Dr. Jacqueline Romero
11181 Health Park Boulevard
Suite 2260
Naples, FL 34110

JACQUELINE ROMERO, DO
RENEW & RESTORE

New Patient Form

Date: _____ **Social Security Number**: _____

Patient: _____ **Date of Birth**: ____ **Age**: _____ **Sex**: ___

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: _____ Ethnicity: _____ Primary Language: _____

If other family members are patients, please give their names: _____

Parent or Spouse: _____ Relationship: _____

Children/Names (please give even if adult): _____ Ages: _____

****

Education Completed:_____ Referred by: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: Home:_____Cell: _____Work: _____

Email Address: _____

Employer: _____Occupation: _____

Name of person to contact in case of an emergency: _____ Phone: _____

****

Primary Health Insurance Company: _____ Policy #: _____
Group #: _____ Name of insured if other than patient: _____

Relationship to insured: _____ Date of Birth of Insured: _____

Social Security Number of Insured: _____

****

Patient Consent Form

I hereby give my consent for **Dr. Jacqueline Romero, DO, PA** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (Dr. Jacqueline Romero PA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy prior to signing this Consent. **Dr. Jacqueline Romero, DO, PA** reserves the right to review its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Jacqueline Romero,DO, PA 11181 Health Park Boulevard, Suite 2260, Naples, FL 34110.

With this Consent, **Dr. Jacqueline Romero, DO, PA** may mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this Consent, **Dr. Jacqueline Romero, DO, PA** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked **Personal and Confidential**.

By signing this Consent, I am consenting to Dr. Jacqueline Romero, DO, PA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, or later revoke it, **Dr. Jacqueline Romero, DO, PA** may decline to provide treatment to me.

AGREED:

_____ _____

Patient's Name Date

_____

Patient's Date of Birth

_____

Signature of Patient or Legal Guardian

JACQUELINE ROMERO, DO

RENEW & RESTORE

Insurance Authorization and Assignment

I request the payment of authorized Medicare/other insurance company benefits be made on my behalf to **Dr. Jacqueline Romero, DO, PA** for any services furnished to me by that party which accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to me or to the party that accepts assignment. I understand it is mandatory to notify the health care provider of any other party that may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 38/01-3812 provides penalties for withholding this information.)

I request that payment under the Medicare or other medical insurance program(s) be made to **Dr. Jacqueline Romero, DO, PA** for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by **Dr. Jacqueline Romero, DO, PA** from Medicare and/or other insurance company(ies), I will immediately endorse them and turn them over to **Dr. Jacqueline Romero, DO, PA** for services rendered.

I understand that I am responsible for payment of all charges and fees to **Dr. Jacqueline Romero, DO, PA** to which they are entitled to collect which are not paid for by Medicare or other insurance.

Signature of Patient/Guardian _____ Date _____

Prescription Renewal Policy

Dr. Jacqueline Romero, DO, PA's physicians are available for emergencies twenty-four hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with the nurses between the hours of 8:30 a.m. and 4:30 p.m., Monday through Friday. We will get back to you within forty eight hours. Refills are handled more quickly by calling your pharmacy and asking them to fax your request to our office. If you are unable to call your pharmacy, please call our office at 239-514-7315. Please do not wait for your medication to run out completely before calling our office!!! By following this policy, we can assure you the highest quality of medical care.

_____ _____

Patient Signature Date

MEDICAL HISTORY

List all surgeries, hospitalizations, injuries or medical problems for which you have been under a doctor's care. Include Pregnancies.

Year	Surgery/Medical Problems/Injuries/Accidents

Current Medications (Include all prescriptions, vitamins, calcium, birth control, and all other frequently used over the counter medications.)

Medication Name	Dosage	Reason for taking

Allergies to Medications: _____ Reaction:_____

Smoking History: How many years: _____ Quit: Y or N # of Packs Per Day:_____

Alcohol Intake: # of Ounces Per Day:_____ Type of Alcohol Used:_____

History of Alcoholism: Y or N Use of Recreational drugs? Y or N Type:_____

Family History	Name	Alive/Deceased	Age	Cause of Death/Medical Problems
Mother				
Father				
Brother(s)				
Sister(s)				

Do Any of your blood relatives have a history of any of the following diseases?

Heart Attack	Y or N	Who?		Strokes	Y or N	Who?
Migraines	Y or N	Who?		Breast Cancer	Y or N	Who?
Colon Cancer	Y or N	Who?		Diabetes	Y or N	Who?
Mental Illness	Y or N	Who?		Bleeding Disorder	Y or N	Who?
Other:						

Current Problems/Past History (Mark X in the box indicating whether it is a current problem or a problem you have experienced in the past.)

Problem	Current	Past History	Problem	Current	Past History
Numb/Painful Feet			Leg pain when walking		
Peptic Ulcer			Decreased hearing		
Ringing in the ears			Abdominal Pain		
Loss of Appetite			Dizzy/Fainting Spells		
Glaucoma			Weight Loss # of pounds____		
Chronic Fatigue			Chronic Back Pain		
Anemia/Easy Bruising			Problem Swallowing		
Depression			Hepatitis		
Falling/Double Vision			Persistent Nausea/vomiting		
Gallbladder disease			Chest pressure/tightness		
Shortness of breath			Frequent Urinary Tract Infections		
Frequent Sinus Infections			Arthritis		
Change in bowel/bladder			Persistent Constipation		
Tremors/hands shaking			Swollen ankles/feet		
Mental Illness			Persistent Diarrhea		
Numb/tingling sensation			Diverticulitis		
High blood pressure			Heart Murmur		
Asthma/Emphysema			Black/Bloody Stools		
Tuberculosis (T.B)			Decrease in concentration		
Incontinence			Palpitations		
Hay Fever			Venereal Diseases		

Females Only:

Menstrual Cycle: Age of Onset _____ ( ) Regular ( ) Irregular
( ) Heavy ( ) Moderate ( ) Light

Menopause Age:___Have you ever taken Hormone Replacements?___ # of yrs_____

Pregnancy Total:____ # of Miscarriages/abortions:____ # of Living Children:_____

Is there anything else not mentioned on this form regarding your health that you feel should be brought to the doctor's attention:

_____

Consent for Diagnostic and/or Therapeutic Procedures

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunization(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Signature of Patient/Guardian _____ Date _____