

# SOUTH MIAMI GYNECOLOGIC ONCOLOGY GROUP

## RICARDO ESTAPE MD, LLC

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_  
*Nombre del Paciente*  
Home Address: \_\_\_\_\_  
*Direccion del Hogar*  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
*Ciudad Estado Codigo Postal*  
Occupation: \_\_\_\_\_  
*Ocupacion*  
Employer: \_\_\_\_\_  
*Empleo*  
Emergency Contact: \_\_\_\_\_  
*Contacto de Emergencia*  
Referred By: \_\_\_\_\_  
*Referido Por*  
Allergies/Alergias \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
*Telefono del Hogar Telefono del Celular*  
Work Phone: \_\_\_\_\_  
*Telefono del Trabajo*  
Date of Birth: \_\_\_\_\_  
*Fecha de Nacimiento*  
Social Security #: \_\_\_\_\_  
*Numero de Seguro Social*  
Marital Status: \_\_\_\_\_  
*Estado Civil*  
Phone Number: \_\_\_\_\_  
*Telefono*  
Driver's License #: \_\_\_\_\_  
*Numero de Licencia de conducir*  
E-mail address: \_\_\_\_\_

**\*\*IF YOUR VISIT IS FOR A WELL WOMAN EXAM, CHECK HERE: \_\_\_ Si su visita es para un examen anual, marque aqui \_\_\_**

### INSURANCE INFORMATION

Name of Primary Insurance: \_\_\_\_\_  
*Nombre del Seguro*  
Address: \_\_\_\_\_  
*Direccion*  
Group Number: \_\_\_\_\_  
*Numero de Grupo*  
Name of Subscriber: \_\_\_\_\_  
*Nombre del Asegurado*  
Subscriber's Employer: \_\_\_\_\_  
*Empleo del Asegurado*  
Name of Secondary Insurance: \_\_\_\_\_  
*Nombre del Seguro Secundario*  
Address: \_\_\_\_\_  
*Direccion*  
Group Number: \_\_\_\_\_  
*Numero de Grupo*  
Name of Subscriber: \_\_\_\_\_  
*Nombre del Asegurado*  
Subscriber's Employer: \_\_\_\_\_  
*Empleo del Asegurado*

Phone Number: \_\_\_\_\_  
*Telefono*  
Policy or I.D. Number: \_\_\_\_\_  
*Numero de Poliza*  
Date of Birth: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
*Fecha de Nacimiento Relacion al Paciente*  
Phone Number: \_\_\_\_\_  
*Telefono*  
Policy or I.D. Number: \_\_\_\_\_  
*Numero de Poliza*  
Date of Birth: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
*Fecha de Nacimiento Relacion al Paciente*

### FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card, American Express and Discover Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card, American Express y Discover. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

### PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Ricardo Estape,MD, LLC Inc. of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by Ricardo Estape,MD, LLC. I understand that I am financially responsible to Ricardo Estape,MD, LLC for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a Ricardo Estape,MD, LLC, todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S/GUARANTOR'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Ricardo Estape, MD, FACOG**

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