Suarez Medical Center

Sergio G. Suarez, MD **Diego H. Suarez, MD**

Personal Information:

Name:______________________________ Date of birth:________________

Address:______________________________ Apt #________________

City: ________________________ State______________ Zip code: ________

Sex: Male / Female Social Security Number: ______-_____-________

Home number: ______________ Work: ________________ Cell____________

In case of emergency contact____________________ Phone#________________

Email______________________________________

Marital Status: Married ( ) Single ( ) Divorced ( ) Other ( ) Decline ( )

Insurance Information:

Primary Insurance:____________________ ID#:________________________

Secondary insurance: __________________ ID#:________________________

Co-pay:_______ Diagnostic co-pay________ Deductible____________

Relationship to policy holder: Self ( ) Husband/ Wife ( ) Child ( ) Other ( )

Policy Holder's name:____________________ DOB______________

Race: White ( ) Black ( ) Asian ( ) Native American ( ) Other ( ) Decline ( )
Ethnicity: Hispanic ( ) Non- Hispanic ( ) Decline ( )

Communication Needs: None ( ) Deaf ( ) Mute ( ) Blind ( ) Cognitive ( ) Other ___________

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-cover services. I also authorize the physician to release any information required in the processing of this claim.

Patient Signature:________________________ **Date:**________________

Have you ever had any of the following medical problems? (Please check)

___ Diabetes
___Stroke
___Rheumatic Fever
___Seizure Disorder
___Bleeding Disorder
___High blood pressure
___Heart Disease
___Venereal disease
___Arthritis
___Other

___Anemia
___Poor Circulation
___Thyroid problems
___Ulcer or other stomach problems
___Nervous Conditions
___Phlebitis
___Heart Attack
___Hepatitis
___Cancer
___HIV/AIDS

What medications, if any are you presently taking?

Name:______________________________ Name:______________________________

Name:______________________________ Name:______________________________

Name of Pharmacy you use:____________________________**Phone #:**________________________

Are you Allergic to any medication/ Food? _____ if yes, please explain:

____

List any hospitalizations/ Surgeries you have had (Indicate Dates)____________________________

____

Social History: Please Complete Each Section:

Do you drink Alcohol? Yes ( ) No ( )
Frequency: ( ) daily ( ) Weekly ( ) Monthly ( ) Recovering Alcoholic ( )
Quantity __________ **oz.**

Do you use tobacco? Yes ( ) No ( )

Smoke____________ cigarettes per day) Chew ( ) 2nd Hand Smoke ( )

High-Risk sexual behavior assessment:
Are you sexually active? Yes ( ) No ( ) Decline ( )

Illicit/IVDA User: Yes ( ) No ( )
If **Yes**, please explain:____

Living Will: Yes/No/Decline
Advanced Directives: Yes/No/decline

Health Care Proxy (Name /Relationship) _________________________Phone Number:________________

SERGIO G. SUAREZ, M.D.
72 GUY LOMBARDO AVE
FREEPORT, N.Y. 11520

Permission for Electronic Communication:

Practice Fusion would like to contact you via text messaging using your personal phone regarding appointment reminders. Some limited personal information may be included however no medical or test results will be specified. Initial below if you wish to be contacted via text messaging or not.

__________ **Yes, I want** Practice Fusion to use my cell phone listed below to send text messages (Initial) for the purposes of appointment remind.

Cell/Text Message Number: ____

__________ **NO, I do not want** Practice Fusion to use my cell phone listed below to send text messages.

Recordatorios de citas.

Practice Fusion desea contactarlo a través de mensajes de texto usando su teléfono personal con respecto a los recordatorios de citas. Es posible que se incluya cierta información personal limitada; sin embargo, no se especificarán resultados médicos o de pruebas. Inicial a continuación si desea ser contactado a través de mensajes de texto o no.

__________ **Sí, quiero** que Practice Fusion use mi teléfono celular que para enviar mensajes de texto con el propósito de recordar la cita.

__________ **NO, no quiero** que Practice Fusion use mi teléfono celular a para enviar mensajes De texto.

Print Name (Firma del Paciente) ____

Date of Birth (Feche De Nacimento) : ______________________________

SERGIO G. SUAREZ, M.D.
72 GUY LOMBARDO AVE, SUITE 1
FREEPORT, NY 11520

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE APRIL 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used and about certain rights that you have.

Ligia Estevez is in charge of privacy matters at our office. You can contact her at (516) 377-2727. If you desire further information, or have any questions or concerns.

Use and disclosure of protected information.

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you (example: such as, "if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS)")

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you (example: such as, "under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered").

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you (example: such as, our accountants may see your name, dates of treatment and procedure codes during audits of our books) (as a possible second example: we may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer).

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law.
2. Required for public health purposes;
3. Required by law to report child abuse;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the department of health, office of professional discipline or office of professional Medical Conduct
5. Required by law in judicial or administrative proceedings.
6. Required for law enforcement purposes by a law enforcement official;
7. Required by a coroner or medical examiner
8. Permitted by a law to funeral director;
9. Permitted by law for organ donation purposes;

10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of the armed forces of the United States;
12. [research purposes (if applicable to your practice, see details at 45 CFR § 164.512 (i))]

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided below.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have.

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR § 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law [or for research or public health purposes after being de-identified or limited to remove personally identifiable information] or disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Sergio G. Suarez Medical Center, 72 Guy Lombardo Ave, suite 1, Freeport, N.Y. 11520, (516) 377-2727.

No retaliatory action will be taken against you for any complaint you may make.

I have received a paper copy of this notice

____
Signature

____
Print Name

____
Date

I make the following special request for confidential communications:

____
____
____
____

______________________ ______________________
Signature Date