WELLCOME TO MARTINEZ CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, MD

_____
Today's date

PATIENT INFORMATION

Name : _____
Last **First** **Middle Initial**

Address : _____
City, State, Zip Code

Home phone: _____ **Cell phone:** _____ **SS Number** _____ - _____-_____

Email : _____@_____.com **Sex:** ____F ___M **Date of Birth:** _____-_____- _____

_____**Minor** _____**Single** _____**Married** _____**Divorced** _____**Widowed** **Language:**_____

Ethnicity: ____ **Caucasian** _____**African-American** _____**Latino** _____**Other** _____

Whom should we thank for referring you? _____

Emergency contact: _____ **Phone:** _____**Occupation:**_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____

Company Address: _____**Phone:**_____

Insured's Name: _____**DOB:**_____

Policy No:_____ **Group No.** _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Company Address : _____**Phone:**_____

Insured's Name: _____**DOB:**_____

Policy No.:_____ **Group No.** _____

I hereby authorize payment directly to Bayoan Martinez-Cruz, M.D. of all insurance benefits, otherwise payable to me for Service rendered. I understand that I am financially responsible for all charges and services rendered, whether or not paid by insurance, on behalf of myself and my dependents. I authorize the above doctor/provider/supplier or services in this office to release any information required to secure the payment of benefits.

_____ _____
Signature of Responsible Party **Today's date**

MARTINEZ CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, MD

Name: _____ _____ ____ _____
Last First M.I. Date of Birth

MEDICAL HISTORY

Purpose of your visit today: _____

Past illnesses, including dates:

_____

_____

Surgeries, including dates: _____

_____

_____

Allergies to medications? Please list, including reaction(s): _____

_____

Current medications, including dosages and frequency: _____

_____

_____

Immunizations, including dates:

Influenza: _____ Pneumonia _____ Shingles _____

SOCIAL HISTORY

Marital Status: ____Married ____ Single ____ Divorced ____Widowed Children ages _____

Smoker: ____Yes ____No If stopped, when, and how long did you smoke? _____

Alcohol use: ____No ____Occasional ____Frequent Exercise: ____Never ____Occasional ____Frequent

FAMILY HISTORY

	Living/Deceased	If deceased, date and cause of death
Father	_____	_____
Mother	_____	_____
Sibling(s)	_____	_____
	_____	_____
Children:	_____	_____

MARTINEZ-CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
BAYOAN MARTINEZ-CRUZ, M.D.

Name: _____ _____ ___ _____
Last First M.I. Date of Birth

REVIEW OF SYMPTOMS THAT YOU FREQUENTLY HAVE

GENERAL	EYES	EARS
• Weakness • Fatigue • Fever • Night sweats • Dizziness • Headaches • Weight loss • Weight gain • Others _____ • None	• Contact lenses • Cataracts • Blurred vision • Glaucoma • Double vision • Pain • Others _____ • None	• Hard of hearing • Deafness • Ringing • Ear ache • Dizziness • Wax • Others _____ • None
NOSE	**MOUTH/THROAT**	**BREASTS**
• Nose bleeds • Pain • Nasal drip • Runny nose • Sinus congestion • Polyps • Others _____ • None	• Bleeding • Ulcers • Sore throat • Hoarseness • Difficulty to swallowing • White spots • Loss of taste • Gum problems • Others _____ • None	• Discharge • Nodules/lumps • Skin changes • Tenderness • Others _____ • None
LUNGS	**HEART**	**GASTROINTESTINAL**
• Cough • Shortness of breath • Wheezing • Asthma • Chest pain • Congestion • Blood • Phlegm • Others _____ • None	• Palpitations • Chest pressure • Rapid heart beat • Blood clots • Murmur • Swollen legs • Others _____ • None	• Abdominal pain • Nausea/vomiting • Indigestion • Constipation • Blood in stool • Irregular bowels • Food intolerance • Heartburn • Others _____ • None
GENITOURINARY	**GYNECOLOGICAL**	**MUSCULOSKELETAL**
• Urgency • Incontinence • Flank pain • Kidney stones • Frequent urination at night • Blood in urine • Bed wetting • Burning while urinating • Others _____ • None	• Post menopausal • Vaginal discharge • Hot flashes • Painful intercourse • Menstrual cramps • Loss of libido • Others _____ • None	• Pain • Cramps • Joint pain/stiffness • Back pain • Joint swelling • Injuries • Weakness • Others _____ • None
NEUROLOGICAL	**PSYCHIATRIC**	**ENDOCRINE**
• Seizures • Hand trembling • Slurred speech • Shuffling gait • Tingling/numbness • Paralysis • Weak grip • Loss of sensation • Others _____ • None	• Depression • Poor sleep • Anxiety • Panic attacks • Mania • Obsessiveness • Suicidal thoughts • Others _____ • None	• Diabetes • Hypoglycemia • Heat/cold intolerance • Loss of hair • Erectile dysfunction • Others _____ • None