

PLEASE PRINT

IT IS IMPORTANT THAT YOU PROVIDE US WITH COMPLETE, CURRENT INFORMATION,
PLEASE PRESENT YOUR INSURANCE I.D. CARD(s) AND YOUR DRIVER'S LICENSE.

Today's Date: _____ Referring Doctor: _____
(Fecha de Hoy) (Doctor que refirió)

Patient's Name: _____
(Nombre del Paciente) LAST (Apellido) FIRST (Primer Nombre) MI (Inicial)

Address: _____
(Dirección)

City _____ State _____ Zip _____
(Ciudad) (Estado) (Código Postal)

Home Phone (_____) _____ Cellular/Mobile (_____) _____
(Número de Teléfono Residencial) (Número de Teléfono Celular)

Birth Date: ___/___/___ Current Age: _____ Sex: M ___ F ___ SS#: _____
(Fecha de Nacimiento) (Edad) (Sexo) (Número de Seguro Social)

Personal Status: Single/Separated ___ Married ___ Divorced ___ Widow ___ Student: Full Time ___ Part-time: ___
(Estado Civil) (Soltero/Separado) (Casado) (Divorciado) (Viuda) (Estudiante) (Tiempo Completo) (Tiempo Parcial)

Employer: _____ Occupation: _____
(Empleo) (Ocupación)

Work Phone: (_____) _____ Ext. _____ Driver's Lic.: _____
(Teléfono del Trabajo) (Número de Licencia)

Notify in Emergency: _____ Relationship: _____ Phone: _____
(En Caso de Emergencia) (Relación) (Teléfono)

RESPONSIBLE PARTY (GUARANTOR)

If patient is under 18, who is the **person** responsible for payment of any deductible, co-payment, co-insurance, non-covered services, or services rendered **if insurance is terminated**? (Do not Provide insurance information in this section).

Name: _____ Relationship to patient: _____
(Nombre) (Relación con paciente)

Birth Date: _____ Driver's Lic.: _____ SS#: _____
(Fecha de Nacimiento) (Número de Licencia) (Número de Seguro Social)

Employer: _____ Work # (_____) _____ Ext. _____
(Empleo) (Número del Trabajo)

PLEASE TURN THIS PAGE OVER AND COMPLETE THE BACK-SIDE OF THIS FORM

THANK YOU!

(Favor de llenar éste formulario del otro lado)

INSURANCE INFORMATION / INFORMACION DEL SEGURO

Name of **Primary** Insurance Co.: _____ Policy # _____ Group # _____
(Nombre del Plan Médico) (Número de Póliza) (Número de Grupo)

Name of Policy Holder Relationship to Patient Social Security Number Date of Birth
(Nombre del Asegurado Principal) (Relación con Paciente) (Número de Seguro Social) (Fecha de Nacimiento)

Additional Insurance: (Secondary)
(Plan Médico Secundario)

Name of secondary insurance company: _____ Policy # _____ Group # _____
(Nombre del Plan Médico Secundario) (Número de Póliza) (Número de Grupo)

Name of Policy Holder Relationship to Patient Social Security Number Date of Birth
(Nombre del Asegurado Principal) (Relación con el Paciente) (Número de Seguro Social) (Fecha de Nacimiento)

PATIENT CONSENT FOR DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications be made by alternative means, such as sending correspondence to the individual's office, instead of the home.

Home Phone: () _____ OK to leave a message with detailed information
 Leave message with call back number only

Daytime Phone: () _____ OK to leave a message with detailed information
 Leave message with call back number only

Cell Phone: () _____ OK to leave a message with detailed information
 Leave message with call back number only

Authorized persons that can obtain my personal health information:

Print Name Relationship

Print Name Relationship

X _____
Patient's Signature (Parent of guardian if minor) Date

Relationship to the Patient: Mother Father Other: _____
(Relación con el Paciente): (Madre) (Padre) (Otro)

**ALLERGY, ASTHMA, ARTHRITIS CENTER OF CENTRAL FLORIDA
JOSE ANDRADE M.D., P.A.**

Medical Authorization for Minors

I, _____, the parent of or legal guardian of _____,

a minor, do hereby authorize any one or more of _____,

_____ or _____, as agents for myself in my absence or incapacitation to consent to any procedure, examination and allergy injection, medical or surgical diagnosis or treatment and medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician, provision of the Medical Practice Act on the medical staff of any hospital whether or not such diagnosis or treatment is rendered at the office of Jose Andrade, M.D. or at said hospital.

It is understood that this authorization is given in advance of any specific procedure, diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such procedure, diagnosis, treatment or hospital care which aforementioned physician in the exercise of his or her best judgment may deem advisable.

I hereby authorize Jose Andrade, M.D. and his medical staff which has provided treatment to the above-named minor to surrender physical custody of such minor to the above-named agents upon the completion of treatment.

These authorizations shall remain effective until _____.

Signature of Parent or Legal Guardian

Date

Witness Print Name

Witness Signature

Copies of this form, duly executed, should be in the possession of the named minor: at least one adult named in the document and present at the event: and the parent or guardian executing the Medical Authorization.

Allergy, Asthma, Arthritis Center of Central Florida requires minor participants (i.e., those having to have waivers) whose parents or legal guardians are not present at the event to have a valid Medical Authorization form. Allergy, Asthma, Arthritis Center of Central Florida recommends use of the Medical Authorization for all minors whose parents or legal guardians are not present.

Diplomate of the American Board of Allergy and Immunology
A conjoint of the American Board of Internal Medicine and the American Board of Pediatrics
Recertified Diplomate of the American Board of Pediatrics
Recertified Diplomate Pediatric Rheumatology – Subboard American Board of Pediatrics
Diplomate and Senior Disability Analyst of the American Board of Disability Analysts
General Acupuncture