



**Directions**

1. This form should be fully completed. Please print legibly in black ink.
2. This form will not be valid in case of erasures or overwriting, it will be submitted in original.
3. AXA Seguros will be released from any liability in case of misrepresentation or misstatement in the medical information provided in this form.
4. This form is to be updated every 6 months or every time the treating physician is changed or the medical treatment or medical condition changes.
5. Every treating physician or consulting physician will be required to complete a medical report.

Place:	Date:	Month	Day	Year
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**General Information**

Data of the concerned Insured (patient)				
Paternal surname:		Maternal surname:		First name(s):
Age:	Date of birth:	Month	Day	Year
Sex:		Height:	Weight:	Blood pressure:
<input type="checkbox"/> Male <input type="checkbox"/> Female				

**Reason for seeking medical care**

Illness     
  Accident     
  Maternity     
  Second medical opinion

**Place of Service**

Emergency Room     
  Inpatient     
  Short stay/outpatient     
  Office visit

**Past Medical History**

Pathological history (please specify the onset date of illness or how long since you got ill mm/dd/yyyy): <input type="checkbox"/> Heart condition _____ <input type="checkbox"/> Diabetes mellitus _____ <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Seizures _____	<input type="checkbox"/> High blood pressure _____ <input type="checkbox"/> HIV/AIDS _____ <input type="checkbox"/> Liver condition _____ <input type="checkbox"/> Other condition _____	Non-pathological history (please specify frequency, quantity and for how long) <input type="checkbox"/> Does the patient smoke? _____ <input type="checkbox"/> Does the patient drink alcohol? _____ <input type="checkbox"/> Does the patient do drugs? _____
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**Obstetrics and Gynecology history**

Gestation ___ Deliveries ___ Abortions ___ Cesarean Sections ___ Date of the last menstruation: _____ Month Day Year _____ Did you undergo infertility treatment? _____ Time of evolution: _____	<b>Perinatal history (evolution, complications, treatments)</b> _____ _____ _____ Time of evolution: _____
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Referred by another physician or medical unit:  Yes  No Who/which? \_\_\_\_\_

**Diagnosis**

Current medical condition (main signs, symptoms and evolution details):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Date of medical condition:			Month	Day	Year	Date of diagnosis:			Month	Day	Year
<input type="checkbox"/> Congenital	<input type="checkbox"/> Acquired	<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic	Time of evolution _____							
Cause or etiology of medical condition (in case of accident, describe when, how and place of injury occurrence):											
Is there any relationship with other medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Which? _____											
Did the medical condition cause any disability?			From:	Month	Day	Year	To:	Month	Day	Year	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Partial	<input type="checkbox"/> Total								
Diagnosis, (stating whether unilateral or bilateral, right or left):											
ICD Code: _____			Is it cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No TNM stage: _____								
Physical Examination:											
Laboratory and Radiological Data:											
<b>Plan or treatment</b>											
Proposed treatment (surgical, non-surgical):								Date of Surgery:			
								Month	Day	Year	
Inpatient date:			Month	Day	Year	Discharge date:			Month	Day	Year
Days during which medical care was provided:											
Where will the procedure will be performed?											
<input type="checkbox"/> Doctor's office	<input type="checkbox"/> Hospital	<input type="checkbox"/> Imaging center	<input type="checkbox"/> Other	Specify: _____							
Provider Name:											
Was a histopathologic study conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No											
Describe the results of the study:											



Did complications arise?  Yes  No  
 Describe the complications:

Will the Insured continue to get treatment in the future?  Yes  No  
 Plan or treatment:

**Other treatments and/or materials, equipment and/or biological/monitoring**

Specify treatment (Chemotherapy cycles, physical therapy sessions, number of rounds/sessions, quantity, frequency and how long):

**Scheduling of rounds of chemotherapy or radiation therapy sessions (should more than 10 drugs are prescribed, please fill out another form)**

#	Name and presentation of the drug (e.g. acetaminophen 100 mg)	Quantity (e.g. 1 tablet)	Frequency (e.g. every 24 hours)	How long (e.g. For one month)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**Scheduling of physical therapy sessions**

Days: \_\_\_\_\_ Number of sessions: \_\_\_\_\_

**Home care**

Days required: \_\_\_\_\_  Morning  Evening  Night  24 hours

Name of medicines:



In case of immunotherapy, biological therapy, etc., justify the treatment:

List of materials used or that will be used during surgery and/or special equipment (monitor, Da Vinci or others):

Type of therapy:

Certificate of specialization:

Evolution detail:

**Comments**

If there is any additional comment, please include them here:

**Physician information**

Physician or specialist	
Type of participation	
Name	
Specialty	
Board member ID	
Address	
Phone number	

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Signature of the Physician	Place and date

**In case of reimbursement and/or service scheduling, the Insured must fill out the following section:**

**Personal Data**

AXA Seguros S.A. de C.V. (AXA), with address at Avenida Félix Cuevas número 366, piso 6, Colonia Tlacoquemécatl, Delegación Benito Juárez, C.P. 03200, Mexico City, will process your personal data to comply with the Insurance Contract and all other purposes stated in the full privacy notice at axa.mx under the Privacy Notice section.

I authorize my personal data, both my financial and assets information, to be processed and transferred for the purpose of complying with the Insurance Contract and all other purposes stated in the Privacy Notice.

**Transfer of Data to third parties**

To be filled in by the concerned Insured, or in the absence thereof by the parents or guardians in case the Insured is a minor.

I authorize AXA to process my sensitive personal data and to transfer them to physicians in Mexico and/or abroad as well as to medical service providers with whom it has entered into an agreement for the purpose of complying with the obligations deriving from the Insurance Contract.

Yes, I do      Signature of the Insured: \_\_\_\_\_  
 No, I do not

I authorize AXA Seguros S.A. de C.V., upon my registration to any of the programs included in the major medical expenses insurance policy, to transfer my sensitive personal data to specialized physicians in Mexico and/or abroad as well as to service providers, so they offer me assistance services for a specific follow-up of my medical condition and so I can request a second medical opinion and, if applicable, so they offer me alternatives for the treatment of my illness

Yes, I do      Signature of the Insured: \_\_\_\_\_  
 No, I do not

This translation is only a courtesy, for any situation related to its content the version in its original language (Spanish) will prevail for all contractual and legal effects.