MEDICAL REPORT
(TO BE FILLED BY THE TREATING DOCTOR)

MetLife Mexico

Patient's Data

Paternal Surname Maternal Surname Name (s)

Date when you first treated the patient Month Day Year

___ ____ Accident □ Disease □ Pregnancy □ either for sickness, accident or pregnancy _____ __ ____

Age Sex Reason of the Claim

Clinical Backgrounds

Pathologic Personal Backgrounds

Surgical Backgrounds

G P A C Mention the Cause

Gynecology-obstetric Backgrounds

Mention the most relevant diseases suffered although they are not related to this claim.

Yes □ No □

Did another physician refer the patient? Name of the other physician

Address Phone Number Specialty

Current Disease

Main signs and symptoms

Date when the first signs or symptoms appeared _____ ____ _____ The disease is: Congenital □ Acquired □

Month Day Year

With an evolution of: 1 - 30 days □ 1 – 3 Months □ 3 – 6 Months □ 6 – 12 Months □ Over a year □ Over twelve years □

X rays and laboratory tests practiced

Diagnosis Impression

Final Diagnosis

Mention the treatment and / or surgical procedure

Complications

Mention the names of the physicians who participated in the surgery (Surgeon, assistants and anesthesiologist)

In between consultations, mention specialty and dates

_____ Yes ☐ No ☐
Was any other Medical tx practiced?

_____
If affirmative, explain:

_____ _____
Physician name Specialty

_____
Patient current condition

_____
_____ Yes ☐ No ☐
Are you receiving Medical tx up to date or in the future?

_____
If affirmative, explain:

_____ _____
What type of treatment are your following? Treatment duration

_____
Estimated date of patient discharge

In case of hospitalization

_____
Hospital's name
Admission date _____ ___ ____ Surgical procedure date _____ ___ ____ Discharge date _____ ___ ____
Month Day Year Month Day Year Month Day Year
Yes ☐ No ☐ Partial ☐ Total ☐ From_____ ___ ____ _____ ____ ____
To Month Day Year Month Day Year

Surgery Scheduling

Do you have an agreement with the insurance company Yes ☐ No ☐

* I accept the tabulators understanding that I release the insurance company and the patient from any supplementary payment for this surgery and / or treatment Yes ☐ No ☐

Surgeon $_____ Assistant $_____ Anesthesiologist $_____
Fee budget for medical or surgical treatment

_____ Surgery exact date _____ ____ ____
Hospital where the surgery will be performed Month Day Year

_____ _____
Physician name Specialty

_____
Address

_____ _____ _____
Phone Number Professional Certificate Num. Federal Taxpayers' Registry

_____
Pager and Mobile Phone

Note: As treating doctor I authorize the hospitals where the patient has been admitted to provide to MetLife Mexico, S. A. all the information related to the patient's health, even the data of former diseases. For such purpose in this case I release the institutions or people involved in the professional secret and certify that a copy of this authorization has the same value as the original. I state under oath to tell the truth that the information provided in this form was obtained directly from the insured patient as well as from the clinical records filed in my office.

_____ _____
Place and date Treating doctor signature

Note: The physician is informed herein that any inexact or false statement provided in this questionnaire shall annul every liability of the Institution.