Prevem seguros

Bar code

Medical Report

Instructions: This form shall be filled out in print hand writing and signed by each attending physician except by the Anesthesiologist and the Assistant. It shall be void if it shows erasures or corrections. It shall be entirely filled out. No subsequent changes shall be accepted to the statements made herein.

Reason for medical attention: Direct payment ☐ Surgery-treatment scheduling ☐ Reimbursement ☐

Type of event: Disease ☐ Accident ☐ D Pregnancy ☐ Emergency ☐

Has the physician entered into an Agreement YES ☐ NO ☐

Is the physician a Staff physician YES ☐ NO ☐

A. Patient identification card.

Patient's Name (Paternal Last Name, Maternal Last Name and First Name) _____

Age _____ Sex: F ☐ M ☐

B. Medical History (specifying progression time writing down dates of pathologies and surgeries).

Pathological Personal History

Cancer ☐ Cardiac ☐ Convulsive ☐

Diabetes Mellitus ☐ Hepatic ☐ HIV/AIDS ☐

Other ☐ Specify: _____

Surgeries ☐ _____

Antecedentes Personales no Patológicos

☐ Does the patient Smoke (Specify Quantity) _____

☐ Does the patient Consume Alcoholic Beverages (Specify Type and Quantity) _____

☐ Does the patient Consumes or has ever Consumed any Type of Drug (Specify Type and Quantity) _____

☐ Unintentional Weight Loss (Describe) _____

☐ Other _____

Gynecological and Obstetric Background

Pregnancy(ies) _____ Delivery(ies) _____ Caesarean(s) _____ Abortion(s) _____ LMP1 _____ Gestation Age _____

Perinatal Background (if necessary)

APGAR _____ Silverman _____

Current Condition (main signs and symptoms)

First Symptoms Starting Date MM/DD/YYYY

First Consultation Date MM/DD/YYYY

Diagnosis Date MM/DD/YYYY

Please specify Progression and Current Status of Condition: _____

With one progression: 1 to 3 months ☐ 3 to 6 months ☐ 6 to 12 months ☐ More than 1 year ☐

Diagnosis Description

Type of Condition: Congenital ☐ Acquired ☐ Severe ☐ Chronic ☐ Idiopathic ☐

Has it been related to any other condition, illness or accident: Yes ☐ No ☐ Which one? _____

Did condition cause Disability? Yes ☐ NO ☐ Total ☐ Partial ☐

RESULTS OF PHYSICAL EXAMINATION AND STUDIES CARRIED OUT (Attach Interpretation Conflrmine Diagnosis)

Electrocardiogram ☐ Electroencephalogram ☐ Tomography ☐ Radiography ☐ Magnetic Resonance ☐

Blood ☐ Urine ☐ Histopathology ☐ Coproparasitoscopic ☐ Other (Specify): _____

Results: _____

Height	Cm	Weight	Kg	B/P	mmHg	CF	x1	RF	x1	Temp.	C°

FSIN-003

Tecoyotitla 412 edificio arena! piso 3 Col. Ex hacienda de Guadalupe Chimalistac C.P. 01050 Mexico, D.F. Tel: 91•78•26•00/01•800•2 PREVEM (77•38•36) www.prevemseguros.mx

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Treatment Description

Please Indicate: ☐ Treatment Scheduling ☐ Description of already Performed Treatment

☐ Surgical Treatment (Please Specify performed Procedure, Surgical nme and Completion Date) MM/DD/YYYY

Description: _____

☐ Medical Treatment (Please describe starting date, Treatment and Dosage) MM/DD/YYYY

Description: _____

Was there a complication? ☐ YES ☐ NO Please Describe Complications: _____

Did the patient require hospitalization? **YES** ☐ **NO** ☐ If you have replied yes please answer:

Hospital Name _____ City _____

Type of stay: Emergency ☐ Short Stay / Ambulatory ☐ Hospital Stay ☐

Admission Date	MM/DD/YYYY
Discharge Date	MM/DD/YYYY

C. Data of Attending physician

Name (Paternal Last Name, Maternal Last Name and First Name) _____

Provider N° (Only if the attending physician has entered into an agreement with Prevem Seguros, S.A de C.V.) _____

Specialty _____ Professional License _____

Specialty License or Certification _____ TAX ID[2] _____

Telephone _____ Email _____

Cell phone _____

Does the physician Receive Payment by Prevem Seguros: YES ☐ **NO** ☐ **Provider No.:** _____

ndicate Name and specialty of (those) being involved in the surgery or as interconsultant(s):

Anesthesiologist: _____ Does he/she receive Payment by Prevem Seguros? YES ☐ NO ☐

Assistant 1: _____ Does he/she receive Payment by Prevem Seguros? YES ☐ NO ☐

Assistant 2: _____ Does he/she receive Payment by Prevem Seguros? YES ☐ NO ☐

Other Physician(s): _____ Does (Do) he/she (they) receive Payment by Prevem Seguros? YES ☐ NO ☐

D. Signatures

Note: As attending physician, I here by consent hospitals where the patient was admitted to provide all reports related to the patient's health to Prevem Seguros, S.A. of C.V., including all information of previous diseases. For this purpose, I release all involved institutions or persons from the professional secrecy obligation and I hereby certify that a copy of this authorization has the same effect as the original. I declare under penalty of perjury that the information provided herein was directly obtained from insured patient or, in case of minors or disabled individuals, from relatives responsible as well as from the clinical file in my possession.

_____

Signature of Attending Physician

Date MM/DD/YYYY Place _____

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