Name: Date of Birth: Date of Service**:**

HISTORY AND PHYSICAL

Name:		**Date**:	
Age: years old	**Date of Birth**:	**Sex**: ☐ Male ☐ Female	
Referred By:	Email:	Cell/Tel.:	
What is your main complaint?			
Occupation:		☐ Employed ☐ Unemployed ☐ Retired	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other			
Do you have any children?		**Ages** :	

Do you smoke?	☐ No	☐ Yes	If yes, for how long? _____
Do you drink alcohol?	☐ No	☐ Yes	If yes, for how long? _____
Do you take unprescribed drugs or medicines?	☐ No	☐ Yes	If yes, for how long? _____
Do you take any pain killers?	☐ No	☐ Yes	If yes, for how long? _____
Have you been tested for HIV?	☐ No	☐ Yes	If yes, when? _____
Are you currently a patient on dialysis?	☐ No	☐ Yes	If yes, what kind? ☐ CAPD ☐ CCPD ☐ Hemodialysis
Have you received a kidney transplant?	☐ No	☐ Yes	If yes, when? _____

Do you have a history of:			
Diabetes Mellitus	☐ No	☐ Yes	If yes, for how long? _____
Hypertension	☐ No	☐ Yes	If yes, for how long? _____
Kidney Disease	☐ No	☐ Yes	If yes, for how long? _____
Kidney Stones	☐ No	☐ Yes	If yes, for how long? _____
Urine or Bladder Infections	☐ No	☐ Yes	If yes, for how long? _____
Heart Disease	☐ No	☐ Yes	If yes, for how long? _____
Lung Disease	☐ No	☐ Yes	If yes, for how long? _____
Cancer	☐ No	☐ Yes	If yes, for how long? _____
Systemic Lupus Erythematosus	☐ No	☐ Yes	If yes, for how long? _____
Anemia	☐ No	☐ Yes	If yes, for how long? _____
Arthritis	☐ No	☐ Yes	If yes, for how long? _____
Blood Transfusions	☐ No	☐ Yes	If yes, for how long? _____
Other:			For how long? _____

Have you had any surgeries?	☐ No	☐ Yes	If yes, please list them:	
			1.	2.
			3.	4.

Are you allergic to any of the following:	☐ NKDA		If you answered yes to any of these, please list them:
Medication	☐ No	☐ Yes:	_____
Ray contrast materials	☐ No	☐ Yes:	_____
Foods	☐ No	☐ Yes:	_____
Chemicals or environmental	☐ No	☐ Yes:	_____
Other:			

Have you had the following adult immunizations:		
Influenza	☐ No	☐ Yes
Hepatitis B	☐ No	☐ Yes
Pneumovax	☐ No	☐ Yes

Name: Date of Birth: Date of Service**:**

Please list your medications: Do you have any side effects due to your medicines? ☐ Yes ☐ No

Medication	Start Date	End Date	Medication	Start Date	End Date
1.			11.		
2.			12.		
3.			13.		
4.			14.		
5.			15.		
6.			16.		
7.			17.		
8.			18.		
9.			19.		
10.			20.		

Is there any family history of:

Diabetes Mellitus	☐ No	☐ Yes	If yes, in whom:	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Children
High Blood Pressure	☐ No	☐ Yes	If yes, in whom:	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Children
Kidney Stones	☐ No	☐ Yes	If yes, in whom:	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Children
Cancer	☐ No	☐ Yes	If yes, in whom:	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Children
Strokes	☐ No	☐ Yes	If yes, in whom:	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Children
Anemia	☐ No	☐ Yes	If yes, in whom:	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Children
Heart Attacks	☐ No	☐ Yes	If yes, in whom:	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Children
Other:			In whom:	☐ Father	☐ Mother	☐ Brother	☐ Sister	☐ Children

Please check the boxes with an X if you have any listed below. Please write under "Other" if not listed here:

General

☐ Changes in weight ☐ Reduced appetite
☐ Fever ☐ Breast changes
☐ Sweats ☐ Temperature intolerance
☐ Sleeping problem ☐ Increased thirst
☐ Skin rashes or discoloration

Head

☐ Headaches ☐ Vertigo
☐ Recent injury ☐ Nose bleeds
☐ Visual changes ☐ Tooth/mouth problems
☐ Hearing change ☐ Frequent ear aches

Urinary

☐ Burning sensation when you urinate
☐ Increase in frequency ☐ Do you urinate at night
☐ Abnormal bleeding ☐ Sexual dysfunction
☐ Discharge from your sexual organs
☐ Recent sexually transmitted diseases
☐ Other:

Chest

☐ Cough ☐ Wheezing ☐ Chest pain
☐ Shortness of breath ☐ Palpitations

Extremities

☐ Arthritis ☐ Joint swelling ☐ Phlebitis
☐ Varicose veins ☐ Legs swelling ☐ Muscle cramps
☐ Weakness in arms or legs

GI

☐ Nausea ☐ Vomiting ☐ Bleeding
☐ Heartburn ☐ Constipation ☐ Diarrhea
☐ Bowel Problems ☐ Abdominal pain

Bleeding

☐ Easy bruising ☐ Are you pale
☐ Excessive bleeding

Neurologic

☐ History of seizures ☐ Mood swings ☐ Depression
☐ Paralysis ☐ Fainting spell ☐ Loss of sensation

X _____

Signature of Patient

Office Use Only						
☐ ROS discussed with patient			☐ ROS is negative			
VITAL SIGNS:	BP:	P:	R:	TEMP:	WT:	HT:
Spo2:			**Referred:** ☐ **Yes** ☐ **No**			
SAMPLES GIVEN:				**Initial:**		

Name: Date of Birth: Date of Service**:**

Consent to Treatment

Social Security #: _____

I hereby voluntarily consent to medical treatment by Bernardino Flores Abaya, M.D., P.A. encompassing routine diagnostic procedures, examination, and medical treatment including, but not limited to, routine laboratory work such as blood, urine, and other studies.

Release of Information: (a) I authorize Bernardino Flores Abaya, M.D., P.A. to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care. (b) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.

I understand that this consent form will be valid and remain in effect as long as I receive medical care from Bernardino Flores Abaya, M.D., P.A. This form has been explained to me, and I fully understand this Consent to Treatment and agree to its contents.

Signature of Patient:	Date:
Signature of Witness:	Date:

Name: Date of Birth: Date of Service**:**

FINANCIAL POLICY

This is an agreement between BERNARDINO FLORES ABAYA, M.D., P.A, a Professional Association, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you", "your, and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we" and "our" refer to BERNARDINO FLORES ABAYA, M.D., P.A.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statements is approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment options if you have no insurance:

☐ You choose to pay by ☐ cash, ☐check on the day the treatment is rendered.
☐ On more than one visit/medical consultation, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.
☐ **A deposit of $ 2,000.00** is required if one or more medical consultation is anticipated before medical services are rendered.

Payment options if you have insurance:

☐ You choose to pay your deductible of $ _____ and any out-of-pocket portions at the time services are rendered by ☐ cash, ☐ check.
☐ You choose to pay all of your treatment by ☐ cash, ☐ check. We will request your insurance carrier to send their payment directly to you.
☐ For visits under $ 200.00, payment is due at the time of service in full payment, regardless of insurance. We will request your insurance carrier to send their payment directly to you.

PATIENTS WITH INSURANCE: It is your responsibility to monitor your benefits and annual maximum. If your insurance company does not respond within 60 days, you are responsible for the remaining balance. We will be happy to assist you with any resubmissions.

The Financial Policy continues on the back side of this page.

Print Patient's Name: _____

Responsible party (if not the patient):_____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____