MIDWAY SPECIALTY CARE CENTER

Diana Clabots, MD
Andres Rivero, MD
777 E 25th St., Suite 516
Hialeah, Florida 33013
(305) 671-3722 tele
(305) 671-3799 fax

**New Patient Questionnaire**

***(Nouvo Keysonè pasyan)***

**Personal Information**
***(Enfomasyon pèsonèl)***

Today's Date: _____
*(Dat jodi a)*

Last Name, First Name, Middle Initial: _____ Date of Birth: _____
*(Siyati, Premye Non, Inisyal non mitan)* *(Dat nesans)*

Preferred Name: _____ Social Security Number: _____
*(Non Prefere)* *(Nimewo Sekirite Sosyal)*

Gender Assigned at Birth: □ Female □ Male □ Intersex □ Prefer not to answer
*(Sèks yo bay nan nesans)* *(Fi)* *(Gason)* *(Fi & gason)* *(Pito pa reponn)*

Relationship Status: □ Single □ Sig Other □ Separated □ Married □ Divorced □ Widowed
*(Estati Relasyon)* *(Selibatè)* *(Patnè)* *(Separe)* *(Marye)* *(Divòse)* *(Vèv)*

Home Address: _____ City, State and Zip Code: _____
*(Adrès Lakayou)* *(Vil, Eta ak Kòd Postal)*

Mailing Address □ Same as Above _____ City, State and Zip Code: _____
*(Adrès Postal) (Menm jan ak lakayou)* *(Vil, Eta ak Kòd Postal)*

Phone Number(s) □ Home: _____ □ Cell: _____ □ Work: _____
*(Nimewo(s) telefòn)* *(Lakay)* *(Pòtab)* *(Travayou)*

*Check box representing preferred number for patient reminders, etc.*(*Tcheke kare ki reprezante nimewo pi pito pou rapèl pasyan yo)*

Email Address: _____ Enable Patient Portal: □ Yes*(Wi)* □ No*(Non)*
*(Electronik)* *(Aktive Pòtal pasyan:)*

Emergency Contact: _____ Phone: _____ Relationship: _____
*(Kontak pou ljans:)* *(Telefòn)* *(Risaliye Pouou)*

Name of Primary Care Provider: _____
*(Non doktè swen prensipal)*

Address: _____ City, State and Zip Code: _____
*(Adrès)* *(Vil, Eta ak Kòd Postal)*

Employment Status: □ Full time □ Part time □ Retired □ Self □None
*(Sitiyasyon Travay:)* *(Tan plen)* *(Tan pasyèl)* *( Ou retrèt)* *(Pou ko)* *(Okenn)*

Student: □ Full time □ Part time □None
*(Elèv)* *(Tan plen)* *(Tan pasyèl)* *(Okenn)*

Employer Name/School Name: _____
*(Non anplwayè/Non lekòl la:)*

Address: _____ City, State and Zip Code: _____
*(Adrès)* *(Vil, Eta ak Kòd Postal)*

Occupation: _____
*(Okipasyon:)*

Who may we thank for referring you: _____
*(Kiyès nou ka remèsye pou refere w?)*

**Insurance Information** ***(Enfòmasyon sou Asirans)***

Primary Insurance Company: _____ Policy Holder: _____
*(Konpayi asiranss Prensipal:)* *(Titulè kontra a:)*

Policy Number: _____ Group Number: _____
*(Nimewo règleman:)* *(Nimewo Gwoup)*

Secondary Insurance Company: _____ Policy Holder: _____
*(Compañía de seguros secundario)* *(Titulè kontra a:)*

Policy Number: _____ Group Number: _____
*(Nimewo règleman:)* *(Nimewo Gwoup)*

Financial Responsible Party: _____
*(Pati responsab finansye:)*

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I hereby consent to Midway Specialty Care Center, Inc .obtaining my **Prescription History** from any/all sources.
*(Mwen dakò pou Midway Specialty Care Center, Inc jwenn i**stwa preskripson** mwen man nenpòt/tout sous.)*

Patient's Signature: *(Siyati pasyan an:)* _____

## CONSENTS
***(KONSANTMAN)***

### Health Insurance Portability and Accountability Act
***(Lwa sou Transparans ak Responsablite Asirans Sante)***

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we ask your permission before disclosing certain healthcare information to certain people or entities. *(Lwa 1996 sou Transparans ak Responsablite Asirans Sante (HIPAA) egzije pou nou mande pèmisyon w anvan nou divilge sèten enfòmasyon sou swen sante a bay sèten moun oswa antite)*

In accordance with the Act, I *(An akò ak Lwa a, mwen)* _____Hereby
*(Patient signature)* *(Siyati pasyan an)*
authorize Midway Specialty Care Center, Inc. to release any information regarding my health to the following persons or entities:
*(otorize Midway Specialty Care Center, Inc. pou divulge nenpòt enfòmasyon konsènan sante mwen bay moun oswa antite sa yo:)*

| Name *(Non)* | Date of Birth *(Dat nesans)* | Relationship *(Relasyon)* | Phone Number *(Nimewo telefòn)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

### Leaving Messages for You ***(Kite Mesaj pou ou)***

In the event that I am not available when Midway Specialty Care Center, Inc. calls with medical information: *(Nan ka mwen pa disponib lè Midway Specialty Care Center, Inc. rele ak enfòmasyon medikal:)*

*(Please check the applicable box **and** initial beside it.) (Tcheke kare ki aplikab la **ak** inisyal akote li.)*
□ _____ Please DO leave messages on my answering machine or voicemail. *(Tanpri kite mesaj sou repondè oswa mesajri mwen an)*
□ _____ Please DO NOT leave messages on my answering machine or voicemail. *(Tanpri PA kite mesaj sou repondè oswa mesajri vwa mwen*
□ _____ I DO NOT HAVE an answering machine or voicemail. *(MWEN PA GENYEN yon mesajri.)*

Printed Name: *(Non enprime:)* _____

□ Self *(Pwòp tèt ou)* or Relationship to Patient: *(oswa Relasyon ak pasyan)*_____

Signature: *(Siyati)* _____ Date: *(Dat:)* _____

**Insurance Authorization and Assignment**

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***(Asirans Otorizasyon ak Plasman)***

All Charges are payable at the time of service. *(Tout frè yo peye nan moman sèvis la.)*

All professional services rendered are charged to the patient. Necessary forms will be complete to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage; it is also customary to pay for services when rendered unless other arrangements have been made in advance. *(Tout sèvis pwofesyonèl yo bay yo sou kont pasyan yo pou peye. Nou pral konplètè tout fòm ki nesesè yo pral konplè pou ede akselere peman konpayi asirans yo. Sepandan, pasyan an responsab pou tout frè, kèlkeswa kouvèti asirans lan; li abitye tou pou peye pou sèvis yo lè yo rann yo sof si yo te fè lòt aranjman davans.)*

Insurance Authorization and Assignment: I hereby authorize Midway Specialty Care Center, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. *(Otorizasyon ak Devwa Asirans: Mwen otorize Midway Specialty Care Center, Inc. pou bay konpayi asirans yo enfòmasyon konsènan maladi mwen ak tretman mwen epi mwen bay tout peman pou sèvis medikal mwen menm oswa pou moun ki depandan mwen yo. Mwen konprann ke mwen responsab pou nenpòt ki kantite lajan asirans mwen pa kouvri.)*

Furthermore, I am aware that if I have an HMO Plan a referral must be obtained from my primary care provider for EACH visit to Midway Specialty Care Center. If one is NOT obtained, I understand that I will be held responsible for all charges. *(Anplis de sa, mwen konnen si mwen gen yon Plan HMO yo dwe jwenn yon referans nan men founisè swen prensipal mwen an pou CHAK vizit nan Midway Specialty Care Center. Si yo PA jwenn youn, mwen konprann ke mwen pral responsab pou tout chaj yo.)*

Printed Name: *(Non enprime:)* _____

□ Self *(Pwòp tèt ou)* or Relationship to Patient: *(oswa Relasyon ak pasyan)*_____

Signature: *(Siyati)* _____ Date: *(Dat:)* _____