RF MEDICAL SERVICES

Patient Registration Form

PATIENT INFORMATION

First Name: _____ **Last Name:** _____ **MI:** _____

Sex: M / F **Date of Birth:** _____ **Age:** ___ **Social Security #:** _____ **Marital Status:** _____

Address: _____ **City:** _____ **State:** _____

Phone - Home: _____ **Work:** _____ **Cell:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Pharmacy: _____ **Address:** _____ **Phone:** _____

Who referred you to our practice? _____

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Plan Name: _____	Plan Name: _____
Policy/Suscriber ID #: _____	Policy/Suscriber ID #: _____
Group #: _____	Group #: _____

MEDICAL HISTORY

Personal History

Smoker: Yes / No If yes,	**Drink Alcohol?:** Yes / No If yes,
How much: _____ For how long: _____	How much: _____ For how long: _____
List all prior surgeries:	List any chronic medical problems/conditions:
_____	_____
_____	_____
_____	_____

Family History

Indicate which family member(s): M=Mother F=Father S=Sibling A=Aunt U=Uncle GP=Grandparent

Cardiovascular disease	Cancer
Diabetes	Alzhaimer
High Cholesterol	Stroke/CVA/TIA/Seizures
High Blood Pressure	Other(s)

I hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of RF Medical Services, Inc. which they may deem advisable. I hereby certify that, to the best of my knowledge, all treatments contained herein are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid HMO contract. I read and fully understand the above consent for treatment, financial responsibility, release of medical records and insurance authorization. I have been given a copy of the Privacy Rights and I agree with them.

SIGNATURE: _____ DATE: _____

NAME (Please Print): _____ RELATIONSHIP TO PATIENT: _____

RF MEDICAL SERVICES
Rodolfo Freire MD.
12264 Tamiami Trail East
Unit 201, Naples FL, 34113
P 239-304-9071
F 239-304-9320

MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: ___/___/_____
LAST FIRST MI MM DD YYYY

Phone: (_____) _____-_____ ☐ Cell ☐ Home ☐ Work SS #: _____

Address: _____
City State Zip

PLEASE RELEASE MY RECORDS **FROM:**

Name of Provider: _____ Phone: _____

Address: _____ Fax: _____

_____

To: _____ Relationship to Patient: _____

Phone: (_____) _____-_____ Fax: (_____)_____-_____

Address: _____

_____

☐ Complete Record

☐ Records of care from _____ to _____

☐ Records of care concerning the following condition(s): _____

☐ Other. Specify: _____

I authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) above) or to otherwise release confidential information.

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)