Romero Family Medicine, PLLC

New Patient Information

Patient's First Name________________________ Patient's Last Name___________________________________

Social Security Number __________________ Date of Birth _______________Gender: ○ Female ○ Male

Home Address ____

Email Address ____

Pharmacy Name_______________________________ Pharmacy's Tel. Number ______________________________

Pharmacy's Address ____

Home Phone Number ______________________________ Cell Phone Number ____________________________

Marital Status (Circle One) Single Married Divorced Separated Widowed Other

Spouse's Name (If Applicable) _______________________ Spouse's Phone Number______________________

Patient's Employer __________________ Occupation ________________ Work Number _______________________

Employer's Address ____

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Primary Medical Insurance ____

Policy Number ___________________________________ Group Number ________________________

Policy Holder's Name _____________________________ Relationship to Patient ___________________

Seconday Medical Insurance (If Applicable) ____

Policy Number ____________________________________ Group Number __________________________

Policy Holder's Name _____________________________ Relationship to Patient __________________

We Accept Payments in Cash, Check, Visa or Mastercard

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, not a substitute for payment. Some companies pay fixed allowances for certain procedures; others pay a percentage of the total charges. It is your responsibility to meet deductibles, pay co-insurance fees or any other balance not paid by your insurance. IT IS OUR POLICY THAT YOU PAY FOR CHARGES DUE ON THE DAY OF YOUR VISIT.

Please read and sign below

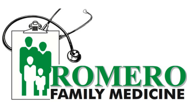
I accept financial responsibility for charges incurred on my behalf including cost of collection (if applicable). In the event that the insurance is filed for surgery or other services rendered to me, I hereby authorize Romero Family Medicine to release information to my insurance company and assign benefits directly to Romero Family Medicine. After insurance is paid any remaining balance is due and payable by me.

_________________________________ _________________________________

Patient's Signature or Guardian Today's Date

_________________________________ _________________________________

Guardian's Name Relationship



Medical History

Name______________________________ Date of Birth ______________________

Smoke: (Circle One) Yes / No Number of Cigarettes / Pack per day ______________________

Alcohol Consumption: None / _____ Number of alcoholic drinks consumed per week

Recreational Drug Used: None / Name of Drug(s) ______________________________

Sexual Orientation: ❑ Straight, heterosexual ❑ Lesbian, gay, homosexual

Allergies ____

Medications

Drug Name/mg	Pills per day	Start Date	Reason

Medical conditions, chronic illnesses

Disease	When did it begin?

Hospitalizations/Surgeries

Reason for Admission/Surgery	Date	Reason for Admission/Surgery	Date

Family History

	Alive or Deceased	Current Age	Medical Problems
Mother			
Father			
Brother			
Sister			

Other Family History *(circle if applicable)*

Cancer Diabetes Tuberculosis Strokes Heart Disease High Blood Pressure

Other ____

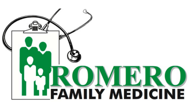
Adults Only (please write year, if applicable)

Last Tetanus Shot ______________________ Last Flu Shot __ ______________________

Last Pneumonia Shot ____________ Last Hepatitis Shot ____________ Last Colonoscopy ____________

WOMEN: Last Mammogram ____________________ Last Pap ______________________

MEN: Last Prostate Exam ____________________ Last Prostate Blood Test (PSA) ____________



Health Questionnaire

Name________________________________ Date of Birth ____________________________

	YES	NO
Unexpected Weight Loss	❑	❑
Eye Problems, Glaucoma	❑	❑
Ear, Nose or Throat Problems	❑	❑
Heart Problems	❑	❑
Lung Problems	❑	❑
Asthma, Tuberculosis	❑	❑
High Blood Pressure	❑	❑
Emphysema / COPD	❑	❑
Stomach Problems	❑	❑
Gallbladder Stones	❑	❑
Liver / Pancreas Problems	❑	❑
Recurrent Urinary Tract Infections	❑	❑
Kidney Stones	❑	❑
Hepatitis	❑	❑
Arthritis	❑	❑
Skin Rashes	❑	❑
Neurological diseases	❑	❑
Numbness, tingling, seizures	❑	❑
Psychiatric Illness	❑	❑
Endocrine Problems, Thyroid / Diabetes	❑	❑
Breast Nodules	❑	❑
Cancer	❑	❑
Anemia	❑	❑
High Risk Sexual Behavior	❑	❑
HIV Positive	❑	❑

Cancellation Policy

At Romero Family Medicine your scheduled appointment time is reserved just for you. There will be a $25.00 charge if you do not cancel a scheduled appointment with a minimum of 24 hours in advance.

With my signature below I ________________________________ agree to abide by this policy.
(Patient's name)

_____________________________________ ___________________

Patient's Signature or Patient's Guardian **Today's Date**

Romero Family Medicine, PLLC

Authorization for Release of Information

I, ______________________________ ,date of birth,__________________________ give my authorization to
(patient's name) (patient's DOB)

______________________________to give my medical records to
(doctor's or hospital name who has records)

______________________________so that he/she can better understand my condition.
(my doctor's name)

Please send records to:

Romero Family Medicine

1865 N. Corporate Lakes Blvd, Suite 2A

Weston, FL 33326

Tel. # 954-349-4391

Fax # 954-349-4847

By putting my initials by each item below, I understand that I give permission for records to be sent that may contain information about:

___________ My mental health,
___________ Transmittable disease I may have like HIV/AIDS,
___________ Drug and/or alcohol abuse information
___________ Specific information only: ______________________________
___________ Any information, including records of treatment or examination dated between

___________ and ___________

You have the right to revoke this authorization by putting it in writing. I understand that Romero Family Medicine has the right to disclose as per "Notice of Privacy/Health Information Practices."

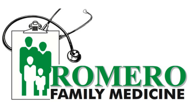
Patient's Name ______________________________ Social Security # ______________________

Patient's Signature____ Date ______________________________

Authorized Representative's Signature__________________________ Date ______________________________

Name and relationship of Authorized Representative__________________________________

⌖ This authorization expires six months from the original date of signature ⌖



Family or Notification Disclosure

Name_________________________________ **Date of Birth __________________________**

I hereby authorize Romero Family Medicine to disclose information regarding my illness, medications and/or treatment to the following:

Spouse ___________________________________ Tel Number _______________________
Son / Daughter _____________________________ Tel Number _______________________
Parents ___________________________________ Tel Number _______________________
Other ____________________________________ Tel Number _______________________
Other ____________________________________ Tel Number _______________________

I wish to be contacted in the following manner (check all that apply)

- ❑ **Home or Cell phone # __________________________**
- ❑ **Work Telephone # _____________________________**
- ❑ **Email message _________________________________**
- ❑ **Written Communication to my home address**

Today's Date: ____

Patient's Signature____

HIPAA Notice of Privacy Practice

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclosure health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclosure health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclosure your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. We may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by your name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Required by Law: We may use or disclosure your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclosure healthcare information to report problems with products, reactions to medications, products recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

You have the right to inspect and copy your protected health information Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complains You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with a HIPAA Compliance Officer in person or by phone.

Your signature below is only an acknowledgement that you have received the Notice of our Private Practices.

Print name: ______________________ Date: ______________ Signature: ______________________________