RECORDS, LAB RESULTS, PRESCRIBED MEDICATIONS, TREATMENT PLANS, EXAMINATIONS AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ PHONE NO.: _____
NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ PHONE NO.: _____
NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ PHONE NO.: _____

HIPPA PRIVACY

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), I HAVE CERTAIN RIGHT TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I ACKNOWLEDGE THAT I RECEIVED OR HAVE BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF YOUR NOTICE PRIVACY AND THAT I MAY CONTACT THE PRACTICE AT ANY TIME TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICE.

PATIENT SIGNATURE: _____ **DATE:** ___/___/ ____

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Record Release Authorization Request

TO:

NAME _____ OR ORGANIZATION/FACILITY _____ PHONE NUMBER _____ FAX NUMBER _____

DEAR SIR O MADAM:
I HEREBY AUTHORIZE AND REQUEST THAT YOU RELEASE MY MEDICAL RECORDS TO THE ABOVE-MENTIONED FACILITY.
RECORDS TO RELEASE:

- RESENTS OFFICE VISIT RECORDS
- LABS/PATHOLOGY REPORTS
- RADIOLOGY / EKG / ECHO / STRESS TEST REPORT
- CONSULTATIONS REPORTS
- HOSPITAL / SURGERY / PROCEDURE RECORDS
- OTHER (SPECIFIED BELOW)

IF OTHER SPECIFY
_____
INCLUDING HIV / AIDS TESTING

PATIENT / GUARDIAN SIGNATURE
_____

PATIENT SIGNATURE
_____

RELATIONSHIP TO PATIENT
_____

DATE (FECHA)
___/___/___

DATE (FECHA)
___/___/___

FINANCIAL AGREEMENT

THANK YOU FOR CHOOSING **RONOEL PENALVER MDPA** AS YOUR HEALTHCARE PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THE PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR TREATMENT. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE YOU TO READ AND SING PRIOR TO ANY TREATMENT.

ANY AND ALL PAYMENTS ARE DUE AT THE TIME OF YOUR VISIT

NON-INSURED: CHARGES ARE DUE IN FULL AT THE TIME OF YOUR VISIT, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

INSURED PATIENTS: WE WILL BILL YOUR INSURANCE COMPANY FOR YOUR VISIT AS A COURTESY TO YOU. IF WE HAVE TROUBLE OBTAINING PAYMENT FROM INSURANCE PLANS, WE MAY ASK FOR YOU ASSITANCE IN GETTING YOUR CLAIM PAID. ***PLEASE BE ADVISE THAT IT IS THE PATIENT'S RESPONSIBILITY TO VERIFY THAT WE ARE A PARTICIPATING PROVIDER OF YOUR INSURANCE PLAN***.

MINOR PATIENT: THE PARENTS OR GUARDIAN ACCOMPANYING THE MINOR IS RESPONSIBLE FOR ALL PAYMENT OF THE BILL.

LABORATORY FEE: LABORATORY TESTING IS ADDITIONAL AND WILL BE BILLED DIRECTLY FORM THE LABORATORIES. OUR OFFICE PROVIDE LABORATORY DRAWING SERVICES. THERE IS A $15.00 CONVENIENCE FEE FOR HAVING LABORATORIES DONE IN THE OFFICE.

RETURNED CHECKS: ANY CHECKS RETURNED FOR ANY REASON, WILL BE SUBJECT TO A $30.00 FEE FOR ADMINISTRATIVE SERVICES.

NON-COVERED SERVICES: YOU WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES "NOT COVERED" BY YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE PLAN'S BENEFITS AND/OR LIMITATIONS.

PATIENTS MUST PROVIDE OUR OFFICE WITH ANY CHANGES TO THEIR NAME, ADDRESS, PHONE NUMBERS, AND/OR INSURANCE CARRIERS AT THE TIME OF THE OFFICE VISIT, FAILURE TO DO SO MAY RESULT IN A DENIAL OF THE CLAIM FROM THE INSURANCE COMPANY.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY, I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH.

PATIENT NAME: _____ DATE: ___/___/ ____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

GUARANTORS NAME: _____ DATE OF BIRTH:___/ __/ ____

RONDEL PENALVER MDPA

APPOINTMENT CANCELATIONS POLICY

IF IT IS NECESSARY TO CANCEL YOUR SCHEDULE APPOINTMENT, WE REQUIRE THAT YOU CALL ONE WORKING DAY IN ADVANCE. APPOINTMENTS ARE HIGH IN DEMAND, AND YOUR EARLY CANCELLATION WILL GIVE ANOTHER PERSON THE POSSIBILITY TO HAVE ACCESS TO TIMELY MEDICAL CARE.

TO REMAIN CONSISTENT WITH OUR MISSION, WE HAVE INSTITUTED THE FOLLOWING POLICY:

1. PLEASE PROVIDE OUR OFFICE A 24 HOUR BEFORE NOTICE IN THE EVENT THAT YOU NEED TO RESCHEDULE YOUR APPOINTMENT. A MESSAGE CAN ALWAYS BE LEFT WHIT THE ANSWERING SERVICE TO AVOID A CANCELLATIONS FEE BEING CHARGED.
2. A "NO-SHOW", "NO-CALL" OR MISSED APPOINTMENT, WITHOUT PROPER 24 HOUR BEFORE NOTIFICATION, MAY BE ASSESSED A $25.00 FEE.
3. THIS FEE IS NOT BILLABLE TO YOUR INSURANCE.
4. IF YOU ARE 15 OR MORE MINUTES LATE FOR YOUR APPOINTMENT, THE APPOINTMENT MAY BE CANCELLED AND RESCHEDULED.
5. AS A COURTESY, WE MAKE A REMINDER CALLS, FOR APPOINTMENTS, ONE TO TWO DAYS IN ADVANCE. PLEASE NOTE, IF A REMINDER CALL OR MESSAGE IS NOT RECEIVED, THE CANCELLATION POLICY REMAINS IN EFFECT.
6. REPEATED MISSED APPOINTMENT MAY RESULT IN TERMINATION OF THE PHYSICIAN/PATIENT RELATIONSHIP.

INF YOU HAVE ANY QUESTIONS READING THIS POLICY, PLEASE LET OUR STAFF KNOW AND WE WILL BE GLAD TO CLARIFY ANY QUESTIONS YOU HAVE. A COPY OF THIS POLICY WILL BE PROVIDED TO YOU. PLEASE SIG AND A DATE BELOW YOU ACKNOWLEDGE.

I HAVE READ AND UNDERSTAND THE APPOINTMENT CANCELATION POLICY AND I ACKNOWLEDGE ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERM MAY BE AMENDED FOR TIME TO TIME BY THE OFFICE.

_____ _____ ____/____/____
PRINTED NAME OF PATIENT SIGNATURE OF PATIENT DATE

PHONE NO.: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____