LoCicero Medical Group
Multi-Specialty Private Practice

2605 W. Swann Avenue
Suite 600
Tampa, Florida 33609
Phone: (813) 876-7073
Fax: (813) 877-1277

We are pleased to welcome you to our practice and look forward to meeting you at your scheduled appointment. Our goal is to provide our patients with compassionate, high quality care. Please review our policies below, developed over 25 years in private practice, and **complete the enclosed new patient paperwork to bring with you to your appointment.**

Appointment Access
Access to the practice is by appointment. We strive to have same-day appointments available. We encourage you to schedule your follow-up appointment at check-out.

Referrals
If you have a medical condition that needs an authorization/referral you will be required to schedule an office visit at our facility prior to obtaining the authorization/referral. Additionally, if it has been more than 3 months since your last visit you may be required to come in for an appointment before an authorization/referral can be issued. Please notify us at least 5 business days prior to your specialist appointment.

Copays, Deductibles, and Coinsurance
Your copay, deductible, or coinsurance is due at the time services are rendered.

Insurance cards and Identification
Please bring your insurance card and photo identification to your appointments, as they must be presented at each office visit.

Prescription Medications
For your safety and well-being, new prescriptions and prescription refills require office visits for evaluation by a provider. Requests for new prescriptions and prescription refills will not be taken over the phone during or after office hours. Please talk to your provider at your appointment to make sure you have enough medication to last until your next visit.

We understand that unexpected events arise, and so a small refill of a chronic medication may be granted during or after office hours, as determined by the on-call provider. You must then schedule an appointment with a provider to evaluate your treatment plan and obtain a full prescription refill. The intent of this policy is to ensure you are receiving safe, high quality care.

Lab and Diagnostic Test Results
At present, lab and diagnostic test results are reviewed at an appointment with your provider. As the functionality of our electronic health record advances, you will be able to view some of these results in your patient portal. For interpretation of any results in your portal, and for a plan of care, you will need to schedule an appointment with your provider.

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Gastroenterology
New Patient Forms

Please do not mail or fax this form.
Bring it with you to your appointment.

Referred by: _____

Reason for today's visit: _____

Patient Name: _____

Address: _____
Street City State ZIP Code

Email address: _____

Home phone: (_____) _____ **Emergency phone**: (_____) _____

Date of Birth: _____ **Sex**: M / F **Marital status**: _____

Social Security #: _____ **Student**: Y / N **If yes**: Full- or Part-time

Are you Hispanic or Latino: Y / N

Circle one or more of the following groups in which you consider yourself to be a member:

American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander

Asian White or Caucasian Unknown Prefer not to respond

Languages Spoken: English Spanish Other: _____

Occupation: _____

Employer: _____

Address: _____
Street City State ZIP Code

Phone: (_____) _____ **Extension**: _____

Emergency Contact: _____

Primary phone: (_____) _____ **Alternate phone**: (_____) _____

Address: _____
Street City State ZIP Code

Primary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured**: _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured**: _____

Secondary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured**: _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured**: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ **Signature**: _____

I hereby authorize LoCicero Medical Group to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made to LoCicero Medical Group or to the party who accepts assignment.

I certify the information I have provided with regard to my insurance is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

Date: _____ **Signature**: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

Date: _____ **Signature**: _____

REGISTRATION FOR THE PATIENT PORTAL

LoCicero Medical Group provides internet-based services offering a secure, private channel for healthcare consultation communications with your physician, personal medical information storage, online healthcare information, and related products, services and content.

You may register for the secure Patient Portal at **lociceromedicalgroup.com/my-lmg/patient-portal**

We are excited to offer our patients this service and believe that this means of communication will enhance your relationship with our practice.

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions.

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

( ) I HAVE MADE SUCH A DECLARATION.

( ) I HAVE **NOT** MADE SUCH A DECLARATION.

Health Care Surrogate

( ) I HAVE DESIGNATED A HEALTH CARE SURROGATE.

( ) I HAVE **NOT** DESIGNATED A HEALTH CARE SURROGATE.

Durable Power of Attorney

( ) I HAVE APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

( ) I HAVE **NOT** APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT.

Signature of Patient or Representative Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Representative Date

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

Signature of Patient	Date	Signature of Patient	Date
Signature of Patient	Date	Signature of Patient	Date
Signature of Patient	Date	Signature of Patient	Date

Patient Name: _____ Date: _____

PAST MEDICAL HISTORY:

Have you had any of the following? Please check if YES:

- □ Anemia
- □ Arthritis
- □ Asthma or emphysema
- □ Bleeding disorder
- □ Blood transfusion
- □ Blood clots
- □ Cancer; type: _____
- □ Celiac disease
- □ Chest pain / angina
- □ Colon polyps
- □ Crohn's disease
- □ Depression
- □ Diabetes; number of years: _____
- □ Diabetic eye or nerve problems
- □ Epilepsy or seizures
- □ Heart attack
- □ Heart disease (including heart murmur)
- □ Hepatitis A, B, or C; list treatments:_____
- □ High blood pressure; number of years:_____
- □ High cholesterol
- □ Intestinal or rectal bleeding
- □ Jaundice (turning yellow)
- □ Kidney disease (or protein in urine)
- □ Kidney stones
- □ Liver disease
- □ Lung disease
- □ Mental illness / disease / disorder
- □ Pancreatic disease
- □ Rheumatic or autoimmune disease
- □ Sickle cell disease
- □ Stoke / TIA
- □ Thyroid problems
- □ Tuberculosis or a positive TB skin test
- □ Ulcerative colitis
- □ Vascular disease (pain in legs with walking?)

Other past medical problems / details:

_____

Surgeries & dates (Please include biopsies and transfusions, if applicable):

_____

Patient Name: _____ Date: _____

Have you ever had any of the following? If YES, please check and provide dates & results if known.

	DATE	DETAILS/RESULTS
□ Colonoscopy		
□ CT scan of the abdomen		
□ Liver biopsy		
□ Upper endoscopy (EGD)		

ALLERGIES: (Please also indicate type of reaction)

	REACTION
□ NO DRUG ALLERGIES	
□ Penicillin	
□ Shellfish	
□ Iodine/Dye	
□ Sulfa	
□ Other:	
□ Other:	
□ Other:	

CURRENT MEDICATIONS: (Please include herbs, vitamins, & over the counter medications)

MEDICATION	DOSE (mg, etc.)	FREQUENCY

Patient Name: _____ Date: _____

WOMEN ONLY:
How many times have you been pregnant? _____
Number of children: _____
Date of last menstrual period? _____
Are you using birth control pills? _____

FAMILY HISTORY: (Please consider parents, grandparents, children, & any other blood relative)

	Father	Mother	Other (specify relative)
Age if living			
Age at death & cause			
Cancer (specify type)			
Genetic disorder			
Ulcer (duodenal or gastric)			
Crohn's Disease			
Ulcerative Colitis			
Liver disease			
Celiac disease			

SOCIAL HISTORY:
Who lives with you? _____
Number of children: _____ Ages: _____

Substance	Ever used?	Current use?	Amount per day / week	Number of years used	If stopped, when? (mm/yyyy)
Tobacco	Y N	Y N			
Street drugs	Y N	Y N			
Injected drugs	Y N	Y N			
Alcohol	Y N	Y N			

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS:
Do you CURRENTLY suffer from any of the following? Please check if YES:

General
□ Poor appetite
□ Easy fatigability
□ Fever, chills, or sweats
□ Weight loss
□ Depression / sadness
□ Itching / rash
□ Weight gain
□ Anxiety
□ Irritability

Head
□ Eye trouble
□ Vision changes
□ Yellow eyes
□ Hearing disorder
□ Sore tongue or mouth

Neck
□ Goiter
□ Lumps or masses
□ Sore throat / hoarseness

Chest
□ Chest pain
□ Asthma
□ Shortness of breath
□ Chronic cough
□ Palpitations
□ High blood pressure

GI
□ Abdominal pain
□ Abdominal swelling
□ Constipation
□ Dark tarry stool
□ Diarrhea
□ Heartburn / indigestion
□ Milk intolerance
□ Passing blood with stool
□ Persistent nausea
□ Swallowing difficulty
□ Vomiting
□ Vomiting blood

GU
□ Difficulty with urination
□ Blood in urine
□ Dark urine
□ Frequent urination
□ Kidney stones

Extremities
□ Arthritis
□ Swollen legs
□ Joint aches
□ Sores on your skin
□ Cold sensitivity

Neurologic
□ Recurrent headaches
□ Loss of memory
□ Weakness
□ Numbness or tingling
□ Loss of consciousness
□ Confusion
□ Trouble concentrating
□ Seizures
□ Tremor / shaking

Other
□ Allergies
□ Anemia
□ Immune deficiency
□ Problems sleeping
□ Temperature sensitivity

Explain: _____

_____

_____

_____

Anything else we should know about your health?

_____

_____

_____

_____