2605 W. Swann Ave Suite 600 Tampa, FL 33609
Phone (813)-873-7073 Fax (813)-877-1277

Patient Information

Last Name _____ Gender _____ Age _____
First Name _____ Date of Birth _____
Address _____ Social Sec # _____
City, State, Zip _____ Home Phone _____

Responsible Party

Last Name _____ Relationship to Patient _____
First Name _____ Gender _____ Marital Status _____
Address _____ Date of Birth _____ Age _____
City, State, Zip _____ Social Sec # _____
Home Phone _____ Work Phone _____

Insurance Information

Primary Insurance _____ Policy Subscriber _____
Address _____ Insured Policy ID _____
City, State, Zip _____ Group # _____
Phone _____ Date of Birth _____
Effective Dates _____ Co Pay Amount _____
Patient Relation to Subscriber _____

Secondary Insurance _____ Policy Subscriber _____
Address _____ Insured Policy ID _____
City, State, Zip _____ Group # _____
Phone _____ Date of Birth _____
Effective Dates _____ Co Pay Amount _____
Patient Relation to Subscriber _____

Emergency Contact Information

Name _____ Home Phone _____
Relation to Patient _____ Work Phone _____
Mobile Phone _____

Authorization to Release Information

I hereby authorize LoCicero Medical Group to release any medical information necessary to process insurance claims related to the medical care rendered by LoCicero Medical Group's medical staff.

Signature _____ Date _____

Assignment of Medical Benefits

I authorize payments of medical benefits of LoCicero Medical Group for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amont not covered by my insurance.

Signature _____ Date _____

Household

Please list all those living in the child's home.

Name	Relation to Child	DOB	Health Problems

1. Are there siblings not listed? If so, please list their names and ages and where they live.

   _____

   _____

2. If mother and father are not living together, or if child does not live with parents, what is the child's custody status?

   _____

   _____

3. If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

   _____

   _____

Birth History

Birth Weight _____

Was the baby born at term? ____ Early? ___ Late? ____

If early, how many weeks gestation? _____

Did the mother have any illness/problem with pregnancy?

_____ Yes _____ No Explain _____

During pregnancy did the mother

Smoke? ____Yes ____ No Drink Alcohol? ___ Yes ___ No

Use Drugs? ___ Yes ___ No Use Medications? ___ Yes ___ No

Was the delivery _____ Vaginal? _____ Cesarean?

If Cesarean, why? _____

Did your baby have any problems right after birth?

_____ Yes _____ No Explain _____

Was initial feeding _____ Breast? _____ Bottle?

Did your baby go home with mother from hospital?

___ Yes ___ No Explain _____

General

Do you consider your child to be in good health?	_____ Yes	____ No	Explain _____
Does your child have any serious illness or medical condition?	_____ Yes	____ No	Explain _____
Has your child had serious injuries or accidents?	_____ Yes	____ No	Explain _____
Has your child has surgery?	_____ Yes	____ No	Explain _____
Has your child ever been hospitalized?	_____ Yes	____ No	Explain _____
Is your child allergic to any medications or drugs?	_____ Yes	____ No	Explain _____

Development

Are you concerned about your child's physical development?	_____ Yes	____ No	Explain _____
Are you concerned about your child's mental/emotional development?	_____ Yes	____ No	Explain _____
Are you concerned about your child's attention span?	_____ Yes	____ No	Explain _____
If your child is in school:			
How is his/her behavior in school?	_____ Yes	____ No	Explain _____
Has he/she failed or repeated a grade in school?	_____ Yes	____ No	Explain _____
How is he/she doing in academic subjects?	_____ Yes	____ No	Explain _____
Is he/she in special or resource classes?	_____ Yes	____ No	Explain _____

Family History

Have any family member had the following:

Deafness	____ Yes	____ No	Who _____	Comment _____
Nasal Allergies	____ Yes	____ No	Who _____	Comment _____
Asthma	____ Yes	____ No	Who _____	Comment _____
Tuberculosis	____ Yes	____ No	Who _____	Comment _____
Heart Disease (Before age 50)	____ Yes	____ No	Who _____	Comment _____
High Blood Pressure (Before age 50)	____ Yes	____ No	Who _____	Comment _____
High Cholesterol	____ Yes	____ No	Who _____	Comment _____
Anemia	____ Yes	____ No	Who _____	Comment _____
Bleeding Disorder	____ Yes	____ No	Who _____	Comment _____
Liver Disease	____ Yes	____ No	Who _____	Comment _____
Kidney Disease	____ Yes	____ No	Who _____	Comment _____
Diabetes (Before age 50)	____ Yes	____ No	Who _____	Comment _____
Bed Wetting (After age 10)	____ Yes	____ No	Who _____	Comment _____
Epilepsy or Convulsions	____ Yes	____ No	Who _____	Comment _____
Alcohol Abuse	____ Yes	____ No	Who _____	Comment _____
Drug Abuse	____ Yes	____ No	Who _____	Comment _____
Mental Illness	____ Yes	____ No	Who _____	Comment _____
Mental Retardation	____ Yes	____ No	Who _____	Comment _____
Immune Problems, HIV, or AIDS	____ Yes	____ No	Who _____	Comment _____

Additional Family History _____

Past History

Does your child have, or has he/she ever had:

Chicken Pox	____ Yes	____ No	When _____	
Frequent Ear Infections	____ Yes	____ No	Explain _____	
Problems with Ears or Hearing	____ Yes	____ No	Explain _____	
Nasal Allergies	____ Yes	____ No	Explain _____	
Problems with Eyes or Vision	____ Yes	____ No	Explain _____	
Asthma, Bronchiolitis, or Pneumonia	____ Yes	____ No	Explain _____	
Any Heart Problem or Heart Murmur	____ Yes	____ No	Explain _____	
Anemia or Bleeding Problem	____ Yes	____ No	Explain _____	
Blood Transfusion	____ Yes	____ No	Explain _____	
Frequent Abdominal Pain	____ Yes	____ No	Explain _____	
Constipation Requiring Doctor Visits	____ Yes	____ No	Explain _____	
Bladder or Kidney Infections	____ Yes	____ No	Explain _____	
Bed-wetting (After age 5)	____ Yes	____ No	Explain _____	
(For Girls) Has she started her menstrual period?	____ Yes	____ No	Explain _____	
(For Girls) Are there problems with her periods?	____ Yes	____ No	Explain _____	
Any Chronic or Recurrent Skin Problem (Acne, Eczema, etc.)	____ Yes	____ No	Explain _____	
Frequent Headaches	____ Yes	____ No	Explain _____	
Convulsions or other Nuerological Problem	____ Yes	____ No	Explain _____	
Diabetes	____ Yes	____ No	Explain _____	
Thyroid or other Endocrine Problem	____ Yes	____ No	Explain _____	
Any other Significant Problem	____ Yes	____ No	Explain _____	
Use of Alcohol or Drugs	____ Yes	____ No	Explain _____	