Iriamar Vélez Quiñones, MD
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60 Calle 16
Arecibo, Puerto Rico 00612
Tel: 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? Home YES_____/ NO_____ Work YES____ / NO____
Cell YES ☐ / NO ☐
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?
❑High school
❑Middle School
❑Some college
❑Elementary School
❑College graduate
❑None
❑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_____