DATE:_____

LOURDES T. SANTIAGO, M.D., P.A.
1305 S. Fort Harrison Ave. Building A, Clearwater, FL 33756
Phone: (727) 483-9188 Fax: (727) 412-8432

Patient Name: _____ Date of Birth: _____ Patient age: _____

Male or Female: _____ Social Security #:_____

Race: _____ Language: _____Hispanic or Latino?_____

Patient Address: _____

Patient Email: _____

Patient Phone (H): _____ (W)_____(c) _____

Primary Care Physician Name: _____Phone #:_____ Fax#:_____

Referred By: _____ Phone #:_____ Fax#:_____

Emergency Contact:_____Phone:_____Relationship:_____

Pharmacy:_____ Phone #:_____ Fax#:_____

Primary Health Insurance
Plan name: _____
Subscriber/Member ID: _____
Secondary Health Insurance
Plan Name: _____
Subscriber/Member ID: _____

Other provider's involver in your care and their specialty:

_____

_____

PERMISSION FOR TREATMENT

The undersigned hereby voluntarily consents to medical care, diagnostic treatment, and/or minor surgical treatment by Lourdes T. Santiago, M.D., P.A. deemed advisable and necessary in the diagnosis and treatment of any condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to this was a result of treatment or examination in the office. I authorize the ease of any past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature of Patient/Responsible party _____Date_____

PATIENT FINANCIAL POLICY

-As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office and/or by our physician(s).

- You agree to have your insurance company pay the doctor directly. If your insurance does not pay the practice, you understand you may be billed for any services rendered.
-We require you to pay the co-payment, co-insurance, and/or deductible at the time of service.
-You must inform the office of all Insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
-There are certain elective surgical procedures that we require pre-payment. You will be informed in advance. In those cases, payment will be made at the time the surgical procedure is scheduled.
-There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee and can only be paid by Money order

Signature of Patient/Responsible party _____Date_____

DATE:_____

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Patient Name: _____ Date of Birth: _____ Patient age: _____

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by Lourdes T. Santiago, M.D., P.A. I authorize any holder of medical information about me to release to CMS/Insurance Carrier(s) and their agents any information needed to determine these benefits or benefits related to services.

l hereby authorize Lourdes T. Santiago M.D., P.A. to furnish information to CMS and/or other Insurance Carrier(s) concerning any medical condition, illness(es) and treatment to determine the benefits for related services. I hereby authorize (assign) CMS and/or other Insurance Carrier(s) to make payment directly to Lourdes T. Santiago, M.D., P.A. for medical diagnostic, and/or surgical benefits payable for the services rendered.
Signature of Patient/Responsible party _____Date_____

NO SHOW and CANCELLATION POLICY

Office appointments cancelled or no showed with less than 24 hours notification may be subject to $50.00 Cancellation/NO SHOW Fee.
Procedure appointments cancelled with less than 5 business day advance notification may be subject to $100.00 Cancellation Fee.
The Cancellation and No-Show Fees are the sole responsibility of the patient, and must be paid in full before the patient's next scheduled appointment.
Signature of Patient/Responsible party: _____Date_____

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES / HIPPA

By signing this Written Acknowledgement of Receipt of Privacy Practices, I hereby expressly acknowledge my receipt of the Notice of Privacy Practices.
Signature of Patient/Responsible party: _____Date_____

DESIGNATED PERSON

I give permission to the staff of Lourdes T. Santiago, M.D., P.A. to discuss my health information with the following person(s):
Myself
My Spouse:_____

My Children:_____

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

Please answer the following questions in order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statues:

-I have decided to Decline Life-Prolonging Procedures (Living Will) – DNR YES OR NO
~I have a Health Care Surrogate (Assigning another person to make medical decision). YES OR NO
~ I have a Durable Power of Attorney (This is done by a Attorney). YES OR NO

I have read and understood the above statement regarding the PATIENT SELF DETERMINATION ACT.

Signature of Patient/Responsible party: _____Date_____

DATE: _____

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Patient Name: _____ Date of Birth: _____ Patient age: _____

Reason for Visit

Please describe your reason for today's visit: _____

How long has this been going on? _____

Does anything make your condition worse: _____ No _____ Yes Please describe: _____

Does anything help with your condition: _____ No _____ Yes Please describe: _____

What are you hoping to get out of today's visit? _____

Medications Taken	Directions
1.	
2.	
3.	
4.	
5.	

Attach Medication list for additional space.

Do you have any Medication Allergies? _____No _____ yes, please list: _____

Are you Allergic to Latex? _No or Yes

Past Medical History: Circle or check all that apply.

Anemia	Depression	HIV	COPD
Arthritis	Cancer: Type_____	Spinal cord injury	Asthma
Atrial fibrillation (a-fib)	Kidney disease	Stroke: _____	Anal/rectal trauma
Angina (chest Pain)	Urinary incontinence	Vision impairment: _____	Celiac disease
Arrhythmia (heart rhythm problems	Hepatitis: type_____	Female: abnormal pap smear	Crohn's disease
Bleeding disorder	MRSA	Genital warts	Irritable bowel syndrome
Blood clots (DVT/ Embolism)	Neuropathy	Enlarged prostate	Diabetes
Anxiety	Seizures	Male: abnormal anal pap smear	Thyroid disease

Other: _____

Past Family History: check all that apply

	Deceased?	Cancer?	Celiac disease	Colon polyps	Crohn's	Ulcerative colitis	Other
Mother							
Father							
Brother/sister							
Grandfather							
Grandmother							

DATE:_____

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Past Surgical History: Circle or check all that apply

Colectomy (Removal of a Portion of Large Intestine/Colon)	Anal Sphincter Repair	Colostomy	Appendectomy
Sacral Nerve Stimulation	Small Bowel Resection	Ileostomy Stoma	cholecystectomy
Closure of ileostomy or Colostomy	Pilonidal Cyst Surgery	tonsillectomy	Hernia repair
Rectal Prolapse Repair (Abdominal or rectal	Hemorrhoid Surgery	Back surgery	Weight loss surgery
Sphincterotomy (Fissure Surgery)	Fistula Surgery	Heart stents	hysterectomy
Drainage of Abscess	Removal of prostate	Oral surgery	Bladder repair

Any Other surgeries not listed_____

_____

_____

Have you had any major problems with anesthesia? _____NO _____YES

Have you have any excessive bleeding with surgery? _____ NO _____Yes

Diagnostic Studies

Please check all that apply and indicate location and date study was performed.

Colonoscopy When / Where? _____
Flexible Sigmoidoscopy When / Where? _____
CT of Abdomen/Pelvis When / Where? _____
CT-PET When / Where? _____
Transit Time Study When / Where? _____
Mammogram (Females) When / Where? _____

Social History

Are you a current smoker? _____ NO _____Yes, how many packs per day _____
Are you a Former Smoker? _____ NO _____Yes, when did you quit? _____
Do you drink? _____ NO _____Yes, how many drinks per day _____
Marital status: _____single _____Married _____ Partnered _____Widowed.
Are you currently employed? _____ NO _____ Yes, occupation? _____
Have you ever used drugs? _____ NO _____Yes - Have you ever had anal sex? _____ NO _____Yes
HIV status _____ Negative _____positive _____Not tested.

.

DATE: _____

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Patient Name: _____ Date of Birth: _____ Patient age: _____

Symptoms	None	Mild	Moderate	Severe	Very Severe
Physical Exhaustion fatigue, (lack of energy, stamina)					
Sleep problems (difficulty falling asleep or sleeping through the night)					
Irritability (mood swings, feeling aggressive, angers easily					
Anxiety (feeling overwhelmed, feeling panicky or nervous)					
Decline in drive or interest (loss of "zest for life" feeling sad or down)					
Difficulties with memory					
Sweating (Night sweats or increased episodes of sweating)					
Hair loss, rapid thinning or change in texture					
Feeling cold all the time, having cold hands or feet					
Headaches or migraines (increase in frequency or intensity					
Weight (difficulty losing weight despite diet/exercise					
Bladder problems (difficulty in urinating, increased need to urinate					
Men Only					
Joint problems, Inability to add muscle					
Sexual desire or performance reduced or diminished					
Erectile changes (weaker erections, loss of morning erections)					
Ejaculations (infrequent or absent)					
Women Only					
Muscle weakness					
Vaginal dryness or difficulty with sexual intercourse					
Change in desire, activity, orgasm and/or satisfaction					
Hot flashes (burst that starts in the chest and lasts for a short duration					

Other symptoms or unique health circumstances to take into consideration: _____

DATE:_____

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Patient Name: _____ Date of Birth: _____ Patient age: _____

Review of symptoms

Circle or check any of the symptoms you are experiencing today.

— **Constitutional** — Chills	— **Integumentary:** (Skin} — Itching (pruritus)
— Fatigue or Weakness	— Rash
— Fever — gain of Recent weight IO or more lbs.	— **Neurological** — Dizziness(Light headed
— Recent unplanned weight loss of I 0 or more lbs	— Extremity numbness/ Tingling — Headaches
— **Hearing/Eyes/Vision(HEENT}** — Loss of hearing/ Diminished hearing	— Memory loss Seizures
— Loss of vision/ Change in vision	— **Psychiatric (Mental Health)** — Anxiety
— **Respiratory** — Chronic or frequent coughing	— Depression
— Shortness of breath	— **Metabolic/Endocrine**
— **Cardiovascular**	— Cold intolerance
— Chest pain	— Heat intolerance
— Irregular heartbeat (palpitations)	— Excessive thirst or urination (polydipsia)
— **Hematologic/Lymphatic (Bleeding)** — Pain with urination (dysuria)	— **Musculoskeletal** — Back pain
— **Gastrointestinal** — Abdominal pain	— Joint pain
— Blood in stools — Change in stools	— **Genitourinary** — Blood in urine (hematuria)
— Constipation	— Urinary incontinence (leakage of urine) Easy bleeding
— Diarrhea	— **Reproductive (Females)**
— Accidental Bowel Leakage (ABL)	— Painful intercourse (dyspareunia)
— Loss of appetite — Nausea	—
— Vomiting	—

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Patient Name: _____ Date of Birth: _____ Patient age: _____

REQUEST FOR MEDICAL RECORDS

INFORMATION REQUEST AND NEEDED FROM

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY INDIVIDUAL identifiable health information as Described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
I understand that this content shall be valid for a period of one year from the date or 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 understand that I may revoke this authorization at any time by notifying the providing organization in writing; l also understand this will not have any effect on the actions taken prior to receiving the revocation.

I further understands that the **CONFIDENTIALITY OF TIDS INFORMATION MAY BE PROTECTED BY Federal Regulations (42CFR, Part 11.).** Prohibiting any further disclosure of this information without specific written authorization of the undersigned or otherwise regulated.

Patient Name | Date of Birth

Signature of Patient or Patient's Legal Representative | Date

Representative's Name | Relationship to the Patient

PLEASE SEND THE FOLLOWING

PROGRESS-NOTES

HISTORY & PHYSICAL

LABS, X-RAVS, EKGS

MEDICATION SHEET

SUMMARY OR CARE

Mark the appropriate box for each symptom you may be experiencing.