**GUADALUPE ZAMORA, M.D., P.A.**
**NEW PATIENT INFORMATION/ INFORMACIÓN DEL NUEVOS PACIENTES**

**LEGAL NAME/NAME ON INS. CARD - NOMBRE LEGAL/NOMBRE EN TRAJETA DE SEGURO**

**_____**
**LAST/APPEIDO** **FIRST/NOMBRE**

**_____**
**MIDDLE/SEGUNDO NOMBRE** **PREFERRED NAME/NOMBRE PREFERIDO**

**_____**
**DL#/LICENCIA DE CONDUCIR#** **SSN#/SEGURO SOCIAL#**

**_____**
**BIRTHDAY/FECHA DE NACIMIENTO** **SEX/SEXO** **LANGUAGE/LENGUA PRINCIPAL**

**RACE/RAZO:** ☐ **AMER. INDIAN/ INDIO AMERICANO** ☐ **ALASKAN NATIVE/ NATIVO DE ALASKA**
☐ **ASIAN/ ASIÁTICO** ☐ **PACIFIC ISLANDER/ ISLEÑO PACÍFICO**
☐ **BLACK/AFROAMERICANO** ☐ **CAUCASIAN/ CAUCÁSICOS**
☐ **OTHER/OTRO:_____** ☐ **DECLINED/ DECLINÉ**

**ETHNICITY:** ☐ **HISPANIC/ HISPANO** ☐ **NON-HISPANIC/ NO HISPANO** ☐ **DECLINED/ DECLINÉ**

**ADDRESS/ DIRECCIÓN_____**
**STREET/CALLE**

**_____**
**CITY/CIUDAD** **STATE/ESTADO** **ZIPCODE/CODIGO POSTAL**

**PHONE#S_____**
**TELEFONOS** **HOME #** **CELL #** **OTHER #**

**EMAIL/CORREO ELECTRÓNICO_____**

**EMPLOYER/ EMPLEADOR_____**
**NAME/NOMBRE** **PH #/TELEFONO**

**RESP. FOR PAYMENT/RESPONSABLE DE PAGO:** ☐ **SELF/YO MISMO** ☐ **PARENTS/PADRES**
☐ **OTHER/OTRO:_____**

**INSURANCE_____**
**ASEGURAZA** **NAME/NOMBRE** **ID#** **GROUP#/ # DE GRUPO**

**INSUR. CLAIMS_____**
**RECLAMOS** **ADDRESS/ DIRECCIÓN** **CITY/CIUDAD** **STATE/ESTADO**

**_____**
**ZIPCODE/CODIGO POSTAL** **ELIGIBILTY PH#/ELEGIBILIDAD TELEFONO**

**POLICY HOLDER_____**
**ASEGUADO PRINCIPAL** **LAST** **FIRST** **MIDDLE** **DOB**

**POLICY HOLDER ADDRESS_____**
**DIRECCIÓN DE ASEGUADO** **STREET** **CITY** **STATE** **ZIPCODE**

**2ND INS. _____**
**ASEGURANZA 2 NAME ID# GROUP#**

**2ND INSUR. CLAIMS_____**
**RECLAMOS 2 ADDRESS/ DIRECCIÓN CITY/CIUDAD STATE/ESTADO**

**_____**
**ZIPCODE/CODIGO POSTAL ELIGIBILTY PH#/ELEGIBILIDAD TELEFONO**

**PREFERRD PHARMACY_____**
**FARMACIA PREFERIDA NAME/NOMBRE PH #/TELEFONO**

**EMERGENCY CONTACT_____**
**CONTACTO EMERGENCIA NAME/NOMBRE PH #/TELEFONO RELATIONSHIP/RELACIÓN**

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**HOW DID YOU HEAR ABOUT US/ CÓMO SE ENTERÓ DE NOSOTROS:**
**☐ WEB SEARCH/ BÚSQUEDA EN INTERNET ☐ INSURANCE/ ASEGURAZA ☐ FAMILY/ FAMILIA**
**☐ FRIEND/ AMIGO ☐ OTHER/ OTRO:_____**

**I AM AWARE DR. ZAMORA HAS HIPAA PRIVACY PRACTICES IN PLACE. I MAY REVIEW THEM AT ANY TIME AND REQUEST A COPY.I UNDERSTAND PAYMENT IS DUE AT THE TIME OF SERVICE AND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. I HEREBY AUTHORIZE DR. ZAMORA TO FURNISH ANY MEDICAL RECORDS CONCERNING MY ILLNESS AND TREATMENTS TO MY INSURANCE CARRIER AND I HEREBY ASSIGN PAYMENT OF MEDICAL BENEFITS TO DR. ZAMORA FOR SERVICES RENDERED TO ME OR MY DEPENDENTS.**

**SOY CONSCIENTE DE LAS PRÁCTICAS DE PRIVACIDAD DE HIPAA DEL DR. ZAMORA. YO PUEDE REVISAR EN CUALQUIER MOMENTO Y SOLICITAR UNA COPIA. YO ENTIENDO QUE EL PAGO ES DEBIDO EL DÍA DEL SERVICIO. Y SOY RESPONSABLE DE CUALQUIER CARGOS NO CUBIERTOS POR MI ASEGURANZA. AUTORIZO SU OFECINA PARA USAR O DIVULGER MI INFORMACION MEDICA, MI ENFERMEDAD Y TRATAMIENTOS A MI COMPAÑÍA DE ASEGURANZA Y LA PRESENTE PAGO DE BENEFICIOS MÉDICOS A EL DR. ZAMORA POR SERVICIOS ASIGNADOS A MÍ O MIS DEPENDIENTES.**

**SIGNATURE_____DATE_____**

**GUADALUPE ZAMORA M.D., P.A.**

MEDICAL HISTORY

**CHRONIC PROBLEMS:** DIABETES BLOOD PRESSURE CHOLESTEROL HEART DISEASE LUNG DISEASE CANCER
**OTHER PROBLEMS:**_____

**SURGERIES, DATE AND SURGEON:**_____

**NAME OF DAILY MEDICATIONS AND VITAMINS, DOSAGE AND DIRECTIONS:**

**DRUG ALLERGIES(SEVERITY AND TYPE OF REACTION):**_____

**PAST PREGNANCIES:** NONE
**HOW MANY?:** 1 2 3 4 5 6 7 8 9 _____C-SECTION _____VAGINAL
**MARITAL STATUS:** SINGLE MARRIED DIVORCED WIDOW **SPOUSE/PARTNER NAME**:_____
**CHILDREN:** NONE 1 2 3 4 5 6 7 ___
**OCCUPATION:** UNEMPLOYED FULL TIME PART TIME TEMPORARY
**NUTRITION:** NONE GOOD NUTRITION DIET HABITS_____ DIET HISTORY
**EXERCISE:** NONE NORMAL GYM EXTREME
WALKING RUNNING SWIMMING WEIGHTS OTHER_____
**SEXUAL ACTIVITY:** ABSTENANCE UNPROTECTED SEX PROTECTED SEX
HOMOSEXUAL HETEROSEXUAL BISEXUAL TRANSEXUAL ASEXUAL
IS SEX SATIFACTORY? YES NO
**CONTRACEPTION:** TUBE LIGATION VASECTOMY CONDOMS ORAL CONTRACEPTIVES NONE OTHER:_____
**SMOKING:** NO EX-SMOKER YES HOW MANY PACKS A DAY OR A WEEK_____
DESIRE TO QUIT? YES NO
**DRINKING:** NO YES OCCASIONAL 3 TIMES A WEEK EVERYDAY
DESIRE TO QUIT? YES NO
**ILLICIT DRUGS:** NO YES DRUG NAME_____

**MOTHER'S HISTORY** ALIVE DECEASED
**BLOOD PRESSURE:** YES NO
**CHOLESTEROL:** YES NO
**CORONARY HEART DISEASE:** YES NO
**TYPE 1 DIABETES:** (BORN WITH IT) YES NO
**TYPE 2 DIABETES:** YES NO
**COPD:** YES NO
**THYROID:** YES NO
**CANCER:** YES NO
**TYPE OF CANCER:**_____
**ALCOHOLISM:** YES NO
**DEPRESSION:** YES NO
**MENTAL ILLNESS:** YES NO
**OTHER ILLNESSES:** YES NO _____

**FATHER'S HISTORY** ALIVE DECEASED
**BLOOD PRESSURE:** YES NO
**CHOLESTEROL:** YES NO
**CORONARY HEART DISEASE:** YES NO
**TYPE 1 DIABETES:** (BORN WITH IT) YES NO
**TYPE 2 DIABETES:** YES NO
**COPD:** YES NO
**THYROID:** YES NO
**CANCER:** YES NO
**TYPE OF CANCER:**_____
**ALCOHOLISM:** YES NO
**DEPRESSION:** YES NO
**MENTAL ILLNESS:** YES NO
**OTHER ILLNESSES:** YES NO _____

**NAME:**_____**DATE OF BIRTH:**_____**TODAY'S DATE:**_____

# GUADALUPE ZAMORA, MD., P.A.

## PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have had been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan with which we do business, payment in full is expected at each visit. If you are insured by a plan with which we do business, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** A co-pay is a predetermined dollar amount that your insurance requires you to pay. A deductible is specific dollar amount that your insurance requires you to reach before they will pay for a claim. Some plans may require patients to pay co-pays after the deductible is met. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **In-Network.** A health care provider (physician) who has contracted with a health insurance company to in order provide services to plan members in exchanged for an agreed payment.
6. **Out of Network.** A health care provider (physician) who is not contracted with a health insurance company. Your cost for services may be higher or you may be responsible for full payment of services.
7. **Claims submissions.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
8. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum

benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

9. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

10. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

_____

**Signature of patient or responsible party**

_____

**Date**