PatronMedical
Study Patient Registration Form

Patients Name:	Gender at birth Male[ ] Female[ ]	Date of Birth: _____/_____/_____ Age:_____	Marital Status Single [ ] Married [ ] Divorced [ ] Widow [ ]
Address:		Home Phone: Cell Phone:	Patients Social Security #:
City:		Email:	

Race: White[ ] Black/African American[ ] American Indian/ Alaska Native[ ] Asian[ ] Island Pacific or Other _____

Ethnicity: Hispanic or Latino [ ] Not Hispanic/Latino [ ]

Preferred Language: English[ ] Spanish[ ] other:_____

Emplyment Status: Employed Full-Time[ ] Employed Part-Time[ ] Unemployed[ ] Self Employed[ ] Retired[ ] Homemaker[ ]

Student Status: Current Student Full Time[ ] Current Student Part-Time[ ]

Name of Employer, School or Current Status	Occupation:	Work Telephone Number:
Address:		
Person to contact in case of emergency: Address:	Relationship to patient:	Emergency Phone Number(s):

Do you currently have a Primary Care Physician?

_____ **Yes**, I currently have a Primary Care Physician.

Name of Doctor:_____

Address: _____

Telephone:__(_____)_____

_____**No**, I do not have a Primary Care Physician.

_____**Dr. Andres Patron is my Primay Care Physician**.

May we contact your Primary Care Physician and request Medical Records ?

_____**Yes**, I give my Study Research Physician permission to request my records.

____**No**, I do not give my Study Reseach Physician permission to request my records

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_____ _____

Patient Signature **Date**

MEDICAL RECORDS RELEASE FORM

We, the office of Dr. Andres Patron want to make your transition as smooth as possible and for the purpose of medical treatment, It is important we obtain a copy of your past medical record(s). Therefore, if you would complete the form below so we may submit it, as necessary to any of your previous attending Physicians, Specialists, Hospitals and or Pharmacies in order to obtain vital background, history and medical information.

I HEREBY AUTHORIZE AND REQUEST THAT YOU SEND A COPY OF MY COMPLETE MEDICAL RECORD TO:

PCP: Andres Patron, D.O. / PatronMedical PHONE (954) 885-5555

ADDRESS:10796 PINES BLVD SUITE 205 PEMBROKE PINES, F L 33026 FAX (954) 885-5333

PATIENT'S NAME: _____ **Relationship to Patient**_____

SSN: _____ **DOB:** _____

ADDRESS: _____

I hereby authorize the release of all medical documentation and other information including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse and or any other covered entity under HIPAA Accountability Act of 1996.
Information to be obtained and or forwarded as follows:

History & Physical	Laboratories	Eye Exam
Progress Note	XRay/Scans	Pap/Cervical Scrn
Consultation/Counseling	EKG/EEG	Mammo
Narrative Summary	Treatment Plan	ColoKit/Colonoscopy

This may also authorize PatronMedical to release /obtain general health Information as well as 1). psychiatric/psychological treatment, 2). HIV/AIDs diagnosis as well as 3). Alcohol and 4). Drug Abuse information, from my medical record, in *accordance with Florida Statutes and Federal regulations.* In addition but not limited to any test, counseling and results of treatment(s), thereof are also authorized. I understand that my records have a privilege and confidential status, and I am in approval and acceptance of such order/request in an effort to establish, provide and set forth an accurate medical patient history and physical Upon Presentation of this authorization or photocopy of you are authorized to release a copy of the records to any person who is my personal representative. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law. The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all the requirements of HIPAA; 45cfr section 16.

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by sending a written and certified notice to my medical provider(s) and revoking a health care agency under law.

Witness to Patient of legal Guardian Signature.: _____

Andres Patron D.O., P.A.

Diplomate American Board of Internal Medicine
Board Certified Physician
10796 Pines Blvd Suite 205
Pembroke Pines, Florida 33026
Telephone: (954) 885-5555 Facsimile: (954) 885-5333
E-Mail: APatron@PatronMedical.com

Dear Sir or Madam

You may be eligible to take part in a research study. The Informed Consent will give important details and information about the study. Please review this information, and if you have any questions, we encourage you to talk to the Study Coordinator and or the Physician about your concerns. If you decide to take part in the research study, it is imperative that you understand that you may **NOT** participate in more than one clinical trial **at a time, at this location or any other location**! Furthermore, there is a minimum waiting period between trials, it varies between one and four months, **before** you may participate in another study. Therefore, please advise the Doctor and or the study staff if you have taken part in **any** research project within such time frame.

By signing this form, I acknowledge and fully understand the requirements and what is expected of me.

_____ _____

Signature **Date**

Estimado Señor o Señora

Usted puede ser elegible para participar en un estudio de investigacion. El consentimiento le dara mas informacion con detailles importante sobre el estudio. Por favor revise la informacion, y si usted tiene alguna pregunta le pedimos que por favor hable con la coordinadora de estudios o con el medico directamente sobre sus preocupaciones. Si usted decide participar en el studio de investigacion, es imprescindible que usted entienda que **NO** puede participar en mas de un estudio investigativo sea en **nuestra oficina o cualquier otro lugar!** Ademas, hay un periodo minimo de espera entre estudios lo cual varia entre uno y cuatro meses antes poder participar en el proximo estudio. Por lo tanto, por favor avise al medico o al personal del estudio si usted ha tomado parte **en cualquier** proyecto de investigacion dentro de este cierto tiempo o periodo.

Al firmar este documento, me comprometo y entiendo perfectamente la afirmacion y los requerimientos y expectativas que hay de mi.

_____ _____

Firma **Date**

Patron Medical

I,_____, whose signature appears below, authorize The Office of Dr. Andres Patron and its providers to view my external prescription history via the Sure Scripts RxHub on EMR.
This consent form authorizes us to obtain and review detailed prescription history and provides the physician with availability of information about the medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information, such as medication names or dosages.
I understand that the prescription history is from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers and may be used and viewed by our providers and staff, and it may also include prescriptions back in time for several years.

My Signature certifies that I read and understood the scope of my consent and that I authorize the access.

Signature Date of Birth Date

Email/Correo: _____

Making Medical Decisions

NSDM: Are you your own Medical Decision Maker? (Non-Surrogate Decision Maker) _____
SDM: Do you have a legal Proxy, agent or Surrogate Decision Maker? _____

Please Answer Yes or No

Toma De Decisiones Medicas

NSDM: Es usted la persona que toma las decisions Medicas por si mismo? _____
SDM: Tiene usted un agente o sustituto legal que tome las decisions Medicas por usted? _____

Por Favor Contestar Si o No