Reiss, Kang, Jayanetti & Pereda, M.D., P.A.
6200 Sunset Drive, Suite 505
South Miami, FL 33143
(305) 668-1660

Patient Information / Informacion De Paciente: **Date/*Fecha*:** ________________

Name/ *Nombre*: ____

Date of birth/ *Fecha De Nacimento*: _____________Age/*Eda*: ________Gender/*Genero*: _________

Address/ *Direccion*: ____

SSN#/ *Numero Social*: ___________________ Marital status/ *Estado Civil*: __________

Primary Number/ *Telefono Primario*: ____

Seoncdary Number / *Telefono Secondario*: ____

Email/ *Correro Electronico*: ____________________________________

Pharmacy & Phone #/ *Farmacia y Telefono*: ____

Referred By/ *Referido Por*: ____________________________ Phone #: ___________________

Primary Care Physician/ *Doctor Primario* : ________________ Phone #:__________________

Emergency Contact/ *Contacto De Emergencia*: Name/ *Nombre*: ________________________

Relationship/*Relacion*:_________________ Phone Number/*Telefono*: ___________________

Race/*Raza*: ☐White ☐ American Indian ☐ Asian ☐ African American ☐ Other ____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other ______________

Insurance Information: Primary Insurance/ *Seguro Primario*: ___________________

Secondary Insurance/ *Seguro Secondario*: _________________

Primary Card Holder/ Persona Responsable del Serguro: ____________________

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law to subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. I HAVE READ AND UNDERSTAND THE ABOVE MEDICAL MALPRACTICE NOTICE

Bajo la ley de la Florida , Los medicos son generalmente requeridos de llevar un seguro medico para negligencia o de otra manera demonstrar reponsabilidad financiera para cubir los reclamos potenciales contra negligencia medica. SU MEDICO HE DECIDIDO NO LLEVAR SEGURO DE NEGLIGENCIA MEDICA. Esto es permitido bajo la ley de la Florida sujeto a ciertas condiciones. La ley de la Florida impone penalidades contra medicos que no estan asegurados que fallen de satisfacer juicios adversos originando de reclamos de negligencia medica. Esta Notificacion esta proporcionada de acuerdo con la ley del estado de la Florida. YO LEI Y ENTIENDO LA NOTIFICACION DE NEGLIGENCIA MEDICA.

REISS, KANG, JAYANETTI & PEREDA, M.D, P.A, AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1. I hereby authorize the following individual(s) or Organization(s):

☐Baptist Hospital ☐South Miami Hospital ☐Homestead Hospital ☐Baptist West Kendall Hospital
☐Mariners Hospital ☐Doctors Hospital ☐Jackson South Hospital ☐Jackson Memorial Hospital
☐ Other: _________________

Patient Name/ *Nombre*: ______________________________________ Date of Birth/ *Fecha De Nacimento:* _____________

2. The health information described below may be used by or disclosed to the following:

Reiss, Kang, Jayanetti & Pereda,M.D., P.A.
6200 Sunset Drive, Suite 505
South Miami, FL 33143
P: (305) 668-1660
F: (305) 668-1650

3. Describe the health information you are authorizing to be used/disclosed:
☐All Records ☐Operative Reports ☐Laboratory ☐HIV/ AIDS
☐ Consultation ☐Pathology Report ☐Discharge Summary ☐Progress Note
☐Imaging Studies Report ☐____________________________

(*If this form authorizes the use/disclosure of mental health records it may not be used to authorize the use/disclosure of any other health information. A separate authorization is needed for any other use/disclosure.) **NOTE:** You must obtain initial HIV antibody testing information from your physician. This form may not be used for marketing or research purposes.

4. Confined to records regarding admission and treatment on or about: _________________________

5. The disclosure of the health information described herein is being made for the reasons below:
☐ At request of Individual ☐ Sharing with other HCP as needed ☐ other: ________________________

6. I understand the I have a right to revoke this authorization at any time, and that if I revoke this authorization, I must send a written request to: *REISS, KANG, JAYANETTI & PEREDA, M.D., P.A, 6200 Sunset Drive, Suite 505, South Miami, FL 33143* Attn: Privacy Officer. I understand that the revocation will not apply to the information that has already been released in reliance of this authorization and to my insurance company when the law provided my insurer with the right to contest a claim under my policy.

7. This Authorization will expire ____________ (* If left blank, this authorization will expire one (1) year form date on which it was signed)

8. I understand that this authorization is voluntary. I understand that once the health information described herein is disclosed, it maybe re- disclosed by the recipient and may no longer be protected by the federal privacy law; however under federal and state laws respectively, the recipient may be prohibited from re- disclosing substance abuse and HIV/AIDS information without specific written consent of the person to whom it pertains; or as otherwise permitted by such laws, I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, enrollment for benefits.

Signature/ *Firma*: ______________________________________ Date/ *Fecha*: _____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this offices Notice of Privacy Practices/ *Yo he recibido una copia del Aviso de privacidad de esta Practica.*

Name/ *Nombre*: ____________________________ **Date/*Fecha*:** __________

Signature/ *Firma*: ________________________________

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Consentimineto de utilizar y divulger informacion Medica

Please inform us as to whom we may disclose health information, Please write their name and relationship to the patient.

Porfavor informenos a quien podemos divuglar su informacion Medica.

1. ___________________________________
2. ___________________________________
3. ___________________________________ **Or No one** ☐
4. ___________________________________
5. ___________________________________

For Physician Office Use Only

T*Solamente para el uso de consulta Medica*

T**he attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**T
Nosotros intentamos obtener un reconocimiento escrito que recibio nuestro aviso de privacidad de la pricatica, pero no pudo ser obtenido por:

☐ T**Individual refused to sign/**T Individuo se nego a firmar

☐ T**An emergency situation prevented us from obtaining the acknowledgement/** TUna emergencia no impidio obtener reconocimiento

☐ T**Communication barries prohibited obtaining the acknowledgement/**T Barreras de comunicacion prohibieron obtener reconocimiento

PATIENT EMAIL AND TEXT MESSAGING REGISTRATION FORM

Due to the changing world of healthcare and technology, Miami Vascular Surgery now has the ability to provide our patients with certain types of information via e - mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.
Miami Vascular Surgery believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from Miami Vascular Surgery via email or text messaging. Miami Vascular Surgery does not share the names, email addresses, and/or telephone numbers of patients with any other company, or with any other patient.

Please print all information neatly and legibly.

Name

Email address

Cell Phone

o Yes, please sign me up to receive email and text messaging confirmations.

o I do not wish to be contacted via email. (Text messaging only)

o I do not wish to be contacted via text messaging. (Email only)

o I do not wish to be contacted by either text messaging or email.

I hereby give Miami Vascular surgery permission to send messages to me via email and/or text messaging as a means of communication as indicated by my selection above.

Signature

Date

Assignment of Benefits Form

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable to related equipment or services to the organization, Health care financing administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to Health care financing administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

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(305) 668-1660
(305) 668-1650

Name of person signing/ *Nombre De Persona Firmando*: ______________________

Relationship to Insured/ *Relacion De Persona Asegurado*: ______________________

Signature/*Firma*: __________________________ **Date/*Fecha*:** _________

Reiss, Kang, Jayanetti & Pereda, M.D., P.A.
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South Miami, FL 33143
(305) 668-1660

Date/*Fecha*: ___________________

Patient Name/ *Nombre*: _________________________________

DOB/ *Fecha De Nacimento*: ___________________

We are switching to Electronic Health Records (E.M.R) and as part of government guidelines we are required to ask the questions below:

Estamos cambiando a un sistema de records medico electronicos (R.M.E) y comoparte de los requisitos guvernamentales es necesario hacerles las siguientes preguntas:

Height/*Estatura***:** ________ **Weight/***Peso***:** ________**Do you Smoke/ *Fumas*?** ☐ **Yes** ☐ **No**

Preferred Language/*Primer Idioma***:** ________________

ALLERGIES/ *ALERGIAS*: ____

____

Please list Medications below / *Lista De Medicacion* :

Medication/ *Medicacion*	**Dosage/ *Doses***	**Route/ *Ruta***	**Frequency / *Frequencia***

NAME: ____________________ D/O/B: _______ DATE: ____________ MR#__________

What problems bring you here today?
(Razón por la cual nos visita hoy?)

Who sent you to us? (Quien lo envía a nosotros?)
Doctor/Other (Un Medico / Otro?) ___________________
Which Doctor? (Cual Medico?) __________________

What surgery Have you had and When? (LIST)
(Que Cirugías ha tenido y cuando) Lista
1.___________________________
2.___________________________
3.___________________________
4.___________________________
5.___________________________
6.___________________________
7.___________________________

How much Alcohol do you Drink approximately? _____DAY ______WEEK _____MONTH
Cantidad de alcohol que consume? Dia Semana Mes

Do You Smoke? (Usted Fuma) YES NO

Have you ever Smoked? (Alguna vez ha fumado) YES NO

When did you Stop? (Cuando dejo de fumar) ______________

Illegal Drugs use? PAST/ PRESENT/ NONE (Drogas ilegales –Pasado / Presente /Ninguna)

Occupation (Currently/ Before Retired)______________ Ocupacion-presente o antes de retirarse_

LIST YOUR FAMILY MEDICAL PROBLEMS: (Problemas Medicos De Familia)

CIRCLE ONE:AGE(S) MAJOR ILLNESS /CAUSE OF DEATH:
Circular Uno: Edad Enfermedad o Razon de fallecimiento

	Circle One (Circular Uno)	Age (Edad)	Major Illness / Cause of Death (Enfermedad o Razon de fallecimiento)
MOTHER: Madre	LIVING / DECEASED Vive / Fallecido	_____	____________________ ____________________
FATHER: Padre	LIVING / DECEASED Vive / Fallecido	_____	____________________ ____________________
SIBILINGS: Hermano/a	LIVING / DECEASED Vive / Fallecido	_____	____________________ ____________________
CHILDREN: Hijos	LIVING / DECEASED Vive / Fallecido	_____	____________________

ANY FAMILY HISTORY OF ANEURYSM OR DVT?
Algun historial familiar de Aneurismo O Trombosis profunda? YES NO

Have you ever had any of the following listed below in the past?
De la siquiente lista -Alguna vez ha tenido?

VASCULAR:

Aneurysm (Aneurisma)	YES NO
Deep Vein Thrombosis (DVT) (Trombosis Venosa)	YES NO
Pulmonary Embolus (Embolia Pulmonar)	YES NO
Carotid Desease (Enfermedad de la Carótida)	YES NO
Leg or Feet Swelling (Inflamación de Pies o Piernas)	YES NO
Varicose Veins (Venas Varicosas)	YES NO
Spider Veins (Venas Arañas)	YES NO
Treatment of Varicose Veins (Tratamiento de Venas Varicosas)	YES NO
Gangrene (Gangrena)	YES NO
Stroke (Embolia del Cerebro)	YES NO
Vascular Problems (Problemas Vasculares)	YES NO

CARDIAC: (CARDIACO)

Heart Problems (Problemas de Corazón)	YES NO
Heart Attack (Ataque del Corazón)	YES NO
High Cholesterol (Cholesterol Alto)	YES NO
Pacemaker (Marca Paso)	YES NO
Automatic Defibrillator (Desfibrilador)	YES NO
Rhythm Problems (Problemas de ritmo cardiaco)	YES NO
High Blood Pressure (Presión Alta)	YES NO
Heart Murmur (Soplo del Corazón)	YES NO

PULMONARY: (PULMONAR)

Asthma (Asma)	YES NO
Bronchitis (Bronquitis)	YES NO
COPD (Emphysema) (Enfisema Pulmonar)	YES NO
Lung Cancer (Cáncer del Pulmón)	YES NO
Pneumonia (Neumonía)	YES NO
Sleep Apnea (Apnea del Sueno)	YES NO

GASTROINTESTINAL: (GASTROINTESTINAL)

Bleeding (Sangramiento)	YES NO
Hepatitis (Hepatitis)	YES NO
Reflux (Reflujo)	YES NO
Gallbladder Disease (Problemas de Vesícula)	YES NO
Colon Polyps (Pólipos del Colon)	YES NO
Inflammatory Bowel (Intestinos inflamado)	YES NO
Ulcer (Ulcera)	YES NO
Irritable Bowel Disease (Intestino Irritable)	YES NO
Other (Otro)	____________

GU: (Genitourinaria –orine)

Prostate Cancer (Cáncer de la Próstata)	YES NO
Kidney Stones (Piedra del Riñón)	YES NO
Kidney Failure (Falla del Riñón)	YES NO
BPH (Hipertrofia Prostática Benigna)	YES NO

ENDOCRINE: (Endocrino)

Gout (la Gota)	YES NO

Overactive Thyroid (Tiroides Hiperactivas) YES NO
Underactive Thyroid (Tiroides Hipoactivas) YES NO
Diabetes (Diabetis) YES NO
Other (Otro) ____________

GYN: (Ginecologia)
Cervical Cancer (Cancer Cervical) YES NO
Hysterectomy (Hysterectomia) YES NO
Other (Otro) ___________

NEUROLOGIC: (Neurologico)
Stroke (Derrame Cerebral) YES NO
Mini-Stroke or TIA (Ataque Isquémico Transitorio) YES NO
Arm or Leg Weakness (Debilidad de Brazos/piernas) YES NO
Episode of loss of visión (Momentos de perdida de visión) YES NO
Difficulty Speaking (Dificultad al Hablar) YES NO
Sciatica (Ciática) YES NO
Fainting spells (Desmayos) YES NO
Seizures (Convulsiones) YES NO
Back injury (lesión de Espalda) YES NO
Headaches (Dolor de Cabeza) YES NO
Other (Otro) ___________

MUSCULOSKELETAL: (Musculoskeletal)
Osteoporosis (Osteoporosis) YES NO
Reumatoid/Inflammatory Arthritis (Artritis Reumatoide) YES NO
Osteoarthritis (Osteoartritis) YES NO
History of fracture (historia de fracturas) YES NO
Fibromyalgia (Fibromialgia) YES NO
Polymyalgia Rheumatic (PMR) (Polimialgia Reumatica) YES NO

BLOOD PROBLEMS AND BLEEDING: (Problemas de Sangre o Sangramiento)
Do you heal cuts slowly (Sana heridas lentamente) YES NO
Anemia (Anemia) WHEN?______ CUANDO?_________ YES NO
Blood Disorder (Trastornos de Sangre) YES NO
Excessive bleeding in surgery (Sangramiento excesivo en cirugías) YES NO
Abnormal bruising or bleeding due to blood thinner meds YES NO
(Moretones anormales O sangramiento a causa de anticoagulantes) YES NO
Phlebitis or blood clots in veins (Flebitis en las venas) YES NO
Other (Otro) ___________

INTEGUMENTARY (SKIN DISORDERS)/AUTO IMMUNE -
(Integumentario(Trastornos de La Piel/ Autoimunes) YES NO
Rashes, Eczema, Psoriasis (Erupciones-Eczema-Psoriasis) YES NO
Lupus, Scleroderma, Sjogrens (Lupus-Escleroderma-Psoriasis) YES NO
Basal Cell/Squamous Cell (Celulas basales-Celulas Escamosas)
Melanoma (Cancer) YES NO

PSYCHIATRIC: (PSIQUIATRICOS)

Anxiety (Ansiedad) YES NO
Depression (Depresion) YES NO
Suicidal Ideation (Pensamiento Suicida) YES NO

OTHER:
Cataracts (Cataratas) YES NO
Glaucoma (Glaucoma) YES NO

WHAT MEDICATIONS ARE YOU ALLERGIC TO?
(Alergias a algun Medicamento)?
____
____
____

ARE YOU ON A BLOOD THINNER? (Toma usted algún Anticoagulante) YES NO
DO YOU TAKE A STATIN? (Toma usted Estatinas) YES NO
DO YOU TAKE COUMADIN? (Toma usted Cumadina YES NO
DO YOU TAKE PREDNISONE? (Toma usted Prednisona) YES NO
DO YOU TAKE ASPIRIN? (Toma usted Aspirina) YES NO
DO YOU TAKE PLAVIX? (Toma usted Plavix) YES NO

NAMES & DOSE OF KNOWN MEDICATIONS: (Nombres y Dosis de sus Medicamentos)
1.__________________________
2.__________________________
3.__________________________
4.__________________________
5.__________________________
6.__________________________

RECENT SYMPTOMS IN THE LAST 6 MONTHS?
Síntomas recientes o en los pasados 6 meses?

Fever/Chills (Fiebres / Escalofríos) YES NO
Weight change in the past 6 months (Cambio de peso en los últimos 6 meses) YES NO
Fatigue (Fatiga) YES NO
Other? (Otro) ________________

ARE YOU PREGNANT? (Esta Embarazada) YES NO
ARE YOU ON BIRTH CONTROL? (Usa algún Contraceptivo) YES NO

Impaired Hearing (Problemas de Audicion) YES NO
Dizziness (Mareos) YES NO
Temporary spells of blindness (Ceguera Temporal) YES NO
Double Vision (Vision Doble) YES NO

NEUROLOGIC: (Neorological)
Arm or Leg Weakness or Paralysis (Paralisis de Brazos o Piernas) YES NO
Difficulty Speaking (Dificultad del Habla) YES NO
Loss of vision in one eye (Perdida de vision en un Ojo) YES NO
Poor balance (Equilibrio Pobre) YES NO
Headaches (Dolores de Cabeza) YES NO
Sciatica (Ciatica) YES NO
Fainting spells (Desmayos) YES NO
Seizures (Convulsiones) YES NO
Back injury (Lesión de la Espalda) YES NO

NEUROPATHY: (NEUROPATIA)
Numbness in legs (Entumecimiento) YES NO
Pins and Needles Hands (Hormigueos en las manos) YES NO
Pins and Needles Feet (Hormigueos en los Pies) YES NO

CARDIOVASCULAR: (CARDIOVASCULAR)	
Chest pain in past 6 months (Dolor de Pecho en los últimos 6 meses)	**YES NO**
Angina in past 6 months (Angina de Pecho en los últimos 6 meses)	**YES NO**
Shortness of breath with walking (Falta de Aire al Caminar)	**YES NO**
Shortness of breath lying down (Dificultad al respirar acostado)	**YES NO**
Heart failure (Insuficiencia Cardiaca)	**YES NO**
Irregular heartbeat (Latidos Irregulares)	**YES NO**

RESPIRATORY: (VIAS RESPIRATIORIAS)	
Spitting up blood (Escupir Sangre)	**YES NO**
Chronic or frequent cough (Tos cronica o Frequente)	**YES NO**
Shortness of breath (Falta de Aliento)	**YES NO**
Chest congestion (Congestion de Pecho)	**YES NO**
Recent upper respiratory infection ((Reciente Infeccion Respiratoria)	**YES NO**
Recent flu symptoms (Sintomas de Gripe Reciente)	**YES NO**
Wheezing (Sibilancia)	**YES NO**
Sleep Apnea (Apnea del Sueno)	**YES NO**

VASCULAR: (VASCULAR)	
Leg pain with walking (Dolor en las piernas al caminar)	**YES NO**
Pain in feet at night (Dolor en los pies en la noche)	**YES NO**
Wounds on legs/feet (Heridas en los pies o piernas)	**YES NO**
Varicose Veins (Venas Varicosas)	**YES NO**
Skin color change (Cambio de color en la piel)	**YES NO**
Gangrene (Gangrena)	**YES NO**

SKIN: (PIEL)	
Itching (Picazon)	**YES NO**
Rashes (Erupciones)	**YES NO**
Wound (Heridas)	**YES NO**
Lesions (Lesiones)	**YES NO**

GASTROINTESTINAL:GASTROINTESTINAL)	
Stomach ulcer (Ulcera de estomago)	**YES NO**
Vomiting blood (Vomitos de Sangre)	**YES NO**
Hiatus hernia (Hernia de Hiato)	**YES NO**
Heartburn or Indigestion (Acidez estomacal o indigestion)	**YES NO**
Gallbladder disease (Enfermedades de la Vesicula)	**YES NO**
Liver trouble (problemas del Higado)	**YES NO**
Black stools (Heces fecales color negro)	**YES NO**
Recent change in bowel movements (cambios recientes en deposiciones)	**YES NO**
Bleeding with bowel movements (Sangramiento con deposiciones)	**YES NO**
Hemorrhoids (Hemorroides)	**YES NO**
Frequent diarrhea (Diarrea Frecuente)	**YES NO**
Abdominal Pain (Dolor abdominal)	**YES NO**

GENITO-URINARY:	
Pain on urination (Dolor al Orinar)	**YES NO**
Impotence (Impotencia)	**YES NO**
Frequent Urination (Orina frecuente)	**YES NO**
Blood in urine now (Sangre en la Orina ahora)	**YES NO**
Frequent urinary tract infection (Infeccion de la orina frecuente)	**YES NO**

HEMATOLOGIC: (HEMATOLOGICAS)

Anemia (Anemia)	**YES NO**
Blood disorder (Trastornos de la sangre)	**YES NO**
Cancer (Cancer)	**YES NO**

MUSCULOSKELETAL: (MUSCULOESQUELETICOS)

Muscle Weakness (Debilidad en los músculos)	**YES NO**
Pain (Dolor)	**YES NO**
Joint Stiffness (Rigidez de las articulaciones)	**YES NO**
Joint Swelling (Inflamacion de las articulaciones)	**YES NO**
Boney Aches (Dolor en los Huesos)	**YES NO**

ENDOCRINE: (ENDOCRINA)

Treatment of thyroids (Tratamientos de la Tiroides)	**YES NO**
Diabetes (Diabetes)	**YES NO**
Other (Otro)	________________

PSYCHIATRIC: (PSIQUIATRICOS)

Depression (Depresion)	**YES NO**
Anxiety (Ansiedad)	**YES NO**

PATIENT SIGNATURE: ___________________
(FIRMA DEL PACIENTE)

DATE: ________________
(FECHA DE HOY)