

JORGE C. BUSSE, M.D., F.A.C.P.
GASPAR A. BARRETO-TORRELLA, M.D.
EMILIO J. GOMEZ, M.D.
FERNANDO C. TRESPALACIOS, M.D.
MARTHA Y. SANDOVAL, APRN/NP-C, CNN
AMAURY LORENZO CLEMENTE, APRN/NP-C

ANTONY A. FARIAS, M.D.
DAVID M. TRUEBA, M.D.
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YAINET VALLE, PA-C

# WELCOME TO OUR PRACTICE

www.kidneydoctorsofmiami.com

- 1. There are 9 pages to complete. Please print legibly and make sure ALL pages are signed
- 2. Please make sure to include your email address for your Patient Portal Access.
- 3. Please make sure to include 2 contact phone numbers, for your result communications.
- **4.** Please make sure you have your Picture ID and Insurance Card **we cannot see you without this.**
- 5. <u>IF REQUIRED</u>, <u>Please make sure you have your Referral</u> It is the responsibility of the patient to ensure that their Primary Care Physician has send this to us. **If YOU DO NOT have your referral**, please contact your PCP immediately and have them fax it to us at 305-273-9385, we cannot see you without this or call you in to see the doctor until it is received.
- 6. Co-pays, Deductibles, or any Past Due Balances are due and payable at the time of your visitwe cannot bill you for these. Thank you
- 7. Please remember to have your lab results and/or any ultrasound results, the list of your medications and the names of all your healthcare providers with you, as this will be needed for your Nephrology Consultation.



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Signed:\_

**Patient or Responsible Party** 

Antony A. Farias, M.D.
David M. Trueba, M.D.
Bernice C. Acevedo, M.D.
Juan E. Kusnir, M.D.
Martha V. Rostran, APRN-BC
Yainet Valle, PA-C

PATIENT NAME:	DOB
Address:	Сіту:
STATE: ZIP CODE: HOM	TE #: CELL #:
SS# (LAST 4 ONLY) XXX-XX SEX	: [ ] M / [ ] F PRIMARY LANGUAGE:
EMAIL ADDRESS:	CONTACT PREFRENCE: [ ] HOME PHONE [ ] CELL PHONE [ ] EMAIL
Marital Status: Race:	ETHNICITY:
EMERGENCY CONTACT: NAME:	RELATIONSHIP: PHONE:
Employer:	Work Phone #:
HAVE YOU BEEN PREVIOUSLY SEEN IN OUR OFFICE?	
WHAT DOCTOR REFERRED YOU TO OUR OFFICE?	
	PHONE #:
WHO IS YOUR PRIMARY PHYSICIAN:	PHONE #: PHONE #:  DIRECTIVES: YESNo: (Please Provide Copies)
Who is your primary physician:  Have you made arrangements for Advance D	PHONE #: PHONE #:  OIRECTIVES: YESNo: (Please Provide Copies)
WHO IS YOUR PRIMARY PHYSICIAN:  HAVE YOU MADE ARRANGEMENTS FOR ADVANCE D  RIMARY INSURANCE COMPANY:	PHONE #: PHONE #:  PHONE #:  PHONE #:  SECONDARY INSURANCE COMPANY:
WHO IS YOUR PRIMARY PHYSICIAN:  HAVE YOU MADE ARRANGEMENTS FOR ADVANCE D  RIMARY INSURANCE COMPANY:  HONE #:	PHONE #:PHONE #:  DIRECTIVES: YESNO: (Please Provide Copies)  SECONDARY INSURANCE COMPANY:  PHONE #:
WHO IS YOUR PRIMARY PHYSICIAN:  HAVE YOU MADE ARRANGEMENTS FOR ADVANCE D  RIMARY INSURANCE COMPANY:  HONE #:  DDRESS:	PHONE #: PHONE #:  Provide Copies  Secondary Insurance Company: PHONE #:
WHO IS YOUR PRIMARY PHYSICIAN:	PHONE #:

Date:



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### 1. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the payment of my medical insurance benefits to be paid directly to Nephrology Associates of South Miami PA. I understand that I am financially responsible for ALL non-covered services and all charges not paid by my insurance, such as Co-Pays, Co-Insurance, and Deductibles. I authorize my physician to release any information required to process all claims to my insurance carrier and my medical care team.

### 2. CONSENT FOR PHOTOGRAPH

I authorize Nephrology Associates of South Miami P.A., to take my picture to be used as part of my medical records for identification purposes only.

#### 3. MEDICATION HISTORY AUTHORIZATION

I authorize Nephrology Associates of South Miami P.A., to download my medication history automatically from pharmacy benefits manager to be used as part of my medical records history.

#### 4. LAB's & TESTING ORDERED- (ABN "Advance Beneficiary Notice)

I have been informed that my physician may order laboratory and/or diagnostic studies that MAY NOT be covered by my insurance company; and that Quest, Lab-Corp, and/or these Out-Patient Centers will give me an "ABN" - Advance Beneficiary Notice of Non-Coverage form to sign. I acknowledge and understand that my physician will NOT be responsible for any studies NOT covered by my insurance company.

#### 5. NEXT OF KIN COMMUNICATION CONSENT

I authorize Nephrology Associates of South Miami, P.A. to communicate with and release my medical information to the following person:

Patient's Signature ⊗	Today's Date:
Print Name:	Relationship if other than patient:
<ul> <li>Name of Person Assigned:</li> <li>Relationship to the Patient:</li> <li>Telephone Number:</li> </ul>	
<ul> <li>Name of Person Assigned:</li> </ul>	

### **AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

PATIENT INFORMATION					
Patient Name:				Date of Birth:	
Social Security No:	al Security No: Telephone N		Telephone No:		
Address:					
		RELEAS	SE TO		
I authorize <b>NEPHROLOGY ASSOCIATES OF And</b> for the purpose of alternative means of					
Person/Organization Name:					
Address:					
Telephone No:		Email A	ddress:		
Dates of Medical Record Release:					
NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, information by email has a number of risks that reasonable means to protect the security and security and confidentiality of email communic that I have read and fully understand this consconditions outlined herein. Any questions I may	patients should confidentiality ation and will not ent form. I und	consider of email in the liable of the liable erstand the	before granting cons nformation sent and le for inadvertent dis ne risks associated v	ent to use email for I received. Howeve closure of confider	r these purposes. <b>NASM</b> will use er, <b>NASM</b> cannot guarantee the ntial information. I acknowledge
	REASO	N FOR	DISCLOSURE		
Continuing Care	Legal			Other Pu	rpose (please specify)
☐ Insurance	Personal	Use			
	INFORMA	TION T	O BE RELEASED		
Complete Medical Record			Operative Re	orts	
Lab Reports			Pathology Re	oorts	
Radiology Reports					
Other (please specify)					
	SPECIFI	IC AUTH	IORIZATIONS		
The Following Information will not be release	ised unless you	u specific	ally authorize it by	marking the rele	vant box(es) below:
☐ Drug/Alcohol Abuse or Treatment			Genetic Testing Information		
HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses			Mental Health Treatment or Psychotherapy Notes (The release of Psychotherapy Notes requires a separate authorization)		
This consent is subject to revocation at any time except to the extent the action has been taken thereon. <i>This authorization and consent will expire one year from the date of authorization written below.</i> Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.					
Patient Signature: (Guardian/Legal Representative)		1		Date Signed:	
Print Name: (Please Print)			Relationship If O	her Than Patient	::
**If other than the patient's signature, a copy of lega		ing the pat	ient's personal represe	ntative <b>MUST</b> accomp	any the request (i.e. court

MEDICAL RECORDS RELEASE Rev.09/19

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

PATIENT INFORMATION				
Patient Name:			Date of Birth:	
Social Security No:		Telephone No:		
Address:				
	REQUES <sup>*</sup>	т то		
Name of Healthcare Fa	cility from which Records are Requested:			
Telephone No.:		Fax No.:		
Address:				
Dates of Treatment Re	quested:	Reason For Disclosure:		
confidential communication has a number of risks that pa confidentiality of email infor for inadvertent disclosure or	OGY ASSOCIATES OF SOUTH MIAMI, P.A.; to obtain the fitnesse of their email address. NASM offers patients the citients should consider before granting consent to use emai mation sent and received. However, NASM cannot guarant confidential information. I acknowledge that I have read consent to the conditions outlined herein. Any questions	opportunity to communicate by en il for these purposes. NASM will us tee the security and confidentialit Il and fully understand this consen	mail. Transmitting patient information by email se reasonable means to protect the security and y of email communication and will not be liable	
Mail Information To:	NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.	Address: 9193 SUNSET DI	RIVE STE 200 MIAMI, FL 33173	
Or Fax To:	305-273-9388/305-273-9385	Email: info@kidneydocto	rsofmiami.com	
	INFORMATION TO	BE RELEASED		
Complete Medical	Record	Operative Reports		
Radiology Reports		Pathology Reports		
Lab Reports				
Other (please spec	ify)			
	SPECIFIC AUTHO	ORIZATIONS		
The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:				
☐ Drug/Alcohol Abus	se or Treatment	Genetic Testing Inform	mation	
HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses		Mental Health Treatment or Psychotherapy Notes (The release of Psychotherapy Notes require a separate authorization)		
This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your healthcare information by the recipient may no longer be protected by law.				
Patient Signature: (Guardian/Legal Representative)			Date Signed:	
Print Name: (Please Print)		Relationship If Other Tha	n Patient:	

\*\*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e., court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. \*\*For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.

## HIPAA – PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

## \*HIPAA – CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.., "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

\*Confirmo que se me ha proveído con la "Nota De Practicas De Privacidad" de **NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A..,** y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.

Patient Name: (please print)
*Nombre Del Paciente: (nombre en letra de molde por favor)
Patient Signature (or legal representative; proof may be requested)
*Firma Del Paciente: (o representante legal; prueba puede ser requerida)
The Late of the contract to the contract of th
Date:
*Fecha:

## EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM \*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information.

NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.., (NASM) offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. NASM will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, NASM cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **NASM** and I, and consent to the conditions outlined herein. Any questions I may have had were answered.

\*Propósito: Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.., (NASM) ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. NASM usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, NASM no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **NASM** y yo, y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

#### Patient Acknowledgment & Agreement / \*Reconocimiento y Acuerdo del Paciente

My Consented Email Address is:		
*Mi Correo Electrónico Consentido Es:		
My Consented Mobile Number For Text Messaging is:		
*Mi Numero Móvil Para Mensaje De Texto Consentido Es:		
Patient Circulus	Data:	
Patient Signature:	Date:	
*Firma del Daciente	*Fecha	

IN CASE OF EMERGENCY: Please call 911 or proceed to the nearest emergency room. Do not use this way of communication for that purpose.
\*EN CASO DE EMERGENCIA: Por favor llame al 911 or proceda al centro de emergencia mas cercano. No use esta forma de comunicación para este propósito.



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NAME:			DATE:	
Date of Birth :	Age :	M / F :	Marital Status:	
Symptoms:				
ALLERGIES :				
MEDICATIONS:				
Name:		Doses:		Indication:
	<del></del>	<del></del>		<del></del>
	·			
	·		<del></del>	<del></del>
		<u>-</u> -		
<b>HOSPITALIZATIONS</b> :				
<u>YEAR</u>	REASON	<u>Hospit</u>		<u>Doctor</u>
Surgeries:				
YEAR_	TYPE OF SUE	RGERY:		



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FAMILY HIST	TORY	FAMILY MEMBER
HEART DISEA HIGH BLOOD DIABETES STROKES		[ ] [ ] [ ]
PNEUMONIA PSYCHIATRIC TUBERCULOS PLEURISY (IN ARTHRITIS CANCER	NES R LIVER PROBLEMS C PROBLEMS / DEPRESSION	
Father:	[ ] Deceased – Age Cause of Death	
Mother:	[ ] Deceased – Age Cause of Death	
Brothers: #_		
	[ ] Deceased - Age Cause of Death	
	[ ] Deceased – Age Cause of Death	
Sisters: #		
	[ ] Deceased – Age Cause of Death	
	[ ] Deceased – Age Cause of Death	
Children: #_		
	[ ] Deceased – Age Cause of Death	
	[ ] Deceased – Age Cause of Death	



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PHARMACY:			
NAME:		PHONE:	
LABORATORY:			
[ ] QUEST [	] LABCORP	[ ] PCP / CL	INIC :
NAME OF OTHER T	REATING PHYSICIAN	NS:	
Cardiologist:	Name:		Phone:
Endocrinologist:	Name:		Phone:
Gastroenterologist:	Name:		Phone:
Hematologist:	Name:		Phone:
Oncologist:	Name:		Phone:
Urologist:	Name:		Phone:
Other Specialty:	Name:		Phone:
WOMEN ONLY:			
No. of Pregnancies:	No. of Childre	en Born:	Miscarriages:
[ ] NATURAL BIRTH #	[ ] C-Section	ı #	
COMPLICATIONS D	URING PREGNANCIE	S:	
		YES	NO
High Blood Pressure Albumin UTI Edema Other Problems:	9		

Reparacion De Anewisma Aortica Abdominal Acid Reflux (GERD) Acid Reflux (GERD) Acid Reflux (GERD) Anemia Anemia Anemia Arthritis Anemia Arthritis Arthritis Asthma YES / NO Actral Fibrillation YES / NO Atrial Fibrillation YES / NO Perlpharal Vascular Disease VES / NO Prostate Hypertrophy (Indiaged Prostate) Pipertropin Prostatica Proteinuria - (Protein in the Urine) Proteinuria Seizures/ Epilepsy Comunisiones/Epilepsia Seizures/ Epilepsy Seizures/ Epilepsy Comunisiones/Epilepsia Seizures/ Epilepsy Seizures/ Epilepsy Comunisiones/Epilepsia Seizures/ Epilepsy Tiber More Seine Proteinuria Thyriol Problems Proteinuria Thyriol Pr	PAST MEDICAL	. HISTORY /	HISTORIAL MEDICO	
Acid Reflux (GERD) Reflug Gostrico Reflugado Reflug Gostrico Reflug Gostrico R	Abdominal Aortic Aneurysm Repair	YES / NO	Kidney Cyst	YES / NO
Reflujo Gastrico Anemia Anemia Anemia Arthritis Arthriti	Reparacion De Aneurisma Aortica Abdominal		Quiste Renal	
Anemia YES / NO Calculo Renal YES / NO Enfermedad del Higado Lupus Entromatoso YES / NO Tibrilacion Auricular Blood Clot YES / NO Cagaulos Sanguineos (Congestiva Grandia Prostatica Corgania Prostatica Pro	Acid Reflux (GERD)	YES / NO	Kidney Disease	YES / NO
Anemia Arthritis Arthritis Arthritis Arthritis Arthritis Arthritis Ashma Ashma Astma Astma Astrial Fibrillation Fibrilacion Auricular Blood Clot Cargulos Sanguineos Blood Clot Cancer Archritis Astra Fibrillation Fibrilacion Auricular Blood Clot Cangulos Sanguineos Blood Transfusion Fransplant Fra	Reflujo Gastrico			
Arthritis	Anemia	YES / NO		YES / NO
Asthma Asthma YES / NO Asthma YES / NO Asthma YES / NO Itupus Eritromatoso	Anemia		Calculo Renal	
Ashma	Arthritis	YES / NO	Liver Disease	YES / NO
Asma   Lupus Eritromatoso   YES / NO   Organ Transplant   YES / NO   Organ Transplant   YES / NO   Transplant   YES / NO   Cangulos Sanguineos   YES / NO   Cancer   YES / NO   Proteinuria   YES / NO   Proteinuria   Proteinuria   YES / NO   Proteinuria   YES / NO   Proteinuria   Pr			Enfermedad del Higado	
Atrial Fibrillation Fibrilacion Auricular Fibrilacion Auriculation Fibrilacion Auricular Fibrilacion Auricular Fibrilacion Auriculation Fibrilacion Auricular Fibrilacion Auricu		YES / NO	· ·	YES / NO
Transplante de Organo   Peripheral Vascular Disease - (Lower Extremity Circulatory Problems)   Peripheral Vascular Disease - (Lower Extremity Circulatory Problems)   Peripheral Vascular Disease - (Lower Extremity Circulatory Problems)   Prostate Hypertrophy   Proteinuria - (Protein in the Urine)   Proteinuria - (Protein in the Urine)   Proteinuria - (Proteinuria - (Proteinu	Asma			
Blood Clot Coagulos Sanguineos Blood Transfusion Transfusion Transfusion de Sangre Cancer Cancer Cancer Cancer Congestive Heart Failure (CHF) Insufficiencia Cardiaca Congestiva Coronary Artery Disease Enfermedad Arterial Coronaria Depression Depression Diabetes Diabetes Gout Heart Disease Tyes / NO Cardiapatia Heart Disease Tyes / NO Cardiapatia Hematuria (Blood in the Urine) Hematuria B Hepatitis B High Cholesterol Colesterol Alto Hypertension (Presion Alta) Today's Date Pate of Birth: Fecha de Nacimento  YES / NO Proteituria Vyes / NO Clorestate Hypertrophy (Enlarged Prostate) Hiph Choresterol Proteinuria - (Protein in the Urine) Proteinuria - (Protein in the Urine) Hyes / NO Proteinuria - (Protein in the Urine) Hyes / NO Proteinuria - (Protein in the Urine) Hyes / NO Enfermedad Pulmonaria YES / NO Enfermedad Pulmonaria YES / NO Seizures/ Epilepsy YES / NO Convulsiones/Epilepsia Sieve Apnea YES / NO Ataque Cerebral Thyroid Problems YES / NO Problems de Tiroides YES / NO Urinary Track Infection Infeccion Urinaria VYES / NO Varices  VYES / NO Vitamin D Deficiency YES / NO Proteinuria - (Protein in the Urine) Proteinuria - (Protein in the Ur		YES / NO		YES / NO
Coagulos Sanguineos   Singuineos   Singuineos   Singuineos   YES / NO   Enfermedad Vascular   YES / NO   Frostate Hypertrophy   (Elaraged Prostate)   YES / NO   Prostate Hypertrofia Prostatica   YES / NO   Proteinuria - (Protein in the Urine)   Proteinuria   Protein	Fibrilacion Auricular			
Blood Transfusion Transfusion de Sangre  Cancer Cancer Cancer Cancer Congestive Heart Failure (CHF) Insuficiencia Cardiaca Congestiva Coronary Artery Disease Enfermedad Arterial Coronaria Depression Diabetes Diabetes Diabetes Petart Disease Petar	Blood Clot	YES / NO		YES / NO
Transfusion de Sangre Cancer Cancer Cancer Congestive Heart Failure (CHF) Insuficiencia Cardiaca Congestiva Coronary Artery Disease Enfermedad Arterial Coronaria Depression Diabetes Diabetes Diabetes Pess / NO Frostatie Hypertrophy (Enlarged Prostatica Proteinuria - (Protein in the Urine) Proteinuria Pulmonary Disease Fulmonary Diseas				
Cancer Cancer YES / NO Cancer YES / NO Cancer YES / NO Congestive Heart Failure (CHF) YES / NO Proteinuria - (Protein in the Urine) Proteinuria (Proteinuria (Pro	Blood Transfusion	YES / NO		YES / NO
Cance r Congestive Heart Failure (CHF) Insufficiencia Cardiaca Congestiva Coronary Artery Disease Enfermedad Arterial Coronaria Depression Diabetes Diabetes Diabetes WES / NO Gout Gout Gota Heart Disease YES / NO Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Highertension (Presion Alta) Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  YES / NO Proteinuria - (Protein in the Urine) Proteinuria Prollmonary Disease YES / NO Aface de Sueño YES / NO Aface de Sueño YES / NO Aface de Sueño YES / NO Interculosis YES /	Transfusion de Sangre		Prostate Hypertrophy	
Congestive Heart Failure (CHF) Insuficiencia Cardiaca Congestiva  Coronary Artery Disease Enfermedad Arterial Coronaria  Depression Depression Diabetes Diabetes Diabetes Diabetes Occurring Fresh NO Diabetes  WES / NO Diabetes  WES / NO Diabetes D	Cancer	YES / NO		
Proteinuria   Proteinuria   Proteinuria   Proteinuria   Proteinuria   Pulmonary Disease   YES / NO   Enfermedad Arterial Coronaria   Pulmonary Disease   YES / NO   Enfermedad Arterial Coronaria   Pulmonary Disease   YES / NO   Seizures/ Epilepsy   YES / NO   Convulsiones/Epilepsia   Siep Apnea   YES / NO   Apnea del Sueño   Stroke   YES / NO   Ataque Cerebral   Apnea del Sueño   YES / NO   Ataque Cerebral   Thyroid Problems   YES / NO   Artaque Cerebral   Thyroid Problems   YES / NO   Artaque Cerebral   Tuberculosis   YES / NO   Problema de Tiroides   YES / NO   Tuberculosis   YES / NO   Tuberculosis   YES / NO   Infeccion Urinaria   YES / NO   Infeccion Urinaria   YES / NO   Infeccion Urinaria   YES / NO   Varicose Veins   YES / NO   Varicose Veins   YES / NO   Varicose Veins   YES / NO   Infeccion Que va a ver hoy:   Pecha   Patient's Name:   Doctor you are seeing Today/Medico que va a ver hoy:   Patient's Name:   Doctor you are seeing Today/Medico que va a ver hoy:   Dr. Barreto   Dr. Barreto   Dr. Barreto   Dr. Barreto   Dr. Barreto   Dr. Barreto   Dr. Gomez   Dr. Gomez   Dr. Gomez   Dr. Trespalacios   Dr. Tres	Cance r			YES / NO
Coronary Artery Disease Enfermedad Arterial Coronaria  Depression Depression Depression Diabetes Diabetes Gout Gout Heart Disease Hematuria (Blood in the Urine) Hematuria Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Highertension (Presion Alta) Today's Date: Fecha Date of Birth: Fecha de Nacimento  YES / NO Presion Problems Press / NO P	Congestive Heart Failure (CHF)	YES / NO	Proteinuria - (Protein in the Urine)	
Enfermedad Arterial Coronaria  Depression Depression Diabetes Depression Diabetes Depression Diabetes Depression Diabetes Depression Diabetes Depression Dep	Insuficiencia Cardiaca Congestiva		Proteinuria	
Depression Depression Depression Depression Depression Diabetes Diabetes Diabetes Diabetes Siep Apnea Apnea del Sueño Stroke Acque Cerebral Thyroid Problems Problema de Tiroides Thyroid Problems Problema de Tiroides Tuberculosis Tuberculosis Tuberculosis Urinary Track Infection Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hyertension (High Blood Pressure) High Cholesterol Colesterol Alto Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  YES / NO Seizures/ Epilepsy Convulsiones/Epilepsia Sleep Apnea Apnea del Sueño Stroke Ataque Cerebral Thyroid Problems YES / NO Tuberculosis Urinary Track Infection Ataque Cerebral Urinary Track Infection VYES / NO Varices Vitamin D Deficiency YES / NO Deficiencia de Vitamina D Deticencia de Vitamina D Doctor you are seeing Today/Medico que va a ver hoy: I pr. Acevedo I pr. Barreto I pr. Barreto I pr. Farias I pr. Gomez I pr. Kusnir I pr. Trespalacios	Coronary Artery Disease	YES / NO	Pulmonary Disease	YES / NO
Depression Diabetes D	Enfermedad Arterial Coronaria			
Diabetes Dia	· ·		Seizures/ Epilepsy	YES / NO
Diabete S Gout Gout Gota  Heart Disease PES / NO Cardiopatia  Hematuria (Blood in the Urine) Hematuria Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (Presion Alta) Today's Date: Fecha Patient's Name: Nombre del Paciente  Date of Birth: Fecha de Nacimento  YES / NO Stroke Ataque Cerebral  Stroke Ataque Cerebral  Thyroid Problems YES / NO Thyroid Problems YES / NO Thyroid Problems YES / NO Truberculosis  Tuberculosis  VYES / NO Urinary Track Infection Infeccion Urinaria  YES / NO Varicose Veins YES / NO Varicose Veins YES / NO Varicose Veins YES / NO Deficiency Deficiency Deficiencia de Vitamina D Doctor you are seeing Today/Medico que va a ver hoy:  [ ] Dr. Busse [ ] Dr. Busse [ ] Dr. Barreto [ ] Dr. Busse [ ] Dr. Gomez [ ] Dr. Gomez [ ] Dr. Gomez [ ] Dr. Kusnir [ ] Dr. Trespalacios	•		Convulsiones/Epilepsia	
Gout Gota Heart Disease Cardiopatia Hematuria (Blood in the Urine) Hematuria Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Hipertension (Presion Alta) Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  YES / NO  YES / NO Ataque Cerebral Thyroid Problems PYES / NO Tuberculosis Urinary Track Infection Infeccion Urinaria Varicose Veins Varicose Veins Varicose Veins Varicose Vitamin D Deficiency Deficiencia de Vitamina D Doctor you are seeing Today/Medico que va a ver hoy: [ ] Dr. Acevedo [ ] Dr. Barreto [ ] Dr. Barreto [ ] Dr. Gomez [ ] Dr. Gomez [ ] Dr. Gomez [ ] Dr. Kusnir [ ] Dr. Kusnir [ ] Dr. Trespalacios		YES / NO		YES / NO
Ataque Cerebral Heart Disease Cardiopatia Hematuria (Blood in the Urine) Hematuria Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Hipertension (Presion Alta)  Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  YES / NO Tyes / NO Ty				
Heart Disease Cardiopatia  Hematuria (Blood in the Urine) Hematuria Hepatitis B Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Hipertension (Presion Alta)  Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  YES / NO Thyroid Problems Problems Problema de Tiroides Tuberculosis Tuberculosis Tuberculosis Tuterculosis YES / NO Tuterculosis VYES / NO Varicose Veins Varicose Veins Varicose Veins Varicose Vitamin D Deficiency Vitamin D Deficiency Doctor you are seeing Today/Medico que va a ver hoy:  [ ] Dr. Acevedo [ ] Dr. Busse [ ] Dr. Farias [ ] Dr. Gomez [ ] Dr. Kusnir [ ] Dr. Trespalacios		YES / NO		YES / NO
A Problema de Tiroides Hematuria (Blood in the Urine) Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Hipertension (Presion Alta)  Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  PYES / NO Tuberculosis Tuberculosis  Urinary Track Infection Infeccion Urinaria Varicose Veins Varicose Varic				
Hematuria (Blood in the Urine)  Hematuria  Hepatitis B  Hepatitis B  High Cholesterol  Colesterol Alto  Hypertension (High Blood Pressure)  Hipertension (Presion Alta)  Today's Date:  Fecha  Patient's Name:  Nombre del Paciente  Date of Birth:  Fecha de Nacimento  Tuberculosis  Tuberculosis Tuberculosis  Tuberculosis  Tuberculosis  Tuberculosis  Tuberculosis  Tuberculosis Tuberculosis  Tuberculosis Tuberculosis  Tuberculosis Tuberculosis Tuberculosis Tuberculosis  Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Tuberculosis Toueralis Toueralis Tones In the second In t	Heart Disease	YES / NO		YES / NO
Hematuria Hepatitis B Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Hipertension (Presion Alta)  Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  Tuberculosis Urinary Track Infection Vericos Varicose Veins Varicose Veins Varicose Veins Varicose Veins Varicose Vitamin D Deficiency Deficiencia de Vitamina D  Doctor you are seeing Today/Medico que va a ver hoy:  [ ] Dr. Acevedo [ ] Dr. Barreto [ ] Dr. Barreto [ ] Dr. Farias [ ] Dr. Gomez [ ] Dr. Kusnir [ ] Dr. Kusnir [ ] Dr. Trespalacios	·			
Hepatitis B Hepatitis B Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Hipertension (Presion Alta)  Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  YES / NO Urinary Track Infection VYES / NO Varicose Veins Varicose Veins Varicose Veins Varicose Vitamin D Deficiency Deficiencia de Vitamina D  Doctor you are seeing Today/Medico que va a ver hoy:  [ ] Dr. Acevedo [ ] Dr. Barreto [ ] Dr. Barreto [ ] Dr. Farias [ ] Dr. Gomez [ ] Dr. Kusnir [ ] Dr. Kusnir [ ] Dr. Trespalacios	·	YES / NO		YES / NO
Hepatitis B High Cholesterol Colesterol Alto Hypertension (High Blood Pressure) Hipertension (Presion Alta)  Today's Date: Fecha Patient's Name: Nombre del Paciente Date of Birth: Fecha de Nacimento  Infeccion Urinaria Varicose Veins Vitamin D Deficiency Deficiencia de Vitamina D  Today/s Dafe:  Doctor you are seeing Today/Medico que va a ver hoy:  [ ] Dr. Acevedo [ ] Dr. Barreto [ ] Dr. Busse [ ] Dr. Farias [ ] Dr. Gomez [ ] Dr. Kusnir [ ] Dr. Trespalacios				
High Cholesterol Colesterol Alto  Hypertension (High Blood Pressure) Hipertension (Presion Alta)  Today's Date: Fecha Patient's Name: Nombre del Paciente  Date of Birth: Fecha de Nacimento  YES / NO Varicose Veins Vitamin D Deficiency Def	•	YES / NO	•	YES / NO
Colesterol AltoVaricesHypertension (High Blood Pressure)YES / NOHipertension (Presion Alta)Deficiencia de Vitamina DToday's Date:Doctor you are seeing Today/Medico que va a ver hoy:Fecha[ ] Dr. AcevedoPatient's Name:[ ] Dr. BusseNombre del Paciente[ ] Dr. FariasDate of Birth:[ ] Dr. KusnirFecha de Nacimento[ ] Dr. Trespalacios	·			
Hypertension (High Blood Pressure) Hipertension (Presion Alta)  Today's Date: Fecha  Patient's Name: Nombre del Paciente  Date of Birth: Fecha de Nacimento  YES / NO  Vitamin D Deficiency Deficiencia de Vitamina D  Doctor you are seeing Today/Medico que va a ver hoy:  [ ] Dr. Acevedo [ ] Dr. Busse [ ] Dr. Farias [ ] Dr. Farias [ ] Dr. Gomez [ ] Dr. Kusnir [ ] Dr. Kusnir [ ] Dr. Trespalacios	_	YES / NO		YES / NO
Hipertension (Presion Alta)  Today's Date:  Fecha  Patient's Name:  Nombre del Paciente  Deficiencia de Vitamina D  Doctor you are seeing Today/Medico que va a ver hoy:  [ ] Dr. Acevedo [ ] Dr. Barreto [ ] Dr. Busse [ ] Dr. Farias [ ] Dr. Farias [ ] Dr. Gomez [ ] Dr. Kusnir  Fecha de Nacimento  [ ] Dr. Trespalacios				
Today's Date:  Fecha  Doctor you are seeing Today/Medico que va a ver hoy:  [ ] Dr. Acevedo [ ] Dr. Barreto [ ] Dr. Busse [ ] Dr. Farias [ ] Dr. Farias [ ] Dr. Gomez [ ] Dr. Kusnir Fecha de Nacimento  [ ] Dr. Trespalacios		YES / NO	·	YES / NO
Fecha       Dr. Acevedo     Dr. Barreto     Dr. Busse   Date of Birth:   Dr. Gomez   Dr. Kusnir   Dr. Trespalacios				<u> </u>
Patient's Name:  Nombre del Paciente  Date of Birth:  Fecha de Nacimento  [ ] Dr. Barreto [ ] Dr. Busse [ ] Dr. Farias [ ] Dr. Gomez [ ] Dr. Kusnir [ ] Dr. Trespalacios				a a ver hoy:
Patient's Name:  Nombre del Paciente  Date of Birth:  Fecha de Nacimento  [ ] Dr. Busse  [ ] Dr. Farias  [ ] Dr. Gomez  [ ] Dr. Kusnir  [ ] Dr. Trespalacios	Fecha			
Nombre del Paciente  [ ] Dr. Farias [ ] Dr. Gomez Date of Birth:  Fecha de Nacimento  [ ] Dr. Trespalacios	Post culls No			
Date of Birth:  Fecha de Nacimento    Dr. Gomez   Dr. Kusnir   Dr. Trespalacios			<b>I</b> ' '	
Date of Birth: [ ] Dr. Kusnir  Fecha de Nacimento [ ] Dr. Trespalacios	Nombre del Paciente			
Fecha de Nacimento [ ] Dr. Trespalacios	Date of Birth			
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