Please Print **Rebello Medical Associates** *Patient Info Sheet*

Patient Name: _____ **Today's Date**:_____
(first name) (middle initial) (last name)
D.O.B.: _____ **Sex**: Male – Female **Social Security**#:_____

Home Phone: _____ **Cell Phone:** _____
(Please Circle One:)
Ethnicity: Hispanic or Latino – Not Hispanic or Latino – Unknown – Declined to specify
(Please Circle One:)
Race: American Indian – Asian – Black or African American – Caucasian – Hispanic or Latino – Native Hawaiian or Other Pacific Islander – Declined to Specify

Email address: _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Marital Status: Single – Married – Separated – Divorced – Widowed

Name of Spouse: _____

Emergency Contact: _____ **Emergency Contact #**:_____

Referred by: _____

Employed: Full – Part – Retired **Employer**:_____

Occupation:_____ **Employer Phone#**_____

Assignment and Release

Assignment of Benefits: I, the undersigned, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, private insurance and any other health plan: Rebello MD Associates, PL. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original.
Financial Policy: I understand that I am financially responsible for all charges whether or not paid by my insurance:
Medical Release: I hereby consent for the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions
Coordination of Benefits: In order for our office to properly submit your claims you must inform us of any changes in your coverage listed above including if your visit is due to a motor vehicle accident, on the job injury, or other instances when your coverage above may not apply. If you are not sure just ask us, we will be happy to help.

I, _____, hereby attest that the above information is to the best of my knowledge, complete and true, I understand and agree with all of the above terms.

_____
Signature

Date- ___/___/_____	**Rebello Medical Associates, MD, P.L**	
First Name:	**Last Name:**	D.O.B.- ___/___/____
Medical History	Check if applicable:	
Hypertension ( )	High Cholesterol ( )	**Weight ( )**
Hyperthyroidism ( )	Angina ( )	**Height ( )ft ( )in**
Diabetes ( )	Coronary Artery Disease ( )	
Other:		
Surgery History:	Check if applicable:	
Appendectomy- ( )	Cataract- ( )	Mastectomy- ( )
Cholecystectomy- ( )	Tonsillectomy- ( )	CABG heart bypass- ( )
Other:		
Medications:	**Frequency:** (example: once a day)	**Dose:**
Allergies:		
Smoker:		
Yes ( ) No ( )		
Quit (●) years ago	**Other-** cigar - pipe	
Family History:		
Mother	**Medical History-**	
◯ Alive – Age ( ) ◯ Deceased – Age ( )		
Father	**Medical History-**	
◯ Alive – Age ( ) ◯ Deceased – Age ( )		

Insurance Information

Primary Insurance:

Company**:**_____

Policy Number**:** _____

Primary Insured**:**_____

Primary Insured D.O.B.**:**_____

Secondary Insurance:

Company**:**_____

Policy Number**:**_____

Primary Insured**:**_____

Primary Insured D.O.B.**:**_____

**** Please present your card with this completed form so that we can copy it for our records. Thank you. ****

Pharmacy Information

Pharmacy:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone: _____ **Fax:** _____

Patient's Request and Authorization for Release of Health Information

I request and authorize Dr. _____ to provide a copy of the specific health and medical information as described below:

Patient Name: _____

This request applies to the following information to be provided, as soon as possible: (circle one)

- All health information pertaining to any medical history, mental, physical condition and treatment received.

  OR

- Only the following records or types of health information (including any dates):_____

The designated information should be sent to:

Rebello Medical Associates
13590 South Jog Road, Suite C3
Delray Beach, FL. 33446
Tel: (561) 637-8383
Fax: (561) 526-8313

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

Signature: _____ Date: _____
(Patient/Representative/Spouse/Financially Responsible Party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness: _____

A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.

Rebello Medical Associates
13590 South Jog Road Suite C3
Delray Beach, Florida 33446
(561) 637-8383

A Notice of Privacy Practices is provided to all patients. This Notice of Privacy Practices identifies: 1) How medical information about you may be used or disclosed; 2) Your rights to access medical information; 3) Our responsibilities for maintaining the privacy of your medical information; 4) Your right to complain if you feel your privacy has been violated.

_____ _____

Name of Patient Signature of Patient

_____

Date of Signature

Any and all of my information may be released to:

_____

_____

_____

_____