BREAST, GENERAL, VASCULAR & ENDOVASCULAR SURGERY

H. CHARLES-HARRIS, MD & ASSOCIATES

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME_____FIRST NAME_____M.I._____

MARITAL STATUS_____SEX M[ ] F[ ] DATE OF BIRTH_____SSN_____

HOME ADDRESS_____APT#_____

CITY_____STATE_____ZIP_____EMAIL_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

OCCUPATION_____EMPLOYER_____

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____PHONE_____

SPOUSE / PARENT CONTACT INFORMATION

NAME_____RELATIONSHIP_____PHONE_____

INSURANCE INFORMATION

PRIMARY_____ID#_____GROUP #_____

INSURANCE THROUGH SELF[ ] SPOUSE[ ] PARENT[ ] INSURANCE THROUGH COBRA YES[ ] NO[ ]

SECONDARY_____ID#_____GROUP #_____

INSURANCE THROUGH SELF[ ] SPOUSE[ ] PARENT[ ] INSURANCE THROUGH COBRA YES[ ] NO[ ]

MEDICAL INFORMATION

REFERRING PHYSICIAN_____PHONE_____

PRIMARY PHYSICIAN (IF DIFFERENT)_____PHONE_____

OTHER TREATING PHYSICIAN_____SPECIALTY_____

OTHER TREATING PHYSICIAN_____SPECIALTY_____

PHARMACY INFORMATION

PHARMACY NAME_____PHONE_____

MY SIGNATURE BELOW INDICATES THAT I AGREE ALL THE ABOVE INFORMATION IS TRUE AND CORRECT.

X_____

PATIENT'S / RESPONSIBLE PARTY'S SIGNATURE DATE

VASCULAR, ENDOVASCULAR, & GENERAL SURGERY
H. Charles-Harris, MD & Associates

RELEASE OF INFORMATION, BENEFIT ASSIGNMENT, PAYMENT AUTHORIZATION, FULL DISCLOSURE STATEMENT, AGREEMENT TO PAY FOR PROFESSIONAL SERVICES, AND SPECIFIC EXAM AGREEMENT

LAST NAME:_____ FIRST NAME:_____ DATE OF BIRTH:_____

I wish to be contacted in the following manner (☑ check all that apply):

* Home / Cell Telephone	* Work Telephone	* Written Communication
☐ Leave detailed message	☐ Leave detailed message	☐ Mail to my home address
☐ Leave name & call-back number only	☐ Leave name & call-back number only	☐ Mail to my office address

I authorize any discussion over the phone regarding my health care and treatment with the following individuals:

Name: _____ Relation: _____

Name: _____ Relation: _____

Please read and ☑ check the following:

☐ **I acknowledge that I have been provided with the Notice of Privacy Practices.**

☐ **I acknowledge that I have been informed that H. Charles-Harris MD PA does not carry Malpractice Insurance.**

- I AUTHORIZE RENDERING PROVIDERS OF H. CHARLES-HARRIS MD PA TO RELEASE ANY INFORMATION REQUESTED BY ANOTHER PHYSICIAN/FACILITY ACTIVELY INVOLVED IN MY MEDICAL TREATMENT, IF MEDICALLY NECESSARY FOR THE PROMPT AND EFFECTIVE TREATMENT OF MY MEDICAL CONDITION(S).
- I AUTHORIZE RENDERING PROVIDERS OF H. CHARLES-HARRIS MD PA TO RELEASE ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM AND TO ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS MY INSURANCE CLAIM(S).
- I AUTHORIZE AND DIRECT MY CARRIER(S) TO ISSUE PAYMENT CHECK(S) DIRECTLY TO RENDERING PROVIDERS OF H. CHARLES-HARRIS MD PA FOR ALL SERVICES RENDERED. REGARDLESS OF MY INSURANCE BENEFITS, IF ANY, I UNDERSTAND THAT I AM FULLY FINANCIALLY RESPONSIBLE FOR ANY AND ALL FEES INCURRED, AND I AGREE TO PAY SUCH FEES IN FULL. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COLLECTION COSTS AND INTEREST (1.5% OF UNPAID BALANCE PER MONTH) SHOULD I FAIL TO MAKE PAYMENT IN A TIMELY MANNER.
- THE INSURANCE INFORMATION FURNISHED HERE REPRESENTS A FULL DISCLOSURE OF THE INSURANCE BENEFITS TO WHICH I AM ENTITLED. I UNDERSTAND THAT FAILURE TO DISCLOSE PRE-CERTIFICATION/SECOND OPINION REQUIREMENTS FOR ANY AND ALL PLANS TO WHICH I SUBSCRIBE PUTS ON ME THE FULL LIABILITY FOR PROFESSIONAL CHARGES AS A RESULT OF NON-PAYMENT BY ANY CARRIER.
- I UNDERSTAND AND AGREE THAT RENDERING PROVIDERS OF H. CHARLES-HARRIS MD PA IS EXPECTED TO ONLY EXAMINE THE SPECIFIC AREA OF COMPLAINT ALONG WITH ANY RELAVENT AREAS IN RELATION TO THIS COMPLAINT. A COMPREHENSIVE PHYSICAL EXAM IS TO BE DONE/HAS BEEN DONE BY MY PRIMARY CARE PHYSICIAN.

X_____

PATIENT'S / RESPONSIBLE PARTY'S SIGNATURE DATE

VASCULAR, ENDOVASCULAR, & GENERAL SURGERY
H. Charles-Harris, MD & Associates

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

LAST NAME:_____ FIRST NAME:_____

SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____

Office Use Only

DATE OF REQUEST:_____

AUTHORIZED:_____

TO RELEASE TO: H. Charles-Harris, MD & Associates
1190 NW 95 Street, Suite 101, Miami, FL 33150
Fax: 305-696-4435

INFORMATION TO BE RELEASED:_____

REASON FOR DISCLOSURE:_____

- I understand that I, or the person authorized to act on my behalf, am entitled to receive a copy of this authorization. The requester may be provided with a copy of this authorization.

- I am aware of the consequences that may occur as a result of my signing this authorization request or my denial to do so. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization.

- I am authorizing any physician, nurse, hospital, or other provider having treated or attended me to having possession of any records and/or information with respect thereto, to provide such records to the requesting party above.

- By signing below I am hereby authorizing Dr. H. Charles-Harris or his representative to request / release the requested information identified above.

X_____

PATIENT'S / RESPONSIBLE PARTY'S SIGNATURE DATE

H. Charles-Harris, M.D. & Associates

General, Vascular, & Endovascular Surgery

ACKNOWLEDGEMENT OF INSURANCE BENEFITS

LAST NAME: _____FIRST NAME: _____DATE OF BIRTH: _____

PRIMARY INSURANCE POLICY: _____ ID NUMBER: _____

GUARANTOR'S NAME: _____ RELATIONSHIP:_____

SECONDARY INSURANCE POLICY: _____ ID NUMBER: _____

GUARANTOR'S NAME: _____ RELATIONSHIP:_____

BY SIGNING BELOW I VERIFY THAT I HAVE NO OTHER MEDICAL INSURANCE OTHER THAN THE ONE/ONES LISTED ABOVE.

X_____ _____

PATIENT'S/ RESPONSIBLE PARTY'S SIGNATURE DATE

1190 NW 95 Street, Suite 101, North Miami, FL 33150 ▪ Tel: 305.691.2941 Fax: 305.696.4435

H. Charles-Harris, M.D. & Associates

General, Vascular, & Endovascular Surgery

MEDICAL MALPRACTICE ACKNOWLEDGEMENT

"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 subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice up to the minimal amount pursuant to Florida Statue s.458.320.
This notice is provided pursuant to Florida law."

I have been informed that Dr. Håkan Charles-Harris, Dr. Jose A. Martin, Elke Ojeda Ulloa PA-C and Shari Selesky PA-C do not carry medical malpractice insurance.

Signed:

_____	_____	_____
Patient/Guarantor Signature	Patient's Name	Date of Birth

Chart copy

1190 NW 95 Street, Suite 101, North Miami, FL 33150 ▪ Tel: 305.691.2941 Fax: 305.696.4435

H. CHARLES-HARRIS, MD & ASSOCIATES

Patient Name:_____ Date of Birth:_____

REVIEW OF SYSTEMS

	PRESENT	PAST
1. CONSTITUTIONAL (Health in General)		
Weight Gain	□	□
Weight loss	□	□
Loss of appetite	□	□
Prior diagnosis of cancer	□	□
2. EYES, EARS, NOSE, THROAT		
Glaucoma	□	□
Cataracts	□	□
Vision Surgery	□	□
Loss of hearing	□	□
Facial pain or numbness	□	□
3. RESPIRATORY (Lungs & Breathing)		
Bronchitis	□	□
Shortness of breath	□	□
Asthma	□	□
4. CARDIOVASCULAR (Heart)		
Heart Attack	□	□
Chest pain/angina	□	□
Phlebitis or blood clots	□	□
Hypertension	□	□
Irregular heartbeat	□	□
5. GASTROINTESTINAL (Stomach & Intestines)		
Heartburn/Reflux	□	□
Hepatitis	□	□
Blood in stools	□	□
Diarrhea/constipation	□	□
6. ENDOCRINE SYSTEM (Glands)		
Diabetes	□	□
Intolerance to heat/cold	□	□
Menstrual irregularities	□	□
Thyroid problem	□	□
Hormone treatment	□	□
7**. INTEGUMENTARY (Skin, Hair, & Breast)**		
Cancers	□	□
Rashes	□	□
Masses	□	□
Genital Infections	□	□
8. URINARY SYSTEM (Kidney & Bladder)		
Kidney stones	□	□
Prostate problems	□	□
Bladder problems	□	□
Trouble urinating	□	□
9. NEUROLOGIC (Brain & Nerves)		
Stroke	□	□
Seizures	□	□
Head injury	□	□
Frequent headaches	□	□
Tremor	□	□
Problems with balance	□	□
10. PSYCHIATRIC (Mood & Thinking)		
Depression	□	□
Anxiety	□	□
Schizophrenia	□	□
Bipolar Disorder	□	□

Patient's Signature:_____

	PRESENT	PAST
11. MUSCULOSKELETAL (Muscles, Bones, Joints)		
Joint pain	□	□
Aching muscles	□	□
Back pain	□	□
Swelling of joints	□	□
12. HEMATOLOGIC (Blood/Lymph)		
Easy bleeding	□	□
Easy bruising	□	□
Anemia	□	□
History of blood transfusion	□	□
Leukemia	□	□
13. ALLERGIC / IMMUNOLOGIC		
Seasonal allergies	□	□
Frequent infections	□	□
HIV	□	□
14. PERIPHERAL ARTERY DISEASE		
Pain that stops me from walking	□	□
Cramping in buttock / calf / thigh	□	□
Pain in the toes / foot	□	□
Dark discoloration toes / foot	□	□
Gangrene of toes	□	□
Swelling of legs/feet	□	□

Past Medical History: _____

_____

Previous Surgery:_____

_____

Allergies:_____

Medications:_____

_____

_____

_____

	YES	NO
Drink:	□	□
If yes, how much _____		
Smoke:	□	□
If yes, how much _____		
Drug abuse:	□	□
If yes, which drug and how much _____		
Employed?:	□	□
Job/Title: _____		

Family History of Cancer:

Breast Cancer □ Colon Cancer □

Ovarian Cancer □ Other: _____

Dialysis?: Mon Wed Fri □

Tues Thur Sat □

Date Signed:_____