RENAL ELECTROLYTE & HYPERTENSION CONSULTANTS OF SOUTH FLORIDA

PATIENT INFORMATION

PATIENT LAST NAME: _____ NAME: _____ MIDDLE: _____
(APELLIDO) (NOMBRE) (INICIAL)

CURRENT ADDRESS: _____ CITY: _____ ZIP: _____
(DIRECCION ACTUAL) (CIUDAD) (ZIPCODE)

DOB: ____/____/____ AGE: _____ SS #____/____/____ Sex: F /M MARITAL STATUS: _____
(FECHA DE NACIMIENTO) (SEGURO SOCIAL) SEXO (F/ M) (ESTADO CASADO, SOLTERO, VIUDO)

HOME PHONE: _____ CELL PHONE: _____ EMAIL _____
(TELEFONO DE LA CASA) (TELEFONO MOBIL) (CORREO ELECTRONICO)

EMPLOYER: _____ EMPLOYER PHONE: _____
(LUGAR DE TRABAJO) (TELEFONO DEL TRABAJO)

PRIMARY INSURANCE: _____ MEMBER ID # _____ GROUP# _____
(NOMBRE SEGURO MEDICO) (NUMERO DE POLIZA) (NUMERO DE GRUPO)

SECONDARY INSURANCE: _____ MEMBER ID # _____ GROUP # _____
(SEGURO MEDICO SECUNDARIO) (NUMERO DE POLIZA) (NUMERO DE GRUPO)

PERSONS TO CONTACT IN CASE OF EMERGENCY
(PERSONAS A LLAMAR EN CASO DE EMERGENCIA)

NAME: _____ PHONE: _____ RELATION: _____
(NOMBRE) (NUMERO DE TELEFONO) (PARENTESCO CON PACIENTE)

NAME: _____ PHONE: _____ RELATION: _____
(NOMBRE) (NUMERO DE TELEFONO) (PARENTESCO CON PACIENTE)

I AUTHORIZE ANY HOLDER Of MEDICAL OR OTHER INFORMATION ABOUT ME, TO RELEASE TO MY INSURANCE CARRIER OR ITS INTERMEDIARIES ANY INFORMATION NEEDED FOR THIS OR RELATED CLAIM, I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO MYSELF OR TO THE PARTY THAT ACCEPTS ASSIGMENT OF

Autorizó a cualquier sostenedor medico u otra información acerca de mí, para mi compañía de seguros o sus intermediarios cualquier información necesaria para REHC o que este o relacionada para ser utilizados en lugar del original y solicitar el pago de beneficios de seguro médico para mí, en la asignación de

PATIENT SIGNATURE: _____ DATE: _____
(FIRMA DEL PACIENTE) (FECHA)

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DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your copy of this form and returning it to this office.

(Como es requerido por la portabilidad de la información de salud y el acto de rendición de cuentas de 1996, tiene derecho a designar a una o más personas para actuar en su nombre con respecto a la protección de información de salud que pertenece a usted. Completando esta forma están informándonos de designar a la persona nombrada con su firma.)

Patient Name: _____ **D.O.B.** _____ **Date:** _____
(Nombre del paciente) **(Fecha de nacimiento)** **(Fecha)**

Address: _____
(Dirección)

Telephone: _____
(Teléfono)

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information.

Name: _____
(Nombre)

Telephone: _____
(Teléfono)

What relationship is this person to you ? _____
(QUE PARENTESCO TIENTE CON EL PCIENTE)

Patient's Signature _____
(FIRMA DEL PACIENTE)

I HEREBY REVOKE THIS DESIGNATION OF A PERSONAL REPRESENTATIVE,

_____

Patient's Signature **Date:**
(Firma del paciente) **(Fecha)**

407 SE 9th Street, Suite 103 Fort. Lauderdale, FL 33316 (954)463-0112 Fax (954)463-0117
4534 N Federal Hwy, Fort Lauderdale, FL 33308 (954) 493-9774 Fax (954)493-8761
2100 E Hallandale Beach Blvd, Suite 202, Hallandale, FL 33009 (954)463-0112 Fax (954) 463-0117
700 E Atlantic Blvd. Suite 101, Pompano Beach, FL 33060 (954)784-6161 Fax (954)493-8761
670 Glades Road, Suite 110, Boca Raton, FL 33431 (561)368-0235 Fax (561) 368-0281
2655 W Atlantic Blvd. Delray Beach, FL 33445 (561)368-0235 Fax (561) 368-0281

RENAL
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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES
AND
CONSENT TO USE AND DISCLOSE HEALTH

I acknowledge that I was provided with a copy of the REHC of South Florida Notice Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that REHC of South Florida continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be change at any time. I may obtain a revised copy by calling the REHC of South Florida Office at (954)463-0112.

I acknowledge that I have received a copy of the REHC of South Florida Notice of Privacy Practice.

Patient Name: _____ **Date:** _____

Signature of Patient: _____

Patient Legal Representative (if applicable) _____**Date:**_____

Signature of Legal Representative: _____

_____

FOR PHYSICIAN'S OFFICE USE ONLY

_____

OFFICE STAFF MEMBER OBTAINING SIGNATURE

- ☐ **Reason Signature and Date were not obtained**
- ☐ **Individual Refuse to Sign**
- ☐ **Communication barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency prevented us obtaining acknowledgement**
- ☐ **Other**

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MEDICATION PROFILE

PATIENT NAME: _____ **DOB:** ____/____/_____

MEDICATION	DOSAGE (MG)	#OF TABS	FRECUENCY

Are you allergic to any Medicaid? Yes /No If yes, which ones: _____

MEDICAL HISTORY

PLEASE INDICATE OF PATIENT OR FAMILY MEMBER HAS HISTORY OF ANY OF THE FOLLOWING CONDITIONS

PROBLEM	PATIENT	FATHER	MOTHER	SIBLING
ANEMIA				
CANCER				
DIABETES				
HEART DISEASE				
HIGH BLOOD PRESSURE				
STROKE				
KIDNEY DISEASE				
KIDNEY STONES				

Other medical conditions: _____

Past Surgical History: YES / NO IF YES LIST PROCEDURES AND DATE: _____

Are you currently using TABACCO products? YES/NO If yes, quantity per day: _____

If you quit, how often did you use per day? _____for how long: _____

Do you drink alcohol? YES/NO if yes, amount: _____ How often: _____

Patient Signature: _____Date: _____

_____

PERIPHERAL ARTERIAL DISEASE (PAD) RISK ASSESSMENT FORM

PERIPHERAL ARTERIAL DISEASE IS A COMMON AND OFTEN SILENT CONDITION THAT AFFECTS THE CIRCULATION TO THE LEGS AND FEET, INITALLY CAUSING ACHING PAIN, CRAMPING AND FATIGE. THE ARTERIES BECOME NARROWED AND WALKING MAY BECOME MORE DIFFICULT AND PAINFUL. THIS CONDITION CAN LEAD TO FOOT AND LEG WOUNDS OR ULCERS THAT DON'T HEAL OR ARE VERY SLOW TO HEAL, AND POTENTIALLY LEAD TO AMPUTATIONS IF LEFT UNTREATED.

THE BELOW ASSESSMENT WILL HELP TO INDENTIFY YOUR RISK FOR PERIPHERAL ARTERIAL DISEASE. PLEASE COMPLETE BOTH SECTIONS IN THEIR ENTIRETY.

PATIENT NAME: _____DATE: _____/_____/_____

STREET ADDRESS: _____

CITY/ STATE/ZIP: _____PHONE #_____

DAY OF BIRTH:_____AGE:_____EMAIL:_____

RISK FACTORS FOR PAD

1.	DO YOU HAVE DIABETES?	YES	NO
2.	ARE YOU CURRENT OR FORMER SMOKER?	YES	NO
3.	DO YOU HAVE LEG PAIN WITH EXERTION?(e.g while walking)	YES	NO
4.	HAVE YOU HAD ANY LOWER LEG, ANKLE OR FOOT WOUNDS THAT ARE/WERE SLOW TO HEAL?	YES	NO

RENAL
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CONSULTANTS
OF SOUTH FLORIDA

TO: REHC OF SOUTH FLORIDA
ATTN: JEANNIE CAPHTOM
Privacy Officer
407 S.E 9th Street
Ft. Lauderdale, FL 33316
(954) 463-0112

ATTN: _____

Authorization for Release of Information for Purposes Request by a Covered Entity from Another Covered Entity.

PATIENT NAME: _____ **D.O.B.** _____

I authorize you to disclose the following protected health information.

(specially describe the information to be disclosed, including, but not limited to, meaningful descriptors, such as date of service, type pf service provided, level of detail to be release, origin of information, etc.

All records, test results scan results, office notes, and any and all other information in my chart, including but not limited to: Further, you are hereby authorized to discuss my medical history with the covered entity named below and provide them with any information requested and or opinions they deem relevant.

This protect health information is being used or disclosed to carry out treatment, payment and/or health care operations in the following manner:

Patient will be seen for evaluation and treatment, including the following

Signature of the Patient: _____ **Date:** _____/_____/_____

Print name of Patient: _____

Se autoriza a discutir mi historial médico con REHC y proporcionar toda la información solicitada para ser utilizada para evaluación o tratamiento médico, pago o cuidado de salud.