7560 Red Bug Lake Road
Suite 2080
Oviedo, Florida 32765
Office: 407-365-9999

Zulma Cintron, M.D., FACP
Diplomate American Board of Internal Medicine

2018 version/ALL NEW PTS.

Registration (please print):

Date: ____________________ Home Phone: (____)_______________ Cell: (____)_______________

Patient: ____
(Last Name) (First Name) (Middle Name)

Date of birth: _______________ Age:_____ Sex: ☐ M ☐ F ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Responsible Party (if a minor):____

Address:____ City:______________________

State:____________ Zip Code:________________ E-Mail:____________________________________

Employer / School:____

Employer / School Address:____

Occupation:____ Work phone: (____)__________

Spouse (or responsible party) Name:___________________________ Birth date:__________________

Business Name and Address:____

Occupation:____ Work phone: (____)__________

Who is responsible for this account?____________________ Relationship to the patient:____________

Social Security #:___________________________ Spouse's Social Security #:____________________

Do you have medical insurance? ☐ Yes ☐ No ⇨ If yes,

Name of Primary Insurer:_____________________ Policy holder:______________________________

Contract #:____________________ Group #:_______________ Subscriber #:____________________

Name of Secondary Insurer (if any):___________________ Policy holder:________________________

Contract #:____________________ Group #:_______________ Subscriber #:____________________

☐ Medicare ☐ Medicaid Claim ID #:____

If Welfare, your number:____________________________ County of: __________________________

In case of emergency, who should be notified?:___________________ Phone:____________________

How did you learn of our practice?:____

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ADULT HEALTH QUESTIONNAIRE

PATIENT NAME:	DOB:	Date:

1. ACTIVE PROBLEMS

1. List any illnesses for which you are now being treated at this office or any other physician's office.

2. PAST MEDICAL HISTORY

1. Have YOU ever had any of the following problems?

YES	NO	PROBLEM	MONTH/YEAR	YES	NO	PROBLEM	MONTH/YEAR
☐	☐	Arthritis/Rheumatism/Gout/ Lupus	/	☐	☐	Stomach Trouble/Ulcers	/
☐	☐	Asthma (wheezing)	/	☐	☐	Bowel Trouble/Colitis	/
☐	☐	Hay Fever/Sinus Trouble	/	☐	☐	Any type of Cancer/Tumor	/
☐	☐	Emphysema/Bronchitis/ Constant Cough	/	☐	☐	Epilepsy (fits, seizures, convulsions)	/
☐	☐	Pneumonia/Pleurisy	/	☐	☐	Stroke or Paralysis	/
☐	☐	Rheumatic Fever/Heart Murmur	/	☐	☐	Thyroid Disorders/Goiter	/
☐	☐	Coronary Artery Disease/Heart Attack/Angina	/	☐	☐	High Blood Pressure/ Hypertension	/
☐	☐	Enlarged Heart/Congestive Heart Failure	/	☐	☐	Venereal Disease (Syphilis, Gonorrhea, Chlamydia) or PID	/
☐	☐	Tuberculosis	/	☐	☐	HIV Infections/AIDS	/
☐	☐	Blood Clots in your Legs or Lungs	/	☐	☐	Yellow Jaundice/Hepatitis/ Liver Cirrhosis	/
☐	☐	Diabetes (sugar)	/	☐	☐	Kidney or Bladder Trouble	/
☐	☐	Anemia (low, weak blood)	/	☐	☐	Osteoporosis	/
☐	☐	Bleeding Tendency/Unusual Bruising	/	☐	☐	Migraine Headaches	/

2. List hospitalizations, starting with most recent:

Illness/Injury (Location)	Onset/Injury Date	Hospital/Location/Physician

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MEDICAL HISTORY

Gynecologic and Obstetric History

Age at onset of periods:__________ Frequency:__________ Length of Periods:__________
Pregnancies:__________ Births:__________ Miscarriages:__________
Are you using birth control? Y N If yes, which method?__________

Do you have any of the following:

Prolonged Bleeding Abnormal Bleeding
Leakage of Urine Pelvic Pain Abnormal Discharge History of abnormal Pap Smear

When was your last: Pap Smear__________ Mammogram__________
Period__________ Breast Check__________ DEXA Scan (bone density)__________

ADDITIONAL INFO:

____
____
____
____
____
____
____

Lifestyle

	Yes	No	
Do you wear seatbelts?	____	____	If no, why not?__________
Do you wear a bike helmet?	____	____	____n/a If no why not?__________
Do you exercise regularly?	____	____	If yes, type & duration per week__________
Do you smoke / chew tobacco?	____	____	If yes, how many packs per day?__________
Do you drink alcoholic beverages?	____	____	If you, how much per week?__________
Do you drink tea?	____	____	If you, how many cups per day?__________
Do you drink coffee?	____	____	If yes, how many cups per day?__________
Do you wish to be tested for AIDS?	____	____	
Do you have a living will?	____	____	
Have you had blood transfusions?	____	____	

Immunization History: Have you had any of the following?

Hepatitis A	Y N	Date:__________	Hepatitis B	Y N	Date:__________
Pneumovax	Y N	Date:__________	Flu	Y N	Date:__________
Tetanus	Y N	Date:__________	Other	__________	

Past Family History: Have any members of your family (parents, grandparents, & siblings) ever had any of the following?

Illness	Family Member(s)	Age Diagnosed
Cancer	__________	______
Hypertension (High Blood Pressure)	__________	______
Heart Disease	__________	______
Diabetes	__________	______
Strokes	__________	______
Mental Disease (Anxiety/Depression)	__________	______
Drug or Alcohol Addiction	__________	______
Glaucoma	__________	______
Bleeding Diseases	__________	______
Other:__________	__________	______

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MEDICAL HISTORY

Name:	DOB:	Date:

To better serve your healthcare needs, Zulma Cintron, M.D., FACP practice uses an electronic health record (EHR). This will not only include your chart contents, but your medication needs as well. Whether it is a one-time prescription or your daily medication, your prescriptions will be transmitted to your pharmacy with the EHR.

In order to meet your prescription needs, we ask that you provide us with your four (4) favorite pharmacies. Put the one you use the most at the top. This will ensure that your prescriptions are sent to the most convenient location for you to pick them up. Since we use the EHR, you may not receive a paper prescription.

Thank you for your information and cooperation in making this transition.

FAVORITE PHARMACY INFORMATION

Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		

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Zulma Cintron, M.D., FACP
Diplomate American Board of Internal Medicine
www.oviedointernalmedicine.com

1400 South Orlando Avenue
Suite 304
Winter Park, Florida 32789
Office: 407-599-0665

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

DATE:______________________________

Patient Name:______________________________ **Date of Birth:**____________

S.S.#:_______-_____-_______ **Phone #:** (______) _______-__________

Patient Address:______________________________

I authorize ______________________ **to release medical information from my medical records.**

Name:______________________________

Phone #: (______) _______-__________ **Fax:** (______) _______-__________

SPECIFIC DOCUMENT TO BE RELEASED:

- ☐ **All records** ☐ **Face Sheet** ☐ **Discharge Summary** ☐ **History / Physical**
- ☐ **Operative Reports** ☐ **Consultation** ☐ **Labs** ☐ **Radiology Reports**
- ☐ **Progress Notes** ☐ **Physician Orders** ☐ **Cardiology Reports** ☐ **Nurses Notes**
- ☐ **Medication List** ☐ **Psychiatric** ☐ **HIV / AIDS** ☐ **Drug / Alcohol**
- ☐ **Specific date(s) of services:**______________________________
- ☐ **Hand Carry** ☐ **Mail** ☐ **Fax**

PURPOSE FOR INFORMATION: ☐ **Continued Medical Care** ☐ **Insurance** ☐ **Personal**

This request is authorized to include any federal and/or state protection under Florida Statutes 394.459 (9) Psychiatric information, 397.053,396.112 Drug and Alcohol Abuse Information, 381.609 HIV and AIDS related condition and/or 397.50(3) records or minor client.

NOTE REQUESTING PARTY: Florida statue has established guidelines and cost for the copying of records. Your signature on this form indicates your knowledge of this statement.

In understand that I have the right to revoke this authorization at any time. If I decide to do so, it must be done in writing and be presented to the Health Information management department.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I hereby release ____________________ and their employees, agents, office and affiliated, from any and all liability, responsibility.

INSTRUCTIONS FOR TRANSFERRING MEDICAL RECORDS TO THE PRACTICE: Before your first appointment please be sure to contact your previous primary care physician and all pertinent specialists to request your medical records be shared with our office.

- Fill out any necessary release of records forms
- Request your records be sent to our office by either mail or secure fax:

  Practice Address: **7560 Red Bug Lake Road, Suite 2080, Oviedo, Florida 32765**
  Practice Fax #: **Fax: (407) 365-4578**

- For any further questions or concerns regarding this process please contact: **Zoraida Rosa at Ext. 103.**

SIGNED:______________________________ **DATE:**____________

Relation to patient:____________________ **Form of ID Verified:**____________________

Witness:______________________________ **Date:**____________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on ____________________ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

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AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage with ______________________________________
Name of Insurance Company (ies)

And assign directly to **ZULMA CINTRON, M.D., FACP** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare / Medigap Authorization:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **ZULMA CINTRON, M.D., FACP** for any services furnished to me by that provider.

To the extent permitted by law, I authorized any holder of medical or other information about me to release to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

______________________________________ ____________________

Signature of Beneficiary, Guardian or Personal Representative Date

______________________________________ ____________________

Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

Zulma Cintron, MD **2018 version**

Patient Name: ______________________ Date of Birth: ____________

Pharmacy Name and phone number: ______________________________

CURRENT MEDICATION LIST

KNOWN MEDICATION ALLERGIES: ______________________ Visit our website at www.oviedointernalmedicine.com

The accuracy of the information in this document depends on the accuracy and completeness of information provided by the patient at the time this document was prepared. The patient is responsible for advising the pharmacist of any change to these medications.