Jesse Salmeron, M.D., F.A.C.S., F.A.A.O.A.
3363 NE 163rd Street, Suite 505, North Miami Beach, Florida 33160

Patient Demographics

Date ____________ ______________________________

Name ____
Last Name First Name Middle Name Jr. Sr.

Gender Female Male

Date Of Birth

Home Phone

Work Phone

Cell Phone

Race **Circle one from the list below**
White
American Indian/ Alaska Native
Black/African American
Native Hawaiian/Pacific Islander
Asian Other Unknown

Ethnicity **Circle from the list below**
Hispanic or Latino
Non-Hispanic or Latino

Language **Circle One from the list below**

English	Russian	German	Other
Spanish	Dutch	Chinese	
French	Italian	Japanese	

We Should Contact You By, Circle One:
Phone, Mail, Email

Email

Authorize Us To Speak With,Circle your choices.
Spouse Family Voice Mail
Name:____________________
Name:____________________

Leave Test Results With, Circle your choices.
Spouse Family Voice Mail
Name:____________________
Name:____________________

Primary Care Physician
Name
Address
Address
Phone
Fax

Home Address
Address
City, State
Zip Code

Social Security No.

Smoking Status: Circle One from the list below
Heavy Tobacco User Never Smoker
Light Tobacco User Former Smoker
Every Day Smoker
Current Status Unknown
Some Day Smoker

Are you Pregnant: Yes or No.
Self Pay: Circle one, Yes or No.
Insurance:

Does your insurance have a copay? Yes or No
Does your insurance have a deductible? Yes or No
Does your insurance pay 80% and you pay 20% Yes/No

Pharmacy
Phone
Address
Fax

Patient Signature:______________________________ Date:____________

Jesse Salmeron, M.D., P.A., F.A.C.S.
Ear, Nose, & Throat
Surgery
Diplomate, American Board of Otolaryngology

Date:______________________________
Fecha

Patient Name:______________________________ DOB:______________
Nombre Fecha de Nacimiento

CURRENT MEDICATIONS / Lista de Medicamentos

Including prescription, over the counter, herbal, vitamin/mineral/dietary supplements
Incluyiendo medicamentos sin recetas, hierbas, vitaminas y suplimentos

Medications Medicamento	Dosage Dosis	Route (eg: by mouth, inhale) Ruta (Por E Por boca, I Inhalar	Frequency Frecuencia

DRUG ALLERGIES / ALERGIAS DE MEDICAMENTOS

____

____

____

____

____

X______________________________
Patient Signature
Firma Del Paciente

excel

3363 NE 163rd Street , Suite 505, North Miami Beach, Florida 33160
Phone (305) 652-8151 • Fax (305) 651-7257

Jesse Salmerón, M.D., P.A.

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OTOLARNYGOLOGY • FACIAL PLASTIC SURGERY • HEAD & NECK SURGERY • ENT ALLERGY

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgment ****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

Name ______________________________

Signature ______________________________

Date ______________________________

FOR 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 ______________________________

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Patient Responsibility Form

Patient Name: ______________________________ DOB: __________

Dear Patient:

It is your responsibility to know and understand any information regarding your insurance deductible/coinsurance/co-payments. Co-payments are your responsibility and are expected prior to services being rendered. In addition, you are responsible for paying for services that fall under your deductible/coinsurance.

As a participating provider, my physician or healthcare practitioner will submit the claim on my behalf for services rendered, directly to my insurance carrier. All office procedures are considered surgery. Upon receipt of my Explanation of Benefits from my insurance carrier, I understand that I am responsible for any applicable deductible/coinsurance and I must provide payment directly to my provider. I have agreed to pay for any applicable deductible/coinsurance. If I do not pay, I understand that my provider may seek alternative methods to collect these monies.

I understand that I am responsible for paying my provider directly for any applicable deductible/coinsurance/co-payment. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier, and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I also understand that if I have longstanding unpaid deductibles/coinsurance/co-payments owed to my provider, my provider may terminate the doctor/patient relationship as a result, subject to the requirements of state and /or federal law.

I further understand that if my provider collects any applicable deductible/coinsurance from me and is also reimbursed directly from my insurance carrier, that I will be reimbursed from my provider any overpayment owed to me.

Patient/Guardian Signature: ______________________________

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Last Name | First Name | MI | Date of Birth | Social Security #

Address | Phone #

Information Released To:

Name
Address
City, State, Z
Phone #
Fax #

From:

Name
Address
City, State, Zip
Phone #
Fax #

Information Requested:

- ___Problem List
- ___Progress Notes
- ___Medication List
- ___History/Physical Exam
- ___Consultation Reports
- ___Operative Reports
- ___Discharge/Transfer Summary
- ___Lab Results
- ___Pathology Report
- ___X-Ray Report
- ___EKG
- ___Ultrasound Report
- ___CT Scan Report
- ___MRI Report
- ___Echocardiogram
- ___Cardiac Stress Test
- ___Other: ________

Information To Be:

___Faxed ___Mailed ___Other:

I understand this information is confidential and there shall be no further disclosure without the written authorization of the patient his/her legal representative. This authorization is valid until ____________ (one year from date of signature if not specified). I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not protected by federal confidentiality rules.

Date | Signature | Printed Name | Relationship (If signed by other than pati

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