

PATIENT REGISTRATION FORM
(Please Print)

Yvonne Santiago, MD PA
16590 N. Dale Mabry Hwy
Tampa, FL 33618
813-960-7959 fax 866-719-9898

Patient: _____ Birthdate: _____
Address: _____ S.S No: _____
_____ Home Phone: _____
_____ Cell Phone: _____

Email: _____
Marital Status: Single Married Divorced Separated Widow/er:

PERSON RESPONSIBLE FOR BILL OR PRIMARY IN THE INSURANCE:

Name: _____ S.S. No. _____
Address: _____ Relationship: _____
Date of Birth: _____ Phone: _____

EMPLOYER

Patient Employed by: _____
Address: _____ Phone: _____
Spouse Employed By: _____
Address: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
Relationship to You: _____ Cell Phone: _____

PRIMARY INSURANCE

Company _____
Address: _____

Group # _____
ID Policy # _____

SECONDARY INSURANCE

Company _____
Address _____

Group # _____
ID Policy # _____

Due to the increased cost of mailing statements, and to help keep our fees as low as possible, we find it necessary to expect our patients to pay their co-pay or non-insurance expenses at the time of service. If you need to cancel an appointment, please notify the office at least 1 day in advance of the appointment.

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

Signed: _____ Date: _____
(Patient or Parent if Minor)

ASSIGNMENT OF BENEFITS:

I authorize payment of medical benefits to myself or the names provided for professional services rendered.

Signed: _____ Date: _____

Release of Information:

I authorize the release of any medical information necessary to process this claim or as required by law.

Signed: _____ Date: _____

HIPAA:

I have reviewed the office record policy and had my questions answered

Signed: _____ Date: _____

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Thank You for Choosing Our Office!

YVONNE SANTIAGO, MD PA

Name: _____ Date of Birth: _____

Previous Medical Providers name and address: _____

Allergies and reaction: _____

Preferred Pharmacy: _____ Location: _____ Phone # _____

Medications: (Prescription and Over the Counter Medicine) Include Name, Dosage and Frequency:

| | |
|----|-----|
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS:

| Problem/Date | Problem/Date | Problem/Date |
|--------------|--------------|--------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you had a transfusion of blood or blood products? Yes No If yes did you have any reaction? Yes No

PERSONAL & SOCIAL HISTORY

ALCOHOL/TOBACCO/DRUGS RISK SCREEN:

Do you use cigarettes, pipes, cigars or chew tobacco? Yes No If yes, packs per day _____ # years _____ Quit date? _____

Do you drink alcohol? Yes No If yes, how many drinks per day _____ or per week _____.

Is your alcohol use a concern to you or others? Yes No

Do you drink coffee, sodas, or other caffeinated beverages? Yes No

Do you use any street drugs or abuse prescription pain medications? Yes No

Social History

Do you think you are at risk for HIV, AIDS or other Sexually Transmitted disease? Yes No

Have you ever been tested for HIV? Yes No

If yes, when _____ / _____. What was the result? _____.

Sexual Activity: Sexually Active Yes No Current sex partner: male female Birth Control Method: _____

Marital Status: Married Single Divorced Widow(er) Separated

Spouses/ Partner's name: _____ # of children _____ Who lives at home with you _____

Education: Jr. High School High School/ GED Vocational School College Other: _____

Occupation: _____ Do you have an Advanced Directive? Yes No

Family History

| Family Member | Age | Alive/Deceased | Health | Cause of Death |
|--|-----|--|--------|----------------|
| Father | | <input type="checkbox"/> Alive <input type="checkbox"/> Deceased | | |
| Mother | | <input type="checkbox"/> Alive <input type="checkbox"/> Deceased | | |
| <input type="checkbox"/> Brother <input type="checkbox"/> Sister | | <input type="checkbox"/> Alive <input type="checkbox"/> Deceased | | |
| <input type="checkbox"/> Brother <input type="checkbox"/> Sister | | <input type="checkbox"/> Alive <input type="checkbox"/> Deceased | | |

| Family History | Relative | Relative |
|---|----------|--|
| 1. Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | 9. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 2. Breast Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | 10. Ovarian Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 3. Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | 11. Prostate Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 4. Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | 12. Cancer _____ <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 5. Depression/ Suicide <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | 13. Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 6. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | 14. Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 7. High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | 15. Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 8. Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | 16. Substance Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| | | 17. Other: _____ |

Health Maintenance

Last Stools, occult blood test ____/____ Colonoscopy ____/____ Bone Density ____/____ Dental Exam ____/____

Dilated Eye Exam ____/____ Foot Exam ____/____ Physical Exam ____/____

Women: Last: Pap Smear: ____/____ Mammogram ____/____ Breast Exam ____/____ Menstrual Cycle ____/____

pregnancies : _____ # deliveries: _____ # abortions: _____ # miscarriages _____

Men: Last: Rectal/Prostate Exam ____/____ Testicular Exam ____/____ PSA: ____/____

Immunizations: Tetanus ____/____ Hepatitis B vaccine ____/____ MMR ____/____ Flu ____/____ Pneumonia ____/____

Tuberculosis Skin Test (date and results) _____

Do you use seatbelts consistently Yes No Do you have a gun at home Yes No Is violence at home a concern Yes No

Please review the list of symptoms below and check yes if you have had it within the last 6 months and no if you have not

| | | | | | |
|--------------------------------|--|---------------------------------|--|-----------------------------------|--|
| <u>Constitutional</u> | | <u>Pulmonary</u> | | <u>Men only</u> | |
| Unexplained weight loss/gain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problems with erection | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fevers/ chills/ sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wheezing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weak urine stream | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fatigue/weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain in testicles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nausea or vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No | <u>Skin</u> | | <u>Musculoskeletal</u> | |
| <u>Eyes</u> | | Skin changes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Pain/Stiffness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change in vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rashes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Red or swollen joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Red Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | <u>Gastrointestinal</u> | | <u>Hematology/oncology</u> | |
| <u>ENMT</u> | | Blood/or black in stool | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia or low blood | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding from gums | <input type="checkbox"/> Yes <input type="checkbox"/> No | Change in movements | <input type="checkbox"/> Yes <input type="checkbox"/> No | Easily bruise | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Problems hearing/ringing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Swallowing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen lymph nodes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change in your voice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heartburn | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nose Bleeds | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nausea or vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unexplained lumps or bumps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <u>Cardiovascular</u> | | <u>Genitourinary</u> | | <u>Psychiatric</u> | |
| Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problems Urinating | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression/ sadness/anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood in Urine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problems with memory | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Leg Pain with walking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Incontinence | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Concentrating | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swelling in Legs | <input type="checkbox"/> Yes <input type="checkbox"/> No | <u>Women Only</u> | | Problem sleeping | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Palpitations, rapid heartbeats | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problems with your period | <input type="checkbox"/> Yes <input type="checkbox"/> No | <u>Neurology</u> | |
| <u>Pulmonary</u> | | Vaginal dryness/ discharge | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breast lump or nipple discharge | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Wheezing | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Numbness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Print and Sign _____ Date: _____ Physician Sign _____ Date: _____

Yvonne Santiago, MD PA

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security# _____

I Request and Authorize _____

To release healthcare information of the patient named above to:

Yvonne Santiago, M.D.
16590 N. Dale Mabry Hwy
Tampa, FL 33618

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates:

- All healthcare information

- Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes simplex, human papilloma virus, wart, condyloma, Chlamydia, non-specific arthritis, syphilis, VDRL, chancroid, lymphogranulomavenereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

- Yes No I authorize the release of my STD results, HIV/ AIDS testing, whether negative or positive, to the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

- Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

This authorization expires ninety days after it is signed.

