



Patient Name: _____ Today's Date: _____

How did you hear about us?

- Friend/Family
- Google
- Advertisement (Postcard on the mail)
- Doctor
- Website: _____
- Other: _____

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

Today's date

PATIENT INFORMATION

Name: _____
Last First Middle Initial

Address: _____
City, State, ZIP

Home Phone: _____ Cell: _____ Email: _____

SS Number: _____ - _____ - _____ Date of Birth _____ - _____ - _____ Occupation _____

Sex: M F Minor Single Married Divorced Widowed

Ethnicity: Caucasian African-American Hispanic Other _____ Language: _____

Whom should we thank for referring you? _____

Emergency contact: _____ Phone: _____

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. _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Bayoan Martinez-Cruz, M.D. of all insurance benefits otherwise payable to me for services 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 of 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, M.D.

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

REVIEW OF SYMPTOMS THAT YOU FREQUENTLY HAVE

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



Name _____

Date _____

PATIENT HEALTH QUESTIONNAIRE

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use X to indicate your answer)

		1	2	3	4
Questions		Not at all	Several days	More than half the days	Nearly everyday
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling/staying asleep, sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety/restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid if something awful might happen	0	1	2	3
8	How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
		0	1	2	3



MARTINEZ CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLC
741 Hwy 466, Lady Lake, Florida 32159

NAME : _____ **DATE :** _____

CAGE-AID:

DO YOU SMOKE, DRINK ALCOHOL, OR USE ANY RECREATIONAL OR NON-PRESCRIPTION DRUG? YES ___ NO ___

IF YES, WHICH ONES, AND HOW MUCH DO YOU NORMALLY USE OR HAVE IN A WEEK'S TIME? _____

HAVE YOU EVER FELT THAT YOU SHOULD CUT DOWN ON YOUR DRINKING, SMOKING OR DRUG USE? YES ___ NO ___

HAVE PEOPLE ANNOYED YOU BY CRITICIZING YOUR DRINKING, SMOKING OR RECREATIONAL DRUG USE? YES ___ NO ___

HAVE YOU EVER FELT BAD OR GUILTY ABOUT YOUR DRINKING, SMOKING OR RECREATIONAL DRUG USE: YES ___ NO ___

HAVE YOU EVER HAD A SMOKE, DRINK OR SOME OTHER KIND OF RECREATIONAL DRUG OR PAIN-KILLER IN THE MORNING,
TO STEADY YOUR NERVES OR GET RID OF HANGOVER? YES ___ NO ___

THANK YOU VERY MUCH!

*WE ARE LOOKING FORWARD TO WORKING TOGETHER WITH YOU TO HELP YOU FEEL MUCH BETTER!

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

Dear Patient:

Florida statutes require that we provide our patients with information concerning their rights to a Living Will and/or Advanced Directive.

An **ADVANCED DIRECTIVE** is a witnessed statement made by a competent member regarding his/her wishes or desires in regard to future health care (for example, provide artificial life support).

A **LIVING WILL** is a formalized version of an **ADVANCED DIRECTIVE**.

Please take this information home and carefully review it. If you wish to execute an Advanced Directive or Living Will, please notify this office on your next visit.

I have received a copy of Health Care Directives and understand my rights relating to Advanced Directive and Living Will.

PLEASE CHECK ONE:

_____ **I do not have a Living Will.**

_____ **I do have a Living Will and will provide a copy to this office.**

Florida law requires that your health provider or healthcare facility recognize your rights while you are receiving medical care, and that you respect the healthcare providers or healthcare facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your healthcare provider or healthcare facility.

Patient's signature: _____

Printed name: _____

Witness: _____

Date: _____

**WELCOME TO MARTINEZ CRUZ MEDICAL ASSOCIATES OF THE VILLAGES, LLL
BAYOAN MARTINEZ-CRUZ, MD**

AUTHORIZATION FOR REQUEST/RELEASE OF MEDICAL RECORDS

Patient's Name: _____

Date of Birth: _____

Phone: _____

Requesting from: _____

Fax: _____

I authorize the release of the following of my protected health information:

All Records

Office Notes

Radiology Reports

Pathology Reports

Laboratory Reports

EKG Results

Last Office Notes

Other _____

To: Martinez Cruz Medical Associates, LLC
741 Hwy 466, Lady Lake, Florida 32159
Phone: (352)750-6650 Fax: (352)750-6653

The purpose of this authorization is for:

Medical Treatment

Other (specify) _____

Patient's signature

Date

Patient's name (print)

If the patient listed above is a minor or is unable to sign and you're a parent, legal guardian or personal representative signing on behalf of the patient, please sign below:

Signature

Date

Representative name (print)

Relationship to the patient

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

HIPAA NOTICE OF PRIVACY PRACTICES

My signature on this document acknowledges that I have received the Martinez-Cruz Medical Associates of The Villages, LLC HIPAA Notice of Privacy Practices.

LIFETIME AUTHORIZATION

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

RELEASE OF INFORMATION: I, the below named patient, do hereby authorize any physicians examining and/or treating me to release to any third payer (such as an insurance company or governmental agencies, e.g., Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol or drug-related condition, and records concerning diagnosis and treatment when requested by such third parties for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT: I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me or any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID: Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify that all insurance pertaining to treatment shall be assigned to the physician treating me.

PERMIT A COPY OF THIS AUTHORIZATION AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE: This assignment will remain in effect until revoked by me in writing.

CONSENT FOR TREATMENT: I, the below named patient, hereby give my consent for treatment to all physicians associated with Martinez-Cruz Medical Associates of The Villages, LLC.

CONSENT TO DISCUSS MEDICAL CONDITION OR RELEASE RECORDS: I, the below named patient, do hereby authorize Martinez-Cruz Medical Associates of The Villages, LLC to discuss my medical condition with, or release my medical records to the below named person(s):

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NO SHOWS/LAST MINUTE CANCELLATIONS/LAST MINUTE RESCHEDULES: Providers and staff of Martinez-Cruz Medical Associates of The Villages, LLC rely on the prescheduled appointments to plan their day-to-day activities. Last minute reschedules or cancellations and no-shows disrupt the daily activities and also curtail the ability to schedule another member/patient in your prescheduled slot. If you have to cancel or reschedule your appointment, please provide us with at least 48 hours of prior notice. If you reschedule, cancel, or are a no-show to your prescheduled appointment, we may charge a \$25.00 fee directly to you. Please note that this charge will not be billed to any third party (including your insurance) but directly to you, and you will be responsible for payment of this charge prior to any further encounters.

COLLECTION AGENCY: In the event your account becomes delinquent and is turned over to a collection agency and/or attorney, you will be financially responsible for all associated collection fees and legal fees that Martinez-Cruz Medical Associates of The Villages, LLC incurs through the process utilized to collect the delinquent balance. Please be aware that if your account is turned over to a collection agency, you can be discharged from the practice. _____

RETURNED CHECKS: Checks returned to Martinez-Cruz Medical Associates of The Villages, LLC by its bank will be assessed a returned check fee, in addition to the original amount of the check. You will have ten (10) days to clear up the outstanding check. If you do not pay the check plus the returned check fee in the specified time, the check will be sent to the State Attorney's Office for further collection. _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, while others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance, and/or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed sixty (60) days.

DATE: _____ PATIENT'S SIGNATURE: _____

SUBSCRIBER'S SIGNATURE (if different from patient): _____

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

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Martinez-Cruz Medical Associates of The Villages, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Bayoan Martinez-Cruz, M.D.'s *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

With my consent, Martinez-Cruz Medical Associates of The Villages, LLC may call designated locations and leave messages on voicemail or in person regarding any items that assist the practice of carrying out TPO, such as appointment reminders, insurance issues, and any call pertaining to my clinical care, including laboratory results, among others. Also, with my consent, Bayoan Martinez-Cruz, M.D. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements

By signing this form, I am giving my consent to Martinez-Cruz Medical Associates of The Villages, LLC for use and/or disclosure of my PHI to carry out TPO. If I do not sign this consent, the practice may decline to provide treatment to me. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance on my prior consent.

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, understand that Martinez-Cruz Medical Associates of The Villages, LLC is authorized by me to use or disclose my PHI for treatment, payment, or other health care operations. I specifically authorize any current employee or owner of Martinez-Cruz Medical Associates of The Villages, LLC, or any other individual listed below, to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used/ disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so in writing, at any time.

Description of the information to be used/disclosed (check all that apply):

The patient's entire health record

Other: _____

Name(s) of person(s) that my PHI may be disclosed to, and my relationship to them (spouse, other family members, friends):

I understand that I have the right to revoke this authorization at any time. In order for the revocation to be effective, Martinez-Cruz Medical Associates of The Villages, LLC must receive the revocation in writing. I also understand that by signing below, I am giving Martinez-Cruz Medical Associates of The Villages, LLC consent for my treatment, and that I agree to all the terms listed above.

Patient's signature: _____

Date: _____

Print patient's name: _____

Legal guardian's signature: _____

Print legal guardian's name: _____

MARTINEZ CRUZ MEDICAL ASSOCIATES, LLC

MEMBERSHIP PROGRAM

(COVER FROM JANUARY 1ST- DECEMBER 31ST)

YEAR 2026

- \$700.00 ANNUAL FEE, VALID FOR FULL YEAR FOR PATIENTS WITH MEDICARE, PPO, AND SECONDARY INSURANCE ONLY.
- APPOINTMENTS ARE AVAILABLE UPON SAME DAY REQUEST OR THE FOLLOWING BUSINESS DAY.
- PATIENTS WILL HAVE MORE FACE-TO-FACE TIME WITH THE DOCTOR.
- PATIENTS WILL RECEIVE HIGHLY PERSONALIZED CARE, WHICH CAN LEAD TO LESS ILLNESS AND MUCH BETTER HEALTH.
- ROUTINE COMMUNICATION WITH DR. MARTINEZ-CRUZ WILL BE AVAILABLE TO YOU VIA EMAIL AND TEXT AFTER HOURS AND WEEKENDS.

-Email: drmartinezcruz@hotmail.com | Text only: (352) 446-4506

- IF YOU NEED TO SPEAK WITH DR. MARTINEZ-CRUZ, PLEASE CALL THE OFFICE DURING THE OFFICE HOURS, WHICH ARE FROM 7:00 AM TO 2:30 PM (MON-FRI) PLEASE PROVIDE YOUR FULL NAME, DATE OF BIRTH AND THE REASON FOR YOUR CALL AND ONE OF OUR OFFICE STAFF WILL RETURN YOUR CALL.

NOTE: THE MEMBERSHIP FEE COVER ANY OFFICE VISIT. IT'S THE PRIVILEGE OF BEING ABLE TO BE IN CONTACT WITH YOUR DOCTOR VIA EMAIL AND TEXT.

