



Joe Garri, MD, DMD
Rafael Alcalde, DDS, PhD
Ramiro Perez, MD
Osbel Borges, DMD
Juan Carlos Portuondo, DDS



Patient's Full Name: _____ Age: _____ DOB: _____

Sex: M / F Marital Status: S / M / W / D

Driver's License #: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Occupation: _____ Employer: _____

Person Financially Responsible (if not patient):

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

EMERGENCY CONTACT:

Name: _____ Relationship to Patient: _____

Phone #: _____

INSURANCE INFORMATION:

Medical Insurance: _____ Policy #: _____ Group #: _____

If patient is not subscriber:

Name of Subscriber: _____ Subscriber DOB: _____

Relationship to Patient: _____

Dental Insurance: _____ Policy #: _____ Group #: _____

If patient is not subscriber:

Name of Subscriber: _____ Subscriber DOB: _____

Relationship to Patient: _____

REASON FOR CONSULTATION: _____

REFERRED BY: _____ PHONE # _____

I hereby authorize payment be made directly to my physician (s) or suppliers for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Patient or Guardian Signature: _____ Date: _____



MEDICAL HISTORY FORM

Please answer the following questions to the best of your ability. Your answers are for our records only and will be considered confidential.

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Any changes in your health in the past year? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had rheumatic heart disease? |
| <input type="checkbox"/> | <input type="checkbox"/> | Damaged heart valves, artificial valve or heart murmur? |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain or shortness of breath with mild exertion? |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease, asthma, bronchitis, emphysema? |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells or seizures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, hepatitis, jaundice? |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcer or hyperacidity? |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures, stroke, fainting spells? |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems, stones, urinary tract infections? |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS, blood disorders, anemia, abnormal bleeding, blood transfusions? |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent swollen neck glands? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for a growth of tumor? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any history of cancer? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol on a regular basis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? |
| | | If you were a smoker at one time, when did you quit? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever taken weight reduction (diet) pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take medications for osteoporosis (bisphosphnates)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wish to speak to the doctor privately about anything? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies? |

WOMEN:

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant or trying to become pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have problems associated with your menstrual period? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking birth control pills? |

How many: Pregnancies: _____ Births: _____ C-sections: _____ Miscarriages: _____



MEDICAL HISTORY FORM CONTINUED

Name of Primary Doctor: _____ Phone #: _____

Height: _____ Weight: _____ BMI: _____

Medical Conditions: _____

Prior operations & Date of operation: _____

Please list Medications that you are allergic to/reaction: _____

Please list current Medications and dosages: _____

Additional information you would like the Doctor to know: _____

(INITIALS) I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY

Comments:

Physician Signature: _____ Date: _____



PATIENT CONSENT & FINANCIAL AGREEMENT FORM

In connection with the medical services that I am receiving, I hereby authorize the release of my information and medical records, including copies of applicable hospital and medical records to:

- A. Any third party payer covering the medical services of the patient
- B. Other health care professional and institutions involved in the delivery of health care to the patient
- C. The proponent of any legally sufficient subpoena, or in response to a court order
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services
- E. Pharmacies
- F. As otherwise required by law

I further consent that photographs may be taken of me or part of my body, under the following conditions:

- A. The photographs may be taken only with consent of my physician and under such conditions and at such time as approved by him/her.
- B. The photographs shall be taken by my physician or by a designated person approved by my physician
- C. The photographs shall be used for medical records and if in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other in the interest of medical education, knowledge, or research; provided, however that it is specifically understood that in any such publications or use I shall not be identified by name and reasonable steps are taken to preserve my identity.
- D. The aforementioned photographs may be modified or retouched in any way that my physician, in his or her direction may consider desirable.

Regarding Financial Arrangements:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must however realize that:

- A. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- B. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- C. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for the assistance in the management of your account.

All Patients Must Sign Below:

Patient/Guardian Signature: _____ Date: _____

Print name of patient or guardian: _____



MALPRACTICE INSURANCE

IMPORTANT NOTICE UNDER FLORIDA STATUTE LAW 458.320

PLEASE READ THIS IMPORTANT DOCUMENT AS THESE ARE YOUR RIGHTS UNDER FLORIDA STATUTE LAW 458.320

Dear Patient:

Under Florida law Statute (458.320 F.S.), physicians are generally required to carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. I HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law under certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant of Florida law statute (459.320 F.S.).

This document MUST BE SIGNED AND WITNESSED before you initiate or continue under the care of Jose I Garri MD, DMD, Ramiro Perez MD, Rafael Alcalde DDS, Osbel Borges DMD or Juan Carlos Portuondo, DDS.

Thank you,

Note: No treatment can be provided by Jose I Garri MD, DMD, Ramiro Perez MD, Rafael Alcalde DDS, Osbel Borges DMD, or Juan Carlos Portuondo, DDS unless this form has been read and signed. This form is provided to protect your rights under Florida Statute 458.320.

I, _____, have read this document and acknowledge and understand its contents.
[Print Full Name Here]

Patient/Guardian Signature: _____ Date: _____

COPY OF STATUE PROVIDED ON REQUEST OR SIGNS CONCERNING THE FLORIDA STATUTE LAW 458.320 ARE POSTED IN OUR OFFICE .

OFFICE USE ONLY

Witness: _____ Date: _____