INTEGRATED Sleep Care

New Patient Form

(Forma de Nuevo Paciente)

Personal information/Informacion personal

First name / Nombre: _____ M.I: _____ Last Name / Apellido: _____

Date of Birth / Fecha de naciemiento: _____ SSN / Numero de Seguro Social: _____-_____-_____

Gender / Genero: Female/Mujer ☐ Male/Hombre ☐ Marital Status/ Estado Civil: S M D W

Cell Phone/Celular: _____ Home phone/Telefono de casa: _____

Address/Direccion: _____

City/Ciudad: _____ State/Estado: _____ Zip code/Codigo Postal: _____

Email: _____ Occupation/Ocupacion: _____

Ethnicity/Etnia: Hispanic/Hispano ☐ Non-Hispanic/ No Latino ☐

Race/Raza: Caucasian/Caucasico ☐ African American/Afroamericano ☐ Asian/Asiatico ☐

Native American/ Nativo Americano ☐ Other/ Otro ☐ _____

Preferred Language/Idioma Preferido: _____

Primary Care Physician/ Medico Primario: _____ Phone: _____

Pharmacy/Farmacia: _____ Phone: _____

Emergency Contact Information / Informacion Contacto de emergencia

Name / Nombre: _____ Relationship/Relacion: _____

Phone/Telefono: _____

Purpose of the Visit / Motivo de Consulta:

_____

Allergies / Alergias:

_____

Medical History / Historia medica:

_____

Surgical History / Historia de Cirugias:

_____

Smoking History / Historia de Fumar

Current Tabaco user/Fumador ☐ Former smoker/ Ex fumador ☐ Never Smoked/ Nunca ha fumado. ☐

How many cigarettes per day / Cuantos cigarillos al dia: _____

For how many years / Cuantos años: _____

Year you quit smoking / Año en que dejo de fumar _____

Alcohol History / Historia de consume de alcohol Yes ☐ No ☐

Drug History / Historia de consumo de Drogas Yes ☐ No ☐ If yes: _____

Family Medical History / Historia de Enfermedades en su familia:

Mother: _____

Father: _____

Siblings: _____

Preventive Care / Cuidado

Flu Shot / Vacuna del flu: Yes ☐ No ☐ Date: _____

Covid vaccine: Yes ☐ No ☐ Date: _____

Pneumonia Shot / Vacuna contra la neumonia: Yes ☐ No ☐ Date: _____

PAP smear / Papanicolau: Yes ☐ No ☐ Date: _____

Colonoscopy / Colonoscopia: Yes ☐ No ☐ Date: _____

Mammogram / Mamografia : Yes ☐ No ☐ Date: _____

Medications / Medicamentos:

Name of medication / Nombre de medicamento	Dose / Dosis	Frequency / Cada cuanto

Review of Systems / Revisión de Síntomas Generales

Have you had any of the following in the last 2 weeks ? / Ha tenido alguno de estos sintomas en las ultimas dos semanas?

General Symptoms / Sintomas	Yes/Si	No	Symptoms / Sintomas	Yes/Si	No
Fever / Fiebre			Fatigue / Fatiga		
Night Sweats / Sudoración nocturna			Weight Loss / Perdida de peso		
Cardiovascular					
Inability to sleep flat / No puede dormir plano			Leg Swelling / Hinchazón en las piernas		
Chest Pain / Dolor de pecho			Palpitations / Palpitaciones		
Respiratory / Respiratorio					
Shortness of Breath / Dificultad para respirar			Sputum production/ Secreción con tos		
Wheezing / Sibilancias o pitos al respirar			Cough / Tos		
Coughing blood / Tos con sangre					
Gastrointestinal					
Nausea			Reflux / Reflujo		
Difficulty Swallowing / Dificultad para tragar			Diarrhea / Diarrea		
Musculoskeletal					
Muscle pain / Dolor muscular			Neck Pain / Dolor en el cuello		
Joint pain / Dolor en las articulaciones			Swollen Joint /Inflamación articular		
Neurologic					
Loss of Consciousness/ Perdida del conocimiento			Headache / Dolor de cabeza		
Seizure/Convulsiones					
Hematology					
Bleeding / Sangrado			Bruising / Moretones		
Ear Nose and Throat / Oidos, Nariz y Garganta					
Hoarseness / Voz ronca			Sore Throat/ Dolor de garganta		
Nose Bleed / Sangrado por la nariz					
Eyes / Ojos					
Pain / Dolor			Visual Loss / Perdida de la vision		
Endocrine					
Very thristy/ Mucha sed			Uncontrolled sugar/Azucar descontrolada		
Urinating a lot/ Orinando mucho					
Psyquiatric/Psiquiatrico					
Depression / Depresión			Hallucinations / Alucinaciones		
Anxiety / Ansiedad					
Genitourinary					
Difficult Urination/ Dificultad para orinar			Blood in the urine / Sangre en la orina		
Pain with Urination/ Dolor al orinar			Urinate at night / Orina en la noche		
Sleep / Sueño					
Snoring/Ronca			Excesive daytime sleepiness/ Se siente cansado durante el dia		
Skin / Piel					
Eczema			New rash / Erupcion en la piel		
Skin moles or growths/ Crecimientos en la piel o lunares nuevos					

INTEGRATED
Sleep Care

PATIENT HIPAA CONSENT FORM

I understand that I Have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that signing this consent, I authorize INTEGRATED SLEEP CARE to use and disclose the protected health information described below to_____ relationship: _____

Extent of Authorization

□ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

□ I authorize the release of my complete health record with the exception of the following information:

- □ Mental health records
- □ Communicable diseases (including HIV and AIDS)
- □ Alcohol/drug abuse treatment
- □ Other (please specify): _____

This medical information may be used for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that: 1. I have the right to revoke this authorization, in writing, at any time. 2. a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. 3.My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. 4. Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative Relationship to Patient

_____ _____

Printed name Date:

14601 SW 29th ST Suite 303 ~ Miramar, Florida 33027
Phone: 954-2896106 ~ Fax: 954-3376101
www.integratedsleepcare.com ~ info@integratedsleepcare.com

AUTHORIZATION FOR RELEASE OF RECORDS

TODAY'S DATE: Month / Mes _____ Day / Dia _____ Year / Año _____

PATIENT'S NAME / NOMBRE

_____

First Name / Primer Nombre Middle Name / Segundo nombre Last Name / Apellido

DATE OF BIRTH: Month / Mes _____ Day / Día _____ Year / Año _____

SSN # : _____

I, _____, HEREBY AUTHORIZE _____

_____

TO RELEASE ALL OF MY RECORDS, WHICH INCLUDES: MEDICAL HEALTH STATEMENTS, INITIAL EVALUATION NOTE, LAST FOLLOW-UP NOTE, PFT RESULTS, SLEEP STUDIES, PATHOLOGY REPORTS AND RADIOLOGY TEST TO:

INTEGRATED Sleep Care

Jose F. Ramirez, M.D., F.C.C.P.
Board Certified in Internal Medicine,
Pulmonary, Critical Care and Sleep Medicine.

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Tel: 954-289-6106 Fax: 954-337-6101
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I understand and acknowledge that this may include treatment for physical and mental illness, alcohol / drug abuse, and or HIV / AIDS test results and diagnosis. Your health care (or payment for care) will not be affected whether or not your sign this authorization. Once your health care information is released, the disclosure of your health care information by the recipient may no longer be protected by law.This authorization and consent will expire one year from the date of authorization written below. You can also request a copy of this authorization. Additionally, you may revoke this authorization at any time by submitting a written request to this office. Your revocation will be honored except to the extent the action has been taken there on.

PATIENT OR LEGAL GUARDIAN *: _____

SIGNATURE : _____ **DATE** _____

PRINT NAME: _____

WITNESS: _____

PRINT NAME: _____

* If other than the patient's signature, a copy of the legal paperwork verifying the patient's personal representative MUST accompany request (i.e. Court appointed guardian, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen. For a deceased patient a court order must accompany an authorization signed by the named individual.