JUAN P. AGUILAR M.D.

PATIENT INFORMATION SHEET

TODAY'S DATE (FECHA DE HOY) _____ EMAIL ADRESS (CORREO ELECTRONICO)_____

WHOM MAY WE THANK FOR RECOMMENDING US? (¿QUIEN LO RECOMENDO A NUESTRA OFICINA?)

_____

NAME (NOMBRE):_____
SEX (SEXO)_____

MARITA STATUS (ESTADO CIVIL) _____ DATE OF BIRTH (FECHA DE NACIMIENTO)_____

SOCIAL SECURITY (NUMERO DEL SEGURO SOCIAL)
_____

_____ _____
_____
PHONE (TELEFONO) HOME (CASA) CELLULAR (CELULAR) WORK (TRABAJO)

_____ _____
_____
ADDRESS (DIRECCION) CITY (CIUDAD) STATE (ESTADO) ZIP (CODIGO POSTAL)

PERSON RESPOSIBLE FOR THIS BILL INSURANCE NAME
(PERSONA RESPONSABLE POR ESTA CUENTA) (NOMBRE DE SEGURO)

_____
_____

EMPLOYER (EMPLEADOR) _____OCCUPATION (OCUPACION) _____

ADDRESS (DIRECCION) _____

EMERGENCY CONTACT (PERSONA A CONTACTAR EN CASO DE EMERGENCIA) PHONE (TELEFONO)

_____ _____

PRIMARY CARE PHYCISIAN (DOCTOR PRIMARIO) PHONE (TELEFONO)

_____
_____

MAY WE CONTACT YOU AT WORK? (¿PODEMOS LLAMARLE AL TRABAJO?) N/A ____
YES ____ NO ____
MAY WE DISCUSS MEDICAL INFORMATION ABOUT YOU WITH YOUR SPOUSE OR FAMILY MEMBER?

(¿NOS AUTORIZA A DISCUTIR INFORMACIÓN MÉDICA CON SU ESPOSO /A – Ó ALGUN FAMILIAR?)
YES _____NO_____

……

PATIENT CONSENT AND TREATMENT

I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician (s).
(El) (La) suscrito (a) voluntariamente acepta someterse al cuidado, incluyendo tratamientos, y administración de anestésicos y ejecución de procedimientos diagnósticos y/o quirúrgicos. Yo entiendo que estoy bajo el cuidado y supervisión del doctor y es la responsabilidad del personal de esta oficina el informarme de las instrucciones del Doctor.
I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Dr. Juan P. Aguilar for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.
(El) (La) suscrito (a) autoriza que, toda la información médica necesaria para procesar cualquiera de mis reclamos a mi compañía de seguros sea puesta a disposición de ésta. Así mismo autorizo el pago de mis beneficios médicos directamente al Dr. Juan P. Aguilar. Entiendo y aceptó que, independiente de mi condición de asegurado (a), soy totalmente responsable di mi cuenta por los servicios profesionales recibidos en este centro. Si acaso esta cuenta fuese enviada a un servicio de cobranzas, todos los gastos que se originen de este recurso legal son también de mi responsabilidad). El/la suscrito/a consiente que al firmar como padre, esposo/a, fiador, guardián o paciente, asume la responsabilidad y obligación por cualquier balance pendiente que derive a causa de tratamiento médico a dicho paciente. En caso de que la cuenta fuese referida a un abogado, el/la suscrito/a pagara dichas cuentas legales y asumirá costos de colección.

SIGNATURE (FIRMA) _____ NAME (NOMBRE) _____

PLEASE SUBMIT YOUR INSURANCE CARDS SO THAT WE MAY MAKE A COPY FOR OUR RECORDS.
(POR FAVOR ENTRÉGUENOS SU TARJETA DE SEGURO PARA HACER UNA COPIA PARA NUESTRO ARCHIVO)

JUAN P. AGUILAR M.D.

CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

Purpose of Consent- By signing this form, you will consent to our use and disclosure of your protected information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices- You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected healthcare information, and of other important matters about your protected health information. A copy of our Notice is available for your review. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a Revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting AGUILAR AND BALLEN PA Administrator:

Paulina F. Silva HIPAA Compliance Coordinator
Juan P. Aguilar M.D. Telephone: 305-774-5700
747 Ponce De Leon Blvd. Suite 402. Fax: 305-774-5900
Coral Gables, FL. 33134

Right to Revoke- You will have the right to revoke this consent at any time by giving us written notice of revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took on reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE
I, (print name) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

SIGNATURE: _____ DATE: _____

JUAN P. AGUILAR M.D.

Dear Patient:

If you wish to have this service done in our office, the charges are due at the time services are rendered.

Estimado Paciente:

Si usted desea hacerse la refracción en nuestra oficina, los cargos deben ser pagados al render este servicio.

I understand the above and agree to pay the $45.00 if services are rendered. / Yo entiendo lo escrito y estoy de acuerdo en pagar $45.00 si este servicio fuera hecho.

Patient signature/ Date/
Firma del paciente: _____ Fecha:
_____

JUAN P. AGUILAR M.D.

Dear Patient: The following is a questionnaire to help the doctor know more about you. Please answer as best as you know.

Family History
Does or did anyone in your family have any of the following?

Diabetes [ ]Mother [ ]Father [ ]Sibling [ ]grandparent

Hypertension [ ]Mother [ ]Father [ ]Sibling [ ]grandparent

Cancer [ ]Mother [ ]Father [ ]Sibling [ ]grandparent

Stroke [ ]Mother [ ]Father [ ]Sibling [ ]grandparent

Glaucoma[ ]Mother [ ]Father [ ]Sibling [ ]grandparent

Aything else? Comments:_____

Social History
Let us know a little about your daily habits. This is confidential.

Smoke? [ ]No [ ]Yes I quit smoking _____ year(s) ago.

Consume alcohol? [ ]No [ ]Social [ ]at dinner

Consume drugs? [ ]No [ ]Rarely [ ]Frequently

Do you exercise? [ ]No [ ]Weekly [ ]More than twice a week

In the last 3 months, your weight has:

[ ]maintained [ ]dropped 10 lbs. [ ]gained 10 lbs. other_____

Do you drive? [ ]No [ ]Yes

Medical History
Have you had or have any of the following?

[ ]Diabetes [ ]Hypertension [ ]Cancer [ ]Stroke [ ]Asthma

[ ]Thyroid [ ]Lupus [ ]Mult Sclerosis [ ]Kidney Stones

[ ]Migraines [ ]Heart Other/Comments:_____

What surgeries have you had? _____

Ophthalmic History
Have you had any of the following?

[ ]Cataract surgery [ ]Cataracts diagnosed [ ]Glaucoma

[ ]Macular Degeneration [ ]Retinal Detachment [ ]laser

Comments:_____

Do you wear contact lenses? [ ]No [ ]Yes Glasses? [ ]No [ ]Yes