Pedro P. Llaneza M.D.,P.A.

Welcome to Our Practice!

Patient Information

Please answer by filling out text or clicking where appropriate.

Date: _____ Patient Id Number :_____(office use)

First Name: _____ Last Name:_____ Date of Birth:_____

Social Security #_____ Age: _____ Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

---

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

Country: _____ Email: _____

Tel: House ( )_____ Work: ( )_____ Cell: ( )_____ Fax: ( )_____

Address (Other):_____ City: _____ State: _____ Zip Code: _____

Country:_____ Zip Code: _____ Email: _____

Tel: House: ( )_____ Work: ( )_____Cell: ( )_____ Fax: ( )_____

In Case of Emergency: _____ Emergency contact number: ( )_____

Person responsible for account (if diff from patient)_____ Relation to patient: _____

Address: _____ Social Security: _____ Date of birth: _____

Primary Physician: _____ Telephone: ( )_____-_____

Primary Insurance: _____

Insured: _____ Date of Birth: _____ Relation to Patient: _____

Social Security of Insured (if other than patient):_____

Policy Number:_____ Group #_____

Employment: _____ Status: ☐Full Time ☐Part-time ☐Retired ☐N/A

School(if student):_____ Status: ☐Full Time ☐Part-time ☐Retired ☐N/A

*****Copy of Insurance card and an official picture id will be required at each visit*****

Date: _____ Signature of Patient or Guardian: _____

Pedro P. Llaneza M.D.,P.A.

Please fill out the text and check the appropriate box of your health information for electronic records.

NAME: _____ DATE: _____

BIRTHDATE: _____AGE:_____ REFERRED BY_____

PREFERRED LANGUAGE _____ PRIMARY CARE DOCTOR _____

PHARMACY (Name, Location, Phone/fax number):_____

Race: ☐ White/Caucasian ☐ African American ☐ Hispanic o Latino ☐ American Indian or Alaskan ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown

Ethnicity: ☐Hispanic/Latino ☐American ☐Armenian ☐Asian ☐British ☐Chinese ☐French ☐German ☐Indian ☐Irish ☐Italian ☐Jewish ☐Korean ☐Middle Eastern ☐Polish ☐Scandinavian ☐Scottish ☐Vietnamese ☐Unknown

ALLERGIES

☐NONE ☐Demerol ☐Iodine dye ☐Morphine ☐Propofol ☐Surgical Tape ☐Codeine ☐Fentanyl ☐Latex ☐Penicillin ☐Sulfa ☐Versed ☐Other: _____

Do you have any prior difficulties with sedation or anesthesia (nausea/vomiting, high intolerance, other)? ☐ Yes ☐No

Explain: _____

REASON FOR YOUR VISIT TO THE OFFICE:

☐Screening colonoscopy
☐Abdominal pain (lower)
☐Abdominal pain (upper)
☐Abnormal liver tests
☐Abnormal ultrasound or CAT scan
☐Anemia
☐Black stools
☐Bloating
☐ Bloody stools
☐Change in Bowel Habits
☐Chest pain
☐Constipation
☐Decreased appetite
☐Diarrhea
☐Difficulty swallowing
☐Excessive belching
☐Family history of colon Polyps/cancer
☐Gas/flatulence
☐Heartburn
☐Hemoccult + Stools
☐Jaundice
☐Narrowed stools
☐Nausea
☐Personal history of colon polyps/cancer
☐Rectal bleeding
☐Rectal pain/itching
☐Regurgitation
☐Vomiting
☐Weight loss
☐ Other: _____

_____

Have you had any of the following done to evaluate the cause of your symptoms?

☐ Laboratory tests or blood work Explain: _____
☐ Radiology imaging (x-rays, ultrasounds, CAT scans, MRIs, barium studies). Explain: _____
☐ Endoscopies (upper GI scope r/EGD, ERCP, colonoscopy). Explain: _____
☐ Emergency room visits Explain:

_____

***IF POSSIBLE, WE WOULD GREATLY APPRECIATE YOU FAX TO OUR OFFICE ANY PERTINENT MEDICAL RECORDS IN ADVANCE, IMMEDIATELY AFTER YOUR VISIT, OR SIGN A RELEASE OF MEDICAL RECORDS for them. **Fax: 305-598-0668**

What medications have you tried to treat your symptoms with (non-prescription and prescription)? _____

Initials_____

PAST MEDICAL ILLNESSES

Gastrointestinal

☐ Heartburn	☐ Gallstones	☐ Ulcerative Colitis	☐ Anal fistula
☐ Hiatal Hernia	☐ Pancreatitis	☐ Crohn's disease	☐ Stool incontinence
☐ Gastritis	☐ Irritable bowel	☐ Colon Polyps	☐ Abnormal liver tests
☐ H. pylori	☐ Spastic colitis	☐ Colon cancer	☐ Fatty liver
☐ Ulcer	☐ Lactose intolerance	☐ Hemorrhoids	☐ Hepatitis
☐ Celiac disease	☐ Diverticulosis/itis	☐ Anal fissure	☐ Cirrhosis
☐ Other: Explain:			

CARDIOVASCULAR

☐ High blood pressure	☐ Heart attack	☐ PVCs	☐ Mitral valve prolapse
☐ High cholesterol	☐ Atrial fibrillation	☐ Rhythm disorder	☐ Rheumatic fever
☐ Angina	☐ Tachycardia	☐ Heart murmur	☐ Congestive heart failure
☐ Other: Explain:			

PULMONARY

☐ Sleep apnea	☐ Emphysema (COPD)	☐ Pulmonary embolism	☐ Lung cancer
☐ Asthma	☐ Pneumonia	☐ Sarcoidosis	☐ Pleurisy
☐ Other :Explain:			

NEUROPSYCHIATRIC

☐ Stroke	☐ Migraines	☐ Dementia	☐ Eating disorder
☐ TIA (mini-stroke)	☐ Chronic headaches	☐ Depression	☐ ADHD
☐ Multiple sclerosis	☐ Parkinson's disease	☐ Anxiety	☐ Hormonal mood
☐ Seizures	☐ Myasthenia gravis	☐ Bipolar disorder	
☐ Other: Explain:			

HEMATOLOGIC

☐ Anemia	☐ Blood clot	☐ Hodgkin's disease	☐ Leukemia
☐ Blood transfusion	☐ Hemochromatosis	☐ Lymphoma	☐ Myelodysplasia
☐ Other: Explain:			

ENDOCRINE

☐ Diabetes	☐ Hyperthyroidism	☐ Goiter	☐ Pituitary problem
☐ Hypothyroidism	☐ Thyroid nodule	☐ Thyroid cancer	☐ Adrenal problem
☐ Other: Explain:			

Initials_____

GENITOURINARY

☐ Kidney disease	☐ Urinary tract infections	☐ Ovarian Cyst (s)	☐ Abnormal pap smears
☐ Kidney stones	☐ Bladder incontinence	☐ Ovarian cancer	☐ Cone biopsy/LEEP
☐ Kidney tumors/cysts	☐ Prostate hypertrophy	☐ Uterine fibroids	☐ Cervical cancer
☐ Bladder cancer	☐ Prostate cancer	☐ Uterine cancer	☐ Endometriosis
☐ Other: Explain:			

BREAST

☐ Fibrocystic breast changes	☐ Breast cancer (L or R)	☐ Radiation	☐ Chemotherapy
☐ Other: Explain:			

MUSCULOSKELETAL

☐ Osteoarthritis	☐ Osteoporosis	☐ Fibromyalgia	☐ Lupus
☐ Rheumatoid arthritis	☐ Osteopenia	☐ Polymyalgia rheumatic	☐ Gout
☐ Other: Explain:			

EYES, EARS, NOSE, AND THROAT

☐ Glaucoma	☐ Macular degeneration	☐ Allergic rhinitis	☐ Oral thrush
☐ Cataracts	☐ Retinal detachment	☐ Sinusitis	☐ Sjogren's
☐ Other: Explain:			

DERMATOLOGIC

☐ Eczema	☐ Vitiligo	☐ Raynaud's syndrome	☐ Squamous cell skin cancer
☐ Psoriasis	☐ Alopecia	☐ Basal cell skin cancer	☐ Melanoma
☐ Other: Explain:			

ONCOLOGIC

☐ Any other malignant tumors not previously mentioned? _____

INFECTIOUS DISEASE

☐ Do you have any communicable disease, such as hepatitis, HIV, or sexually transmitted disease?

_____

☐ Any other hospitalizations or medical conditions not previously mentioned?_____

_____

_____

Initials_____

PREVIOUS SURGERIES AND PROCEDURES

☐ Gallbladder	☐ D&C	☐ Vasectomy	☐ Back surgery
☐ Appendix	☐ C-section	☐ Prostate surgery	☐ Foot surgery
☐ Groin hernia repair	☐ Tubal ligation	☐ Tonsillectomy	☐ Stent/Angioplasty
☐ Other hernia repair	☐ Total hysterectomy	☐ Sinus surgery	☐ Heart bypass surgery
☐ Bowel obstruction	☐ Partial hysterectomy	☐ Cataract surgery	☐ Heart valve surgery
☐ Adhesion surgery	☐ Abdominoplasty	☐ Lasik eye surgery	☐ Pacemaker
☐ Colon resection	☐ Ovarian surgery	☐ Other eye surgery	☐ Defibrillator
☐ Hemorrhoid surgery	☐ Uterine ablation	☐ Other eye surgery	☐ Carotid surgery
☐ Anti-reflux surgery	☐ Benign breast biopsy	☐ Arthroscopy	☐ Vascular surgery
☐ Weight loss surgery	☐ Lumpectomy	☐ Knee replacement	☐ Vein stripping
☐ Other:	☐ Mammoplasty	☐ Hip replacement	☐ Other:
☐ Other:	☐ Other:	☐ Other	☐ Other:

FAMILY HISTORY

	Father	Mother	Son	Daughter	Brother(s)	Sister(s)	Grandmother	Grandfather
Biliary tract cancer								
Brain cancer								
Breast cancer								
Celiac Disease								
Cirrhosis								
Colon polyps								
Colorectal cancer								
**Age of diagnosis*								
Crohn's disease								
Diabetes								
Heart disease								
Ovarian cancer								
Pancreatic cancer								
Stomach cancer								
Ulcerative colitis								
Uterine cancer								

SOCIAL HYSTORY

Marital Status: ☐ Single ☐ Married ☐ separated ☐ Divorced ☐ Widowed **Occupation:** _____

Children (ages and general health):_____

Do you drink alcohol? ☐ Yes ☐ No How many glasses do you drink per day? _____ Per week? _____

Did you ever drink alcohol in the past? ☐ Yes ☐ No How many glasses did you drink per day? _____ Per week? _____

Do you have any problems with alcohol or drug use? _____

Do you use tobacco currently? ☐ Yes ☐ No Number of packs per day? _____ For how many years? _____

Initials_____

Did you use tobacco in the past? ☐Yes ☐No When did you quit? _____ Packs per day?_____ How many years? _____

MEDICATIONS

Please be certain to include birth control pills, hormones, and **ALL non-prescription medications,** such as anti-inflammatories (i.e. aspirin, Advil, Motrin, Aleve, ibuprofen), acid blockers (i.e. Zantac, Pepcid, Tagamet, Prilosec OTC), topical hemorrhoid creams (i.e. Anusol, Preparation H), vitamins, and herbal supplements.

Medications	Dosage	Frequency

REVIEW OF SYSTEMS

General

☐Fatigue	☐Weakness	☐Fever	☐Night sweats
☐Weight loss			

Eyes

☐Glasses	☐Vision changes	☐Eye redness	☐Color blindness
☐Contacts			

Ears/Nose/Throat

☐Hearing loss	☐Runny nose	☐Mouth sores	☐Tooth/gum problems
☐Ringing in ears	☐Nosebleeds	☐Tongue sores	

Respiratory

☐Cough	☐Coughing Blood	☐Shortness of breath	☐Wheezing

Cardiovascular

☐Chest pain	☐Palpitations	☐Shortness of breath with exertion or sleep
☐Ankle swelling/edema	☐Varicose veins	☐Blue color changes in hands with cold

Genitourinary

☐Blood urine	☐Burning urination	☐Urinary incontinence	☐Dark urine

Initials_____

☐ Frequent urination	☐ Frequent urination at night		

Endocrine

☐ Intolerance to cold	☐ Excessive sweating	☐ Abnormal skin pigment	☐ Dry skin
☐ Intolerance to heat	☐ Excessive hunger	☐ Abnormal body hair	☐ Dry hair

Bones/Joints/Muscles

☐ Pain	☐ Swelling	☐ Stiffness

Lymph nodes (glands)

☐ Swollen jaw	☐ Swollen neck	☐ Swollen underarm	☐ Swollen groin

Neurologic

☐ Headaches	☐ Fainting	☐ Localized numbness	☐ Speech difficulty
☐ Dizziness	☐ Tremor	☐ Walking difficulty	☐ Memory Difficulty

Skin

☐ Itching	☐ Rash	☐ Bruising	☐ Scaling

Males

☐ Slow urinary stream	☐ Difficulty initiating urination	☐ Penile discharge
☐ Breast enlargement		

Females

☐ Abnormal periods	☐ Menopause	☐ Vaginal discharge
☐ Breast lump(s)	☐ Breast pain	☐ Nipple discharge

_____ _____

Patient's Signature or Patient's Legal Guardian's Signature **Date**

Physician's Initials _____ **Date**_____

Pedro P. Llaneza M.D.,P.A.

Financial Policy and Disclosure

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

- Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept cash, personal checks, and credit cards.
- We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to comply with the particular requirements of your insurance including a deductible that has not been met and co-payment due at the time of your visit.
- If you are insured by a plan with which we do not have prior arrangement, we will facilitate the claim for you on an unassigned basis. This means the insurance company will send the payment directly to you; therefore, our charges for your care are due at the time of service and/or prior to procedure.
- Not all insurance plans cover all services. In the event the insurance plan to which you subscribe, determines that a service will be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due for services rendered by Dr. Llaneza.
- We will ask you for your insurance card and identification (driver's license or government approved form of identification) at each visit. All co-payments and past due balances are due and payable at the time of service.
- Some plans require that you have prior authorization from your primary care physician or PCP before you visit this practice. It is your responsibility to obtain this authorization (referral). If you do not have this referral, you will be asked to reschedule or pay for the visit your of network.
- I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees, and court costs.
- I understand that my co-payment, if applied, is "not" refundable for any reason.
- I authorize payment of medical services to Pedro P. Llaneza, M.D., PA
- A finance charge of 1.5% will be applied to outstanding balance after 90 days.
- **If my insurance does not pay my medical expenses, charges will be made to my credit card that I present at this moment in the office. I will be responsible for the charges not paid by my carrier.** Scanned by: _____ (Employee initials).
- Failure to keep a **scheduled appointment** or notify this office greater than 24 hours in advance will result in a **$25.00 cancellation fee**.
- Failure to keep a **scheduled procedure** appointment or to notify us less than 48 hours in advance will result in a **$75.00 cancelation fee**. **If this occurs for a second time, the fee will be $125.00 cancellation fee**. Thereafter, may result in dismissal from the practice. These charges are not covered by your insurance and are due and payable prior to any further appointments.
- I have read and understood the practice's financial policy and agree to be bound by the terms stated above. I also understand that such terms may be amended by the practice from time to time.
- I have received the Notice of Privacy Practices.

"Under Florida Law, physicians are generally required to carry medical insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. After many years of carrying malpractice insurance, I have decided not to carry it now (as of October 1, 2003), because of the unconscionable escalation of rates, making it unaffordable. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against non-insured who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law".

We are required by law to give you a copy of this notice to sign, acknowledge its receipt, and keep in your patient file.

Signature of Patient (or responsible party, if minor) Print Patient's Name Date

Pedro P. Llaneza M.D.,P.A.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Name: _____

Date of Birth: _____/_____/_____

Social Security #: _____ Phone Number: (_____) _____

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To read the office's Notice of Privacy Practices before making the decision to sign.
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Please check and write name:

☐ I, _____, have had the opportunity to read and consider the contents of this consent for the use and disclosure of my health information for treatment, payment, and healthcare operations.

☐ I, _____, authorize the following person, _____, to receive health information concerning treatment, payment, and healthcare operations.

Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

You may refuse to sign this acknowledgment

I, _____, have read and received a copy of this office's Notice of Privacy Practices (HIPAA).

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment would not be obtained because:

_____Individual refused to sign

_____Communication barriers prohibited obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgment

_____Other_____