LAMAS MEDICAL CENTER
Allergy • Immunology • Aesthetic & Weight Loss Management
2000 SW 27TH AVENUE, SUITE 301, MIAMI, FL 33145
PH: 305.461.2010 ~ FAX: 305-648-0140

**PATIENT INTAKE FORM** (Información del paciente): Form 738-6 revised 09/16

Last Name_____ Name:_____
(Apellido) (Nombre)

Date of Birth:_____ Sex: M____ F____ SSN: (Last 4 digits only) XXX-XX-_____
(Fecha de nacimiento) (Sexo) (Los últimos 4 números de su Social)

Primary language (circle): English / / Spanish / / other_____
(Primer idioma) (Ingles) (Español) (otro)

Marital status (circle): Single / / Married / / Divorced / / Separated
(Estado civil) (Soltero) (Casado) (Divorciado) (Separado)

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Address:_____
(Dirección)

City:_____ State:_____ Zip:_____
(Ciudad) (Estado) (Código Postal)

Phone: (Home)_____ (Cell) _____
(Telefono)

E-Mail:_____ , Preferred communication: Home / / Cell / / E-mail

Emergency Contact:_____ Relationship:_____ Phone:_____
(Contacto de Emergencia) (Relación) (Telefono)

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Referring Physician:_____PH:_____
(Doctor que lo refiere)

Preferred Pharmacy:_____PH:_____

Address: _____

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I hereby authorize payment directly to Ana M. Lamas, M.D., of benefits due to me from my insurance company otherwise payable to me. A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or their intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization under the terms of my insurance policy.

Por la presente autorizo a Ana M. Lamas, M.D., a cobrar los beneficios por los servicios recibidos por mi. Una copia de esta autorización puede ser usada en sustitución de la original. Yo autorizo al "Social Security Administration" y al "Health Care Financing Administration" la obtención de cualquier información para procesar mis cargos si están relacionados con Medicare. Yo comprendo que soy financieramente responsable de los cargos no cubiertos por mi seguro bajo los terminos de mi póliza.

_____ _____
(Signature / Firma) (Date / Fecha)

# Juan F. Lamas, Inc.
# Ana M. Lamas, M.D.

## Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ***Juan F. Lamas, Inc.*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ***Juan F. Lamas, Inc.*** I understand that diagnosis or treatment of me by ***Ana M. Lamas, M.D.*** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ***Juan F. Lamas, Inc.*** is not required to agree to the restrictions that I may request. However, if ***Juan F. Lamas, Inc.*** agrees to a restriction that I request, the restriction is binding on ***Juan F. Lamas, Inc.*** and ***Ana M. Lamas, M.D.***

I have the right to revoke this consent, in writing, at any time, except to the extent that ***Ana M. Lamas, M.D.*** or ***Juan F. Lamas, Inc.*** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ***Juan F. Lamas, Inc.*** *Notice of Privacy Practices* prior to signing this document. I hereby acknowledge that ***Juan F. Lamas, Inc.*** *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations by ***Juan F. Lamas, Inc.*** The *Notice of Privacy Practices* for ***Juan F. Lamas, Inc.*** is available for your review at 2000 SW 27th Avenue, Miami FL and at 175 W. 49th Street, Hialeah FL and on our website at **www.MDhub.com**. This *Notice of Privacy Practices* also describes my rights and ***Juan F. Lamas, Inc.*** duties with respect to my protected health information.

***Juan F. Lamas, Inc.*** reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I also have the right to designate a personal representative that may have access to or receive personal health information on my behalf. I understand however, that if I choose not to designate a personal representative communications will be made only with me.

(Mark the one that applies): I _____DO _____DO NOT wish to designate a Personal Representative

Name of Personal Representative: _____Relationship:_____

Description of Personal Representative Authority:_____

_____ _____

Name of Patient (please print) Signature / Date

LAMAS MEDICAL CENTER
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2000 S.W. 27TH AVENUE,3rd Floor
MIAMI, FL 33145

PHONE (305) 461-2010
FAX (305) 648-0140

**Patient Name:** _____ **Date:** _____
**(Please Print)**

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this.. I understand that Lamas Medical Center will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Lamas Medical Center policy. Images that identify me will be released and/or used outside the office only upon written authorization from me or my legal representative. This consent does not authorize the use of the images for other purposes, such as teaching or publicity.

I have been informed that my authorization is required for the release of Protected Health Information, which includes patient photography for purposes beyond treatment, payment and healthcare operations.

**(Signature)**_____ **Date**_____

**(Witness)**_____ **Date**_____

## REVIEW OF SYSTEMS (check all that apply) (marque todas las que apliquen)

***1. General:***
- ☐ Recent weight change (*cambio reciente en su peso*)
- ☐ Weakness (*debilidad*)
- ☐ Fever (*fiebre*)
- ☐ Chills (*escalofríos*)
- ☐ Fatigue (*fatiga*)
- ☐ Night sweats (*sudoraciones nocturnas*)

***2. Skin (Piel)***
- ☐ Rashes (*erupción*)
- ☐ Lumps (*masas*)
- ☐ Dryness (*resequedad*)
- ☐ Itching (*picazón*)
- ☐ Eczema
- ☐ Edema (*hinchazón*)
- ☐ Coagulation problems (*problemas de coagulación*)
- ☐ Hives (*ronchas*)
- ☐ Insect Reactions (*reacción a picada de insectos*)
- ☐ Easy Bruising (*moretones*)

***3. Head (Cabeza)***
- ☐ Headaches (*dolores de cabeza*)
- ☐ Head injury (*golpes en la cabeza*)

***4. Eyes (Ojos)***
- ☐ Itching (*picazón*)
- ☐ Burning (*quemazón*)
- ☐ Tearing (*lagrimeo*)
- ☐ Shiners (*ojeras*)
- ☐ Discharge (*secreción*)
- ☐ Swelling (*hinchazón*)
- ☐ Redness (*enrojecimiento*)
- ☐ Photophobia (*sensibilidad a la luz*)

***5. Ears (Oidos)***
- ☐ Difficulty hearing (*problema de audición*)
- ☐ Ear infection (*infección de oído*)
- ☐ Earaches (*dolores de oído*)
- ☐ Itching (*picazón*)
- ☐ Popping (*llenura*)
- ☐ Discharge (*secreción*)
- ☐ Lightheadedness
- ☐ Buzzing (*zumbido*)

***6. Nose & Sinuses (Nariz y senos frontales)***
- ☐ Sneezing (*estornudos*)
- ☐ Nasal Stuffiness (*tupición nasal*)
- ☐ Itching (*picazón*)
- ☐ Nosebleeds (*sangramiento*)
- ☐ Snoring (*ronquidos*)
- ☐ Mouth breathing (*respiración por la boca*)
- ☐ Sinus pain/infection (*sinusitis*)
- ☐ Loss of smell (*pérdida del olfato*)
- ☐ Discharge (*secreción*)

  Color & qty (*color y cantidad*): _____

***7. Neck (Cuello)***
- ☐ Swollen/Tender Lymph nodes (*nódulos limfáticos inflamados*)

***8. Respiratory (Respiratorio)***
- ☐ Asthma (*asma*)
- ☐ Constant coughing (*tos continua*)
- ☐ Coughing up blood (*expectorando sangre*)
- ☐ Bronchitis > 1/month (*bronquitis por >1 mes*)
- ☐ Shortness of breath (*falta de aire*)
- ☐ Chest pain (*dolor de pecho*)
- ☐ Wheezing (*sibilantes*)
- ☐ Pneumonia (*pulmonia*)
- ☐ Expectoration/sputum production (*expectoración*)

  Color & qty (*color y cantidad*): _____

***9. Cardiac (Cardiaco)***
- ☐ Hypertension? (*hipertensión*)
- ☐ Edema (*hinchazón*)
- ☐ Heart murmurs (*murmullos*)
- ☐ Palpitations (*palpitaciones*)

***10. Gastrointestinal (gastrointestinal)***
- ☐ Reflux (*reflujo*)
- ☐ Hiatal Hernia (*hernia Hiatal*)
- ☐ Excess belching/passing gas (*eructaciones/flatulencia*)
- ☐ Constipation (*estreñimiento*)
- ☐ Trouble swallowing (*dificultad de tragar*)
- ☐ Food intolerance (*intolerancia a la comida*)
- ☐ Heartburn (*acidez*)
- ☐ Nausea (*nausea*)
- ☐ Vomiting(*vomito*)
- ☐ Indigestion (*indigestión*)
- ☐ Diarrhea (*diarrea*)
- ☐ Abdominal pain (*dolor del abdomen*)

***11. Mouth & Throat (Boca y garganta)***
- ☐ Frequent Sore Throat (*frequentes dolores de garganta*)
- ☐ Dry mouth (*resequedad*)
- ☐ Loss of taste (*perdida del paladar*)
- ☐ Post Nasal Drip (*flema nasal posterior*)
- ☐ Hoarseness (*ronquera*)
- ☐ Edema of lips/tongue (*hinchazón de boca/lengua*)
- ☐ Irritation (*irritación*)
- ☐ Itchiness (*picazón*)

Name: _____

M/R #: _____

Date: _____

# ANA M. LAMAS, MD

**Diplomates, American Board of Allergy and Immunology**

**Date:** _____
(Fecha)

**Name:** _____ **DOB:**_____
*(Nombre)* *(Fecha de Nacimento)*

***PLEASE PROVIDE MEDICATION LIST.**
*(Por favor proporcione lista de medicamentos)*

*1)* _____ _____*mg*
*2)* _____ _____*mg*
*3)* _____ _____*mg*
*4)* _____ _____*mg*
*5)* _____ _____*mg*
*6)* _____ _____*mg*
*7)* _____ _____*mg*
*8)* _____ _____*mg*
*9)* _____ _____*mg*
*10)* _____ _____*mg*

**Drug Allergies:**
*(allergias a medicamentos)*

_____
_____

***NOTE:***

_____
_____
_____

LAMAS MEDICAL CENTER
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**RECORDS RELEASE REQUEST FORM**

Date:_____

To: **Ana M. Lamas, M.D.**
Medical Records Department

Patient Name:_____ DOB: _____

**I HEREBY AUTHORIZE Lamas Medical Center TO RELEASE MY RECORDS TO:**

TO:_____

PHONE#:_____ FAX#:_____

*Office Notes: _____ *X-Rays: _____

*Allergy Tests: _____ *CT-Scan: _____

*Patch Test: _____ *Hospital Notes: _____

*Lab Work: _____ *Other: _____

NOTES: _____

_____

_____

Signature: _____ Date: _____

Please fax signed Record Release Request to: Medical Records Department

Fax: 305-648-0140 / 305-529-3498

Please allow up to 72 hours for the completion of this Release.

**2000 SW 27TH AVE., THIRD FLOOR**
**MIAMI, FL 33145**
**PH: (305) 461-2010**
**FAX: (305) 648-0140 / (305) 529-3498**

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**RECORD REQUEST TO *OBTAIN* MEDICAL RECORDS**

Form 738-7 revised 10/16

Date:_____ STAT: ☐ Yes ☐ No

To:_____

PHONE#:_____ FAX#:_____

Patient Name:_____ DOB: _____

**I HEREBY AUTHORIZE YOU TO RELEASE MY RECORDS TO: *ANA M. LAMAS, M.D.***

☐ Office Notes: _____

☐ Allergy Tests: _____

☐ Patch Test: _____

☐ Lab Work: _____

☐ X-Rays: _____

☐ CT-Scan: _____

☐ Hospital Notes: _____

☐ Other: _____

*NOTES: _____

_____

_____

Signature: _____ Date: _____

**Please Fax Records ATTN to: Medical Records Department**
**Fax: 305-648-0140 / 305-529-3498**

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