**Iriamar Vélez Quiñones, MD**

519 Miramar Ave

Arecibo, Puerto Rico 00612

Tel/Fax 787-878-3211

**Patient Registration**

## PATIENT INFORMATION:

**Last Names**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**First Name:\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Middle Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alias:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Physical Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Phone Number:** Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth (MM/DD/YYYY**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Birth State or Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Gender:** \_\_\_\_\_Male\_\_\_\_\_ Female

 **Social Security #:**XXX-XX-\_\_\_\_\_\_\_\_\_\_\_\_\_ **Religion**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ID/Number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of ID: \_\_\_\_Driver License \_\_\_\_Real ID \_\_\_Passport\_\_\_Other

 **ID State or Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Demographic Information Request**

 In order to comply with federal regulations, we are required to ask you for the following information:

 **Race:** \_\_\_"American Indian or Alaska Native \_\_\_"Asian" \_\_\_"Black or African American”

 \_\_\_"Native Hawaiian or Pacific Islander" \_\_\_"Declined to Specify" \_\_\_"White"

  **Ethnicity**: \_\_\_"Hispanic or Latino"\_\_\_"Not Hispanic or Latino"\_\_\_"Declined to Specify"\_\_\_\_

 **Advance Directives**

Do you have a health care proxy/living will? □ Yes □ No

Do you want to discuss this with your physician? □ Yes □ No

**Communication Preferences**

Primary Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method for communication: □ Home □ Work □ Cell

Can we leave a message on machine or with whoever answers? (Circle Yes or No) Home Y / N Work Y / N Cell Y / N

DO NOT CALL: □ Home □ Work □ Cell

Can we send you e-mails: Yes or No

Can we send you SMS (text message): Yes or No

**Disclosure to Designated Family/Friends/Caregivers**

 I allow Iriamar Vélez Quiñones, MD to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Relationship Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Relationship Phone Number

|  |
| --- |
| **PERSONAL HISTORY** |
|  |  |
| What is your highest education? ❑Middle School ❑Elementary School❑None | ❑High school ❑Some college ❑College graduate ❑Advanced degree |
| Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other |
| What is your current occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Are you currently working? : ❑ Yes ❑ No  | Hours/week \_\_\_\_\_\_ | If not, are you ❑ retired ❑ disabled ❑ sick leave? |
| Do you receive disability or SSI? ❑ Yes ❑ No  | If yes, for what disability & how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| **Please list the names of other practitioners you have seen:** |
| Cardiology |
| Pulmonology |
| Gastroenterology  |
| Endocrinology |
| Rheumatology |
| Hematology/Oncology |
| Dermatology |
| Nephrology |
| Neurology |
| Ophthalmology |
| Psychiatry |
| Urology |
| Orthopedics |
| Gynecology |
| Other: |

## Favorites Pharmacies:

|  |  |
| --- | --- |
| **Name** | **Telephone or Address** |
|  |  |
|  |  |

**Emergency Contact:**

\* Emergency Contact: Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_Mother \_\_\_\_Father \_\_\_  Spouse\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Representative’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of Signatory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_

Authority to Sign for Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_