



THE GORDON CLINIC

Fee
Cuota \$ _____

YEARLY REGISTRATION Planilla de Registro Anual

PATIENT INFORMATION Información del Paciente

Date/Día _____

NAME/ Nombre _____ SEX/ Sexo _____
ADDRESS/ Dirección _____ PHONE/Teléfono _____
CITY/ Ciudad _____ ZIP CODE/ Zona Postal _____
DATE OF BIRTH/ Fecha de Nacimiento _____ AGE/ Edad _____
STATUS/ Estado Civil SINGLE/Soltero MARRIED/ Casado WIDOW/ Viudo DIVORCED/Divorciado
SOCIAL SECURITY No. _____
OCCUPATION/ Ocupación _____
EMPLOYED BY/ Empleado por _____
ADDRESS/ Dirección _____
SPOUSE/ Nombre del esposo _____
OCCUPATION/ Ocupación _____
EMPLOYED BY/ Empleado por _____
ADDRESS/ Dirección _____

PERSON RESPONSIBLE FOR PAYMENT

Persona Responsable por el pago _____
ADDRESS/ Dirección _____

INSURANCE/Seguro Yes/Sí NO/No MEDICAL/Médico HOSPITAL/Hospital
NAME OF THE COMPANY/Nombre de la Compañía _____ DEDUCTIBLE/Deducible\$ _____
POLICY No./ Póliza No. _____ CERTIFICATE No./Certificado No. _____
MEDICAID _____
Policy # _____

ALLERGIES/Alergias _____

PRESCRIPTION YOU ARE TAKING /Medicinas que está tomando Actualmente

- NEW PATIENTS ONLY / Pacientes nuevos solamente-

1 _____ 3 _____
2 _____ 4 _____

PHYSICIAN RELEASE & ASSIGNMENT-I hereby authorize payment directly to.....of benefits due to me from my insurance company otherwise payable to me.

I further authorize the release of any medical information required by my insurance carrier's.

A copy of this authorization may be used in lieu of the original.

I authorize any holder of medical or other Information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any Information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I understand that I and financially responsible for charges not covered by this authorization.

PATIENT'S SIGNATURE

REFERRED BY/ Referido por _____

BELOW YOU WILL FIND A LIST OF SYMPTOMS AND AILMENTS. PLEASE CHECK THOSE CONDITIONS YOU REMEMBER AS HAVING HAD ANYTIME IN THE PAST. IF THIS IS NOT A NEW REGISTRATION, JUST REPORT NEW SYMPTOMS SINCE LAST REGISTRATION WAS FILLED.

A continuación usted va a encontrar una lista de síntomas y enfermedades. Haga el favor de marcar claramente aquellas que usted ha tenido o padecido en el pasado. Si esta no es una planilla de registro nueva, solo reporte lo síntomas nuevos desde su última planilla.

- | | |
|---|--|
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> Dolor de cabeza |
| <input type="checkbox"/> RASH | <input type="checkbox"/> Erupción |
| <input type="checkbox"/> HAIR CHANGE | <input type="checkbox"/> Cambio en el pelo |
| <input type="checkbox"/> NASAL BLEEDING | <input type="checkbox"/> Hemorragia nasal |
| <input type="checkbox"/> SINUSITIS | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> Falta de aire |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> Asma |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> Dolor en el pecho |
| <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> Palpitaciones |
| <input type="checkbox"/> WEIGHT LOSS | <input type="checkbox"/> Pérdida de peso |
| <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> Dolor Abdominal |
| <input type="checkbox"/> BLOOD IN STOOLS | <input type="checkbox"/> Sangre en las heces fecales |
| <input type="checkbox"/> BLACK STOOLS | <input type="checkbox"/> Heces fecales negras |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> Diarreas |
| <input type="checkbox"/> GALL STONES | <input type="checkbox"/> Cálculos biliares |
| <input type="checkbox"/> BURNING ON URINATION | <input type="checkbox"/> Ardor al orinar |
| <input type="checkbox"/> BLOOD IN THE URINE | <input type="checkbox"/> Sangre en la orina |
| <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> Cólico Nefrítico |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> Estreñimiento |
| <input type="checkbox"/> INCONTINENCE | <input type="checkbox"/> Incontinencia |
| <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> Adormecimiento |
| <input type="checkbox"/> SYNCOPE | <input type="checkbox"/> Síncope |
| <input type="checkbox"/> DECREASED VISION | <input type="checkbox"/> Disminución de la vision |
| <input type="checkbox"/> RINGING IN THE EAR | <input type="checkbox"/> Zumbido de oídos |
| <input type="checkbox"/> PARALYSIS | <input type="checkbox"/> Parálisis |
| <input type="checkbox"/> TREMORS | <input type="checkbox"/> Temblores |
| <input type="checkbox"/> THYROID PROBLEMS | <input type="checkbox"/> Problemas de Tiroides |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> Presión alta |
| <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> Colesterol alto |
| <input type="checkbox"/> VENERAL DISEASES | <input type="checkbox"/> Enfermedades venéreas |
| <input type="checkbox"/> ULCERS | <input type="checkbox"/> Úlceras |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> Artritis |
| <input type="checkbox"/> SEIZURES | <input type="checkbox"/> Convulsiones |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> BLOOD TRANSFUSIONS | <input type="checkbox"/> Transfusiones de sangre |