LoCicero Medical Group
Multi-Specialty Private Practice

Anorectal Care
New Patient Forms

Referring Physician:_____
Reason for today's visit:_____

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

Patient Information:

Date: _____

Full Legal Name: _____/ _____/ _____
Last Name **First Name** **Middle Initial**

Date of Birth: ____/____/____ **S.S. #:** ____/____/____ **Gender: M F Age:** _____

Address: _____/_____/____/_____
Street # **City** **State** **Zip Code**

Telephone: Cell: _____ **Home:** _____ **Work:** _____

Preferred Method of Contact: _____ **Can a Detailed Message be Left? YES NO**

E-Mail Address: _____

Occupation: _____**(circle) Full-Time / Part-Time / Student / Retired**

Emergency Contact: _____/_____
Name **Relationship**

Emergency Contact Number: Cell: _____ **Work:** _____

Primary Care Provider:

Physician Name: _____

Address: _____

Phone: _____ **Fax:** _____

Insurance Information:

(PRIMARY)
Insurance Provider: _____ **Policy#:** _____

Group #: _____ **Subscriber:** _____ **Subscriber D.O.B.:** _____

(Secondary)
Insurance Provider: _____ **Policy#:** _____

Group #: _____ **Subscriber:** _____ **Subscriber D.O.B.:** _____

How did you hear about us?

Referred by: _____

Newspaper: _____ **Internet:** _____ **Radio:** _____ **TV:** _____ **Other:** _____

Clinical History Form

Patient Name: _____ SSN#: _____ Today's Date: _____

Chief Complaint (Please be specific):

What is the reason for your visit? _____

_____

How long have you had the problem? _____

_____

Current Medications: (List all medications/herbal/dietary supplements/alternative medications and treatments that you are currently taking)

MEDICATION	DOSAGE	#PER DAY/FREQUENCY	REASON FOR TAKING

Please list any other medications on the back of this sheet

Medication Allergies: (Are you allergic to any medications?)

Do you have any problems with anesthesia? ☐ Yes ☐ No

Have you had any allergic reaction to tape? ☐ Yes ☐ No

Do you have an allergy to any latex products? ☐ Yes ☐ No

Past Surgical History: (Check all that apply)

	YEAR		YEAR		YEAR
☐ Appendectomy	_____	☐ Hernia Inguinal	_____	☐ Pacemaker Placement	_____
☐ Breast Biopsy	_____	☐ Hernia Ventral	_____	☐ Implanted Device	_____
☐ Chest Surgery	_____	☐ Mastectomy	_____	☐ Gall Bladder	_____
☐ Coronary Artery Bypass	_____	☐ Prostate	_____	☐ Other	_____
☐ Hysterectomy, Abdominal	_____	☐ Tonsillectomy	_____	☐ Other	_____
☐ Hysterectomy, Vaginal	_____	☐ Tubal Ligation	_____	☐ Other	_____

Provider's Initials: _____

Clinical History Form (Continued)

Patient Name: _____ **SSN#:** _____ **Today's Date:** _____

Past Medical History: (Please list all major medical problems)

- ☐ Stroke
- ☐ Seizures
- ☐ Glaucoma
- ☐ Emphysema
- ☐ Asthma
- ☐ Heart Attack/Disease
- ☐ Gallstones
- ☐ Vein Trouble
- ☐ Crohn's/Ulcerative Colitis
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Juvenile Onset Diabetes
- ☐ Thyroid
- ☐ Hepatitis
- ☐ Elevated Cholesterol/Triglycerides
- ☐ Arthritis
- ☐ Familial Polyposis
- ☐ Other _____
- ☐ Kidney Stones/Disease
- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ Diverticulitis
- ☐ Angina
- ☐ Lung Disorders
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Family History:

Family Member	Alive/Deceased	Age	Health Problems (Such as Colon Cancer, Heart Disease, etc.)
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Other			

Social History:

Nutrition Glasses of water per day: _____ Servings of fruit, vegetable, or bran per day: _____

Tobacco ☐ None ☐ Currently Smoke _____Packs/Day and have done so for _____ years.

☐ Previously Smoked _____Packs/Day for _____ years. Stopped in _____ ☐ Smokeless Tobacco

Alcohol ☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Previously Heavy

Caffeine ☐ None ☐ 1-3 Servings Daily ☐ 3-4 Servings Daily ☐ More than 6 Servings Daily

Drug Use ☐ None ☐ _____ ☐ _____

Provider's Initials: _____

Clinical History Form (Continued)

Patient Name: _____ **SSN#:** _____ **Today's Date:** _____

Personal History of Cancer:

Type of cancer: _____ ☐ **Not Applicable**

When was your cancer treatment? _____

What type of cancer treatment did you receive? ☐ **Chemotherapy** ☐ **Radiation Therapy** ☐ **Surgery**

Sexual/Infectious Disease History: (Please check if you have had any of the following)

Sexually Transmitted Disease:

☐ **HPV/Genital or Anal Warts** ☐ **HIV** ☐ **Herpes** ☐ **Gonorrhea** ☐ **Syphilis** ☐ **Chlamydia**

☐ **Anal Receptive Intercourse** ☐ **Intravenous Drug Use** ☐ **Tuberculosis**

OB/GYN:

#/Type of Deliveries: _____/_____ **Traumatic Births:** _____ **Miscarriages:** _____

Last Menstrual Period: _____ **Birth Control:** _____

Have you ever had an Abnormal PAP? _____ **Last PAP** _____ **Last Result:** _____

Preventative Care (Screening and Diagnostic Tests):

Colonoscopy/Sigmoidoscopy: **YES** **NO** **If YES, When:** _____

Reason for Test? _____ **Result:** _____

Mammogram: **YES** **NO** **If YES, When:** _____ **Result:** _____

Prostate Exam: **YES** **NO** **If YES, When:** _____ **Result:** _____

Other Information: (Please write below any other information not covered in this Clinical History that you feel the provider should know about)

_____

_____

_____

Patient's Signature:

I certify that, to the best of my knowledge, the above information is true and accurate.

Patient's Signature: _____ **Today's Date:** _____

Provider's Initials: _____

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Addressed or Fax No.	Description of Disclosure	By Whom Disclosed
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

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PRIVATE PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PATIENT OF RECORD DISCLOSURES

In general, the HIPAA privacy rules give the individual the right to request a restriction on uses and disclosures of private information (PHI). The individual is also provided the right to request confidential communication of PHI, be made by alternative means, such as sending correspondence to the individualôs office instead of home.

I wish to be contacted in the following many (check all that apply):

[ ] Home Telephone: _____
- [ ] O.K. to leave message with detailed information
- [ ] Leave message with call back number only

[ ] Work Telephone: _____
- [ ] O.K to leave message with detailed information

[ ] Written Communication
- [ ] O.K. to mail to my home address.
- [ ] O.K. to mail to my work/office address
- [ ] O.K. to fax to this number _____

[ ] Other: _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Date of Birth

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use of disclosure of PHI, and for the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the use made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will provide adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in emergency.