Health Insurance
Medical Report

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

General Information

Data of the concerned Insured (patient)

Paternal surname:	Maternal surname:	First name(s):

Age:	Date of birth: Month Day Year	Sex: Male Female	Height:	Weight:	Blood pressure:

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):	Non-pathological history (please specify frequency, quantity and for how long)
☐ Heart condition_____ ☐ High blood pressure ☐ Diabetes mellitus_____ _____ ☐ HIV/AIDS _____ ☐ Cancer_____ ☐ Liver condition_____ ☐ Seizures_____ ☐ Other condition_____	☐ Does the patient smoke? _____ ☐ Does the patient drink alcohol? _____ ☐ Does the patient do drugs? _____
Obstetrics and Gynecology history	Perinatal history (evolution, complications, treatments)
Gestation ____ Deliveries ____ Abortions ____ Cesarean Sections ____ Date of the last menstruation: Month Day Year Did you undergo infertility treatment? _____ Time of evolution: _____	Time of evolution: _____

Referred by another physician or medical unit: ☐ Yes ☐ No Who/which? _____

Diagnosis

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

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Date of medical condition: Month Day Year	Date of diagnosis: Month Day Year

☐ Congenital ☐ Acquired ☐ Acute ☐ 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? ☐ Yes ☐ No Which? _____

Did the medical condition cause any disability? ☐ Yes ☐ No ☐ Partial ☐ Total From: Month Day Year	To: Month Day Year

Diagnosis, (stating whether unilateral or bilateral, right or left):

ICD Code: _____ Is it cancer: ☐ Yes ☐ No TNM stage:_____

Physical Examination:

Laboratory and Radiological Data:

Plan or treatment

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?
☐ Doctor's office ☐ Hospital ☐ Imaging center ☐ Other Specify: _____

Provider Name:

Was a histopathologic study conducted? ☐ Yes ☐ No
Describe the results of the study:

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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:

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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.

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