



REGISTRATION FORM

Today's Date: _____ PCP: _____

PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single Mar Div Sep Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):	DOB:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street address:			Social security N°:	Phone N°: ()		
City:		State:	Zip code:	Email Address		
Race:		Ethnicity:		Primary Language:		
How did you hear about Lindo Medical Care? <input type="checkbox"/> Close to home/work		<input type="checkbox"/> Advertising	<input type="checkbox"/> Internet	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family		<input type="checkbox"/> Friend	<input type="checkbox"/> Dr:	<input type="checkbox"/> Other:		

INSURANCE INFORMATION					
(Please give the insurance card to the receptionist)					
Does the patient have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the Policy Holder the same as the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, go to the Primary Insurance information					
Name of Policy Holder:	DOB:	Address (If different)			Phone N°: ()
Please indicate Primary Insurance : <input type="checkbox"/> Medicare <input type="checkbox"/> Humana <input type="checkbox"/> Freedom <input type="checkbox"/> United Health Care <input type="checkbox"/> Optimum <input type="checkbox"/> WellCare <input type="checkbox"/> Ultimate <input type="checkbox"/> Welfare <small>(Please Provide Coupon)</small> <input type="checkbox"/> Other:					
Subscriber's name	Subscriber's social security N°:	DOB:	Group N°:	Policy N°:	Co-Payment \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of Secondary Insurance (if applicable)		Subscriber's name:		Group N°:	Policy N°:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address)	Relationship to patient:	Home phone N°: ()	Work phone N°: ()

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the Physician. I understand that I am financially responsible for any balance. I also authorize Lindo Medical Care, LLC or insurance company to release any information required to process my claims.

_____ Patient/Guardian signature

_____ Date



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

PATIENT NAME:

DOB: m / d / y

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply)

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chem Dependency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> TB |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | LIST ANY OTHERS |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> |

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Do you know your blood type? Yes No Type: _____

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Drug name	Strength	Freq. Taken	Drug name	Strength	Freq. Taken
1			8		
2			9		
3			10		
4			11		
5			12		
6			13		
7			14		

ALLERGIES TO MEDICATIONS

Drug name	Reaction you had	Drug name	Reaction you had
1		3	
2		4	

VACCINES

Vaccine Name	Date Received	Vaccine Name	Date Received	Other Vaccines	Date Received
<input type="checkbox"/> Covid	m / d / y	<input type="checkbox"/> Pneumonia	m / d / y		m / d / y
<input type="checkbox"/> Covid Booster	m / d / y	<input type="checkbox"/> Shingles	m / d / y		m / d / y
<input type="checkbox"/> Flu	m / d / y	<input type="checkbox"/> Tetanus	m / d / y		m / d / y



PATIENT NAME:

DOB: m | d | y

HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	<input type="checkbox"/> Sedentary (no exercise)	
	<input type="checkbox"/> Mil exercise (i.e., climb stairs, walk 3 blocks, golf)	
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)	
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)	
Diet	Are you dieting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat on an average day?	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola	
	# of cups/cans per day?	
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?	
	How many drinks per week?	
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes - pks./day <input type="checkbox"/> Chew - #/day <input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day	
	# of years or year quit	
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision of hearing loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss the issue with a doctor or his staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

Relation	Age	Age of death	Significant Health Problems
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SCREENINGS

Last Colonoscopy:	m d y	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Cholesterol screening:	m d y	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Test for blood in stools:	m d y	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Electrocardiogram:	m d y	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal



PATIENT NAME:

DOB: m | d | y

REVIEW OF SYSTEMS

CONSTITUTIONAL <input type="checkbox"/> Wt. loss or gain <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills EYES <input type="checkbox"/> Blurry vision <input type="checkbox"/> Double vision <input type="checkbox"/> Vision Changes <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma ENT/MOUTH <input type="checkbox"/> Sinus problems <input type="checkbox"/> Runny nose <input type="checkbox"/> Tooth pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing ears <input type="checkbox"/> Gum pain <input type="checkbox"/> Gum bleeding <input type="checkbox"/> Swallowing difficulties <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge ALLERGY/IMMUNO <input type="checkbox"/> Rashes/hives/wealts <input type="checkbox"/> Itchiness <input type="checkbox"/> Allergic asthma/bronchitis	NEURO <input type="checkbox"/> Dizziness <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Headache <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Balance Problems <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness PSYCH <input type="checkbox"/> Depression <input type="checkbox"/> Mood swings <input type="checkbox"/> Memory problems <input type="checkbox"/> Anxiety ENDO <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Hair loss <input type="checkbox"/> Nail changes <input type="checkbox"/> Night sweats <input type="checkbox"/> Hot flashes HEM/LYMP <input type="checkbox"/> Bruising <input type="checkbox"/> Nosebleed <input type="checkbox"/> Lack of energy	GENITOURINARY <input type="checkbox"/> Burning urination <input type="checkbox"/> Excessive urination <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent bladder/kidney infections <input type="checkbox"/> History of sexually transmitted disease GASTROINTESTINAL <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Incontinence of bowels <input type="checkbox"/> Blood in stools <input type="checkbox"/> Bloating <input type="checkbox"/> Poor appetite <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea SKIN <input type="checkbox"/> Skin rashes <input type="checkbox"/> Bruising <input type="checkbox"/> Changes in skin lesions <input type="checkbox"/> Wounds <input type="checkbox"/> Ulcers	RESPIRATORY <input type="checkbox"/> Frequent lung infections <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest highness <input type="checkbox"/> Wessing <input type="checkbox"/> Sleeping problems <input type="checkbox"/> Persistent cough <input type="checkbox"/> Asthma CARDIOVASCULAR <input type="checkbox"/> History of Rheumatic fever <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pain <input type="checkbox"/> Swealing hands <input type="checkbox"/> Swealing feet <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> High or low blood pressure MUSC/SKELETAL <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Muscle pains <input type="checkbox"/> Back pain <input type="checkbox"/> Pain during walking
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WOMEN ONLY

Age at menstruation:	Last PAP smear	m d y	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Number of pregnancies:	Number of live births:	Date of or age at last menstruation:		
Last Mammogram	m d y	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	Bone Density Screening:
Experienced any recent breast tenderness, lumps, or nipple discharge?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Last rectal exam	m d y	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	

MEN ONLY

Do you usually get up to urinate during the night	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, # of times	
Do you fell burning discharge from penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the las 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last prostate and rectal exam:		m d y	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Last PSA test (if any):		m d y	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Is there anything else you would like to discuss with the doctor?

I have reviewed this history with the patient for accuracy and completeness:

Physician signature and date



PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance.

Declaration to Decline Life-Prolonging Procedures

I have I have NOT made a Living Will

Health Care Surrogate

I have I have NOT designated a Health Care Surrogate

Durable Power of Attorney

I have I have NOT appointed a Durable Power of Attorney for Health Care Decisions

If you have a living will and/or an assigned health care surrogate we will gladly make a copy of your documents and place it in your chart

PATIENT PRIVACY QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations)

Name: _____	Name: _____
Address: _____	Address: _____
Phone Number: _____	Phone Number: _____
Relationship: _____	Relationship: _____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name: _____	Phone Number: () _____
Name: _____	Phone Number: () _____

III. Please indicate your understanding that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL":

Check here to indicate that this statement was read

IV. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

Yes No

V. Please print the phone number where you want to receive calls about your appointments

I am fully aware that a cell phone is not a secure and private line

PATIENT NAME AND DATE OF BIRTH

___/___/___

LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE TODAY'S

20 _____



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ (Patient's name)
SS# _____ Date of birth _____

Authorize: _____ (Name of person who is to release information)
Address: _____ Phone: _____

To release information from my medical records. Requested medical information includes

- Information of Psychological, alcohol or drug related nature
- HIV Antibody Test results and AIDS records
- Office notes, Lab Work, Testing & X-rays
- Other

For: Alfredo Lindo, MD

To:

6463 Oregon Jay Road Brooksville, FL 34613 Ph: (352) 596-6114 Fx: (352) 596-0784

The information will be used for the following purpose:

Continued Medical Care _____	Insurance _____
Legal Follow Up _____	Disability _____
Personal Information _____	Other _____

The information to be released shall include:

******IF RECORDS EXCEED 10 PAGES, PLEASE MAIL, DO NOT FAX******

I understand that this consent shall be valid for a period of 1 year from the date authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I further understand that the confidentiality of this information may be protected by Federal Regulations (42 CFR, Part II), prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

Patient's Signature

Date of Signature