LINDO MEDICAL CARE

REGISTRATION FORM

Today's Date: _____ PCP: _____

PATIENT INFORMATION						
Patient's last name: First: Middle:			☐Mr. ☐Miss ☐Mrs. ☐Ms.	Marital Status (Circle One) Single Mar Div Sep Wid		
Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	(Former name):	DOB: m| d | y	Age:	Sex: ☐Male ☐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? ☐Advertising ☐Internet ☐Insurance Plan ☐Hospital ☐Close to home/work ☐Family ☐Friend ☐Dr: ☐Other:						

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

LINDO MEDICAL CARE

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)

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

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
☐ Covid	m / d / y	☐ Pneumonia	m / d / y		m / d / y
☐ Covid Booster	m / d / y	☐ Shingles	m / d / y		m / d / y
☐ Flu	m / d / y	☐ Tetanus	m / d / y		m / d / y

LINDO MEDICAL CARE

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	☐Sedentary (no exercise)				
	☐Mil exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐Regular vigorous exercise (i.e., work or recreation 4x/week for 30 min.)				
Diet	Are you dieting?				☐Yes ☐No
	If yes, are you on a physician prescribed medical diet?				☐Yes ☐No
	# of meals you eat on an average day?				
Caffeine	☐None	☐Coffee	☐Tea	☐Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?				☐Yes ☐No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?				☐Yes ☐No
	☐Cigarettes - pks./day	☐Chew - #/day	☐Pipe - #/day	☐Cigars - #/day	
	# of years or year quit				
Drugs	Do you currently use recreational or street drugs?				☐Yes ☐No
	Have you ever given yourself street drugs with a needle?				☐Yes ☐No
Personal Safety	Do you live alone?				☐Yes ☐No
	Do you have frequent falls?				☐Yes ☐No
	Do you have vision of hearing loss?				☐Yes ☐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?				☐Yes ☐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?	☐Yes ☐No
Do you feel depressed?	☐Yes ☐No
Do you panic when stressed?	☐Yes ☐No
Do you have problems with eating or your appetite?	☐Yes ☐No
Do you cry frequently?	☐Yes ☐No
Have you ever seriously thought about hurting yourself?	☐Yes ☐No
Do you have trouble sleeping?	☐Yes ☐No
Have you ever been to a counselor?	☐Yes ☐No

SCREENINGS

Last Colonoscopy: m d y	☐Normal	☐Abnormal	Cholesterol screening: m d y	☐Normal	☐Abnormal
Test for blood in stools: m d y	☐Normal	☐Abnormal	Electrocardiogram: m d y	☐Normal	☐Abnormal

LINDO MEDICAL CARE

PATIENT NAME: DOB: m d y

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Wt. loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills

EYES
- ☐ Blurry vision
- ☐ Double vision
- ☐ Vision Changes
- ☐ Cataracts
- ☐ Glaucoma

ENT/MOUTH
- ☐ Sinus problems
- ☐ Runny nose
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Gum pain
- ☐ Gum bleeding
- ☐ Swallowing difficulties
- ☐ Ear pain
- ☐ Ear discharge

ALLERGY/IMMUNO
- ☐ Rashes/hives/wealts
- ☐ Itchiness
- ☐ Allergic asthma/bronchitis

NEURO
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Lack of coordination
- ☐ Balance Problems
- ☐ Seizures
- ☐ Numbness

PSYCH
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

ENDO
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Nail changes
- ☐ Night sweats
- ☐ Hot flashes

HEM/LYMP
- ☐ Bruising
- ☐ Nosebleed
- ☐ Lack of energy

GENITOURINARY
- ☐ Burning urination
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections
- ☐ History of sexually transmitted disease

GASTROINTESTINAL
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Incontinence of bowels
- ☐ Blood in stools
- ☐ Bloating
- ☐ Poor appetite
- ☐ Hemorrhoids
- ☐ Nausea

SKIN
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

RESPIRATORY
- ☐ Frequent lung infections
- ☐ Shortness of breath
- ☐ Chest highness
- ☐ Wessing
- ☐ Sleeping problems
- ☐ Persistent cough
- ☐ Asthma

CARDIOVASCULAR
- ☐ History of Rheumatic fever
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swealing hands
- ☐ Swealing feet
- ☐ Irregular heart beat
- ☐ High or low blood pressure

MUSC/SKELETAL
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Back pain
- ☐ Pain during walking

WOMEN ONLY

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

MEN ONLY

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

LINDO MEDICAL CARE

PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having and 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 if 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 QUESTIONAIRE

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

_____ 20___

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE TODAY'S

LINDO MEDICAL CARE

CONSENT TO TREAT

I, the undersigned voluntarily give consent to LINDO MEDICAL CARE, LLC Physicians medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ DOB: m / d / y Date: m / d / y

Patient's name

_____

Signature of Patient/Legal Representative

RECEIPT OF NOTIVE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the LINDO MEDICAL CARE, LLC Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ DOB: m / d / y Date: m / d / y

Signature of Patient/Legal Representative

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

AUTHORIZATION AND ASSIGNMENT

I hereby authorize LINDO MEDICAL CARE, LLC practice location to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to LINDO MEDICAL CARE, LLC (or named physicians or affiliates) for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ Date: m / d / y

Signature of Patient/Legal Representative

LINDO MEDICAL CARE

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: Oscar J. Lindo, MD Mari Castello, MD

To:

☐ 10045 Cortez Blvd.. Ste 154
Brooksville, FL 34613
Ph: (352) 596-6114
Fx: (352) 596-0784

☐ 12587 Spring Hill Drive
Spring Hill, FL 34609
Ph: (352) 600-7960
Fx: (352) 606-3932

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