CLINICAL DATA SHEET

NAME			DATE OF BIRTH	AGE	SEX	SMWD
ADDRESS		ZIP	PHONE		DATE	
CITY			STATE			
			SOCIAL SECURITY #			
OTHER ADDRESS						
OCCUPATION	EMPLOYED BY		ADDRESS		PHONE	
INSURANCE SELF	SPOUSE	OTHER	POLICY NO.			
NAME OF COMPANY			ADDRESS			
MEDICARE NO.		B.S. FL	OTHER	B.S. NO.		
OTHER				PRIMARY DR.		
				PHONE NO.		

DATE			
MO	DAY	YR	

SIMON MIGUEL EDELSTEIN, M.D., M.P.H.
CARLOS I. BUSTAMANTE, M.D., F.A.C.P.
DANIEL KASWAN, M.D.
INFECTIOUS DISEASES

20814 WEST DIXIE HIGHWAY, AVENTURA, FLORIDA 33180 (305) 933-8433 FAX (305) 933-9115

PLEASE PRINT

LAST NAME_____ **FIRST NAME** _____ **MI** _____

PATIENT'S SOCIAL SECURITY NUMBER _____

HOME ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE _____ **WORK** _____ **CELL** _____

E-MAIL ADDRESS _____

MARITAL STATUS (CIRCLE ONE) MARRIED SINGLE WIDOWED DIVORCED SEPARATED OTHER

SEX (CIRCLE ONE) MALE FEMALE

DATE OF BIRTH _____ **PLACE OF BIRTH** _____

ALLERGIES _____ **REFERRED BY** _____

EMPLOYER _____ **EMPLOYER'S PHONE NUMBER** _____

EMPLOYER'S ADDRESS _____

EMERGENCY CONTACT _____ **RELATIONSHIP** _____

EMERGENCY CONTACT HOME ADDRESS _____

EMERGENCY CONTACT PHONE NUMBERS:
HOME _____ **WORK** _____ **CELL** _____

SIGNATURE _____ **DATE** _____

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

REASON FOR TODAY'S VISIT:
CHIEF COMPLAINT: **NAME:**

Past Medical History:			**For MD only; if any changes to initial history obtained**
Have you had any of the following:	**No**	**Yes**	**Please specify dates and changes to condition**
Allergies, Asthma, Hay Fever			
Anemia			
Arthritis			
Cancer			
Emphysema			
Heart Trouble			
Mental Illness			
Rheumatic Fever			
Stroke/Headache/Seizure			
Thyroid			
Osteoporosis			
Glaucoma			

Surgical History:

Social History:	**No**	**Yes**	**If yes, how often and since when:**
Do you smoke or chew tobacco?			
Do you drink alcohol?			
Do you use recreational drugs?			

Family History: **Have parents or siblings had:**	**No**	**Yes**	**Family Member**	**Age**	**Alive**	**Specify Disease**
Stroke/Headache/Seizure			**Father**		**N Y**	**N Y**
Emphysema			**Mother**		**N Y**	**N Y**
Heart Condition/Hypertension			**Brother**		**N Y**	**N Y**
Cancer			**Sister**		**N Y**	**N Y**
Diabetes or Thyroid Disease			**Other:**		**N Y**	**N Y**

Review of Systems:	**Circle if applicable:**
Eyes	Glasses Contacts Blurred Vision Watery Eyes Eye Pain
HENT	Post Nasal Drip Hearing Problems Sore Throat Tonsil Mouth
Cardiovascular	High BP Racing Heart Swelling SOB Chest Pain Heart Attack Murmur
	MVP Congestive Heart Failure Pacemaker Defibrillator Coronary Artery Disease
Respiratory	Wheezing Coughing Chest Colds
GI	Difficulty Swallowing Gastritis Ulcers Reflux Hiatal Hernia Heartburn
	Stomach Pain Diarrhea Loss of Appetite Blood in Stool Other:
Liver	Hepatitis A, B, C, Cirrhosis If yes alcoholic or nonalcoholic Other type of Hepatitis
GU	Urination Problems Discharges Post Menopausal Last PAP
Musculoskeletal	Aching or Swelling of Muscles/Joints Muscle Cramping Weakness
Integumentary/Skin/Breast	Skin Problems Itching Ulcers Last Mammogram:
Neurologic	Faintness Numbness Trembles Memory Headache
Psychiatric	Nervous with strangers Depressed Alcohol/Drug problem
Endocrine	Thyroid problems Sweating Diabetes
Hematologic/Lymphatic	AIDS/HIV Swollen Nodes Excessive Bruising/Bleeding
Allergic/Immunologic	Allergic to: Reaction:

Patient Signature: **Date:**

Reviewed by Dr.: **Date:**

SIMON MIGUEL EDELSTEIN, M.D., M.P.H.
CARLOS I. BUSTAMANTE RIVAS, M.D.
DANIEL KASWAN, M.D.
ANDRES RIVERO, M.D.
PAOLA SOLARI, M.D.

CHRISTINA L. PALINO, PA-C
JAMESE SYMONETTE, ARNP
VERONICA TORRES, ARNP

INFECTIOUS DISEASES

20814 WEST DIXIE HIGHWAY, AVENTURA, FLORIDA 33180 (305) 933-8433

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Giving Consent

Name_____

Address_____

Telephone_____Social Security_____

SECTION B: To the Patient - Please read the following statements carefully

Purpose of Consent. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Edelstein & Bustamante, M.D.'s, P.A.
20814 WEST DIXIE HIGHWAY
AVENTURA, FLORIDA 33180
Phone: (305) 933-8433

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____Date:_____

If other than patient, relationship to patient_____

EMERGENCY CONTACT: _____ Tel:_____ Relationship: _____

SIMON MIGUEL EDELSTEIN, M.D., M.P.H.
CARLOS I. BUSTAMANTE RIVAS, M.D.
DANIEL KASWAN, M.D.
ANDRES RIVERO, M.D.
PAOLA SOLARI, M.D.

CHRISTINA L. PALINO, PA-C
JAMESE SYMONETTE, ARNP
VERONICA TORRES, ARNP

INFECTIOUS DISEASES

20814 WEST DIXIE HIGHWAY, AVENTURA, FLORIDA 33180 (305) 933-8433

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT******

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name:_____

Signature:_____

If other than patient, relationship:_____

Date:_____

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other_____

Signature:_____ Date:_____

SIMON MIGUEL EDELSTEIN, M.D., M.P.H.
CARLOS I. BUSTAMANTE, M.D., F.A.C.P.
DANIEL KASWAN, M.D.
INFECTIOUS DISEASES

20814 WEST DIXIE HIGHWAY AVENTURA, FLORIDA 33180 (305) 933-8433 FAX (305) 933-9115

DATE:

I UNDERSTAND THAT BEFORE MY NEXT APPOINTMENT WITH DR. EDELSTEIN/DR. BUSTAMANTE/DR. KASWAN/DR. RIVERO/DR. SOLARI, I AM REQUIRED TO OBTAIN MY OWN REFERRAL OR AUTHORIZATION NUMBER FROM MY PRIMARY PHYSICIAN, AND I MUST ALSO HAVE RECENT LABORATORY RESULTS.

I HAVE BEEN NOTIFIED THAT IF I DO NOT HAVE A CURRENT REFERRAL WITH THE CORRECT DOCTOR'S NAME/AUTHORIZATION NUMBER, AVAILABLE VISITS, AND RECENT LABORATORY RESULTS, THEN I WILL NOT BE SEEN BY THE DOCTOR AND MY APPOINTMENT WILL BE RESCHEDULED.

x _____

THE FOLLOWING INSURANCES REQUIRE REFERRALS:

AVMED

MY BLUE

AETNA/COVENTRY

CAREPLUS

CIGNA

HUMANA

MEDICAID PATIENTS WITH SUPPLEMENT INSURANCE

NHP/UNITED

WORKMAN'S COMPENSATION

PLEASE REMEMBER THAT YOUR PRIMARY CARE PHYSICIAN PROVIDES THE ABOVE AND IT IS YOUR RESPONSIBILITY TO OBTAIN THIS INFORMATION FOR YOUR OFFICE VISIT.