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.

Asthma, Allergy, and Immunology
New Patient Forms

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

Referring Physician: _____

Reason for today's visit: _____

Patient Name: _____

Address: _____
Street **City** **State** **ZIP Code**

E-mail 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 or PO Box **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 or PO Box **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 mad to Karon R. LoCicero, M.D. 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 a Website and 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: _____

PERSONAL HISTORY

ILLNESS: Do you have or have you ever had:
Please encircle all answers-no or yes

Measles……..no yes
German Measles……no yes
Mumps……no yes
Chicken Pox……no yes
Whooping Cough……no yes
Scarlet fever or Scarleting…..no yes
Diptheria……no yes
Smallpox……no yes
Pneumonia……..no yes
Influenza……no yes
Pleurisy……..no yes
Rheumatic Fever or
Heart Disease……..no yes
Arthritis or Rheumatism…….no yes
Any Bone or Joint Disease….no yes
Neuritis or Neuralgia……..no yes
Bursitis, Sciatica or
Lumbago……no yes
Polio or Meningitis……no yes
Gonorrhea or Syphilis……no yes
Anemia……no yes
Jaundice……..no yes
Epilepsy……..no yes
Migraine Headaches……...no yes
Tuberculosis……no yes
Diabetes……..no yes
Cancer……no yes
High or Low
Blood Pressure……no yes
Ulcer……...no yes
Hepatitis……..no yes
Nervous breakdown……no yes
Food, chemical or
Drug poisoning……...no yes
Hay fever or Asthma……..no yes
Hives or Eczema……no yes
Frequent infections or boils…no yes
Frequent colds or sore throat..no yes

ALLERGIES: Are you allergic to:

Penicillin or Sulfa…… …no yes
Asprin, Codine or
Morphine……no yes
Mycins or other Antibiotics...no yes
Tetanus Antitoxins or
Serums……no yes
Other:_____
_____
_____
_____

INJURIES: Have you had any:

Broken or cracked bones……no yes
Concussion or head injury…..no yes

WEIGHT: Now:_____
One year ago:_____
Maximum:_____When:_____

TRANSFUSIONS: Have you
Ever had:
Blood or Plasma
Transfusion……..…no yes
Date:_____

SURGERY: Have you had:
Appendectomy……no yes
Any other operation……no yes
_____
_____
_____
_____
_____
_____
_____

Have you ever been advised to have any surgical operation which has not been done……no yes
Give details:_____
_____
_____
_____
_____
_____

Have you been treated or hospitalized for any other illness not previously mentioned…….no yes
Give details:_____
_____
_____
_____
_____

X-RAYS: Have you ever had
X-rays of:
Chest……..no yes
Stomach or colon……...no yes
Gall Bladder……...no yes
Extremities……..no yes
Back……no yes
Mammograms(F)……no yes

EKG: Have you ever had an
Electrocardiogram?……no yes
Date:_____

IMMUNIZATIONS: Have you had:
Tetanus Shots……..no yes
Date Last
Tetanus:_____

SYSTEMS REVIEW:

EYES

Eye Strain……..……no yes
Seeing Double……no yes
Seeing Halo about Lights…...no yes

EARS:
Hearing loss……no yes
Infections……no yes
Ringing in ears……no yes
Earache or discharge……...no yes

THROAT AND MOUTH:
Frequent sore throats……..no yes
Hoarseness……..no yes
Bleeding gums……no yes

NECK:
Goiter……..no yes
Lump or Swelling…..……..no yes
Pain or Stiffness……..no yes

BREAST:
Lump……...no yes
Discharge……no yes
Pain……no yes

HEART AND LUNGS:
Chronic cough……no yes
Coughing up blood……no yes
Shortness of breath……no yes
Night sweats……..…..no yes
Chest pain or pressure……no yes
Palpitations or fluttering…….no yes
Swollen ankles……no yes

INTESTINAL:
Loss of appetite……...no yes
Trouble swallowing……no yes
Nausea or vomiting……no yes
Vomiting blood……..…..no yes
Pain in abdomen……no yes
Gall bladder trouble……no yes
Belching or bloating……...no yes
Change in bowel habits……..no yes
Constipation……no yes
Diarrhea……..no yes
Blood in stool or
Hemorrhoids……..…no yes
Black (tarry) stools……no yes

KIDNEY, BLADDER AND GENITALS:

Albumin or sugar in
Urine……...no yes
Blood or puss in urine…….no yes
Kidney or bladder
Infection……..no yes
Getting up nights to urinate
(_____ times)……no yes
Trouble starting urine
Stream……no yes
Discharge……no yes

PATIENT NAME: _____ DATE: _____

MENSTRUATION:(women)
Age of onset of periods_____
When was your last period_____
When was your previous period_____
How long is your period_____days
How many pads per day_____
Usual interval between periods_____days
Bleeding between periods.....no yes
Pain with periods……no yes

NEUROLOGICAL:
Frequent headaches……no yes
Fainting spells……no yes
Convulsions……no yes
Paralysis or weakness……no yes
Dizzy spells……no yes

EXTREMITIES:
Arthritis……..no yes
Any varicose veins……no yes
Cramps in legs……no yes

GENERAL:
Unusual fatigue……..no yes
Unusual weakness……..no yes
Abnormal thirst……..no yes
Unable to sleep……..no yes
Anemia……..no yes
Swolen glands……no yes
Skin trouble……no yes
Back pain……no yes

HABITS:
Coffee_____cups per day
Smoking:
Cigarettes:_____packs per day
Cigars:_____Pipes:_____

Alcoholic beverages:
Present:
Light____Moderate____Heavy____
Past:
Light____Moderate____Heavy____

Work:_____hours per day

Regular exercise……no yes

MEDICATIONS: Please list all medications:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Laxatives:
Never___Occ___Freq___Daily____
Vitamins:
Never___Occ___Freq___Daily____
Tranquilizers:
Never___Occ___Freq___Daily____
Sleeping pills or sedatives:
Never___Occ___Freq___Daily____
Cortisone, ACTH:
Never___Occ___Freq___Daily____
Antacids/Tums,Maalox,etc:
Never___Occ___Freq___Daily____

Heart tablets……no yes

Thyroid: Never___ Yes in past – none now___
Now on _____grams daily

Appetite suppressants:
Never___Occ___Freq___Daily____

Have you ever taken insulin for diabetes……...no yes

Have you ever taken hormone shots or tablets……no yes

Any other information that may be helpful:_____
_____
_____
_____
_____
_____
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REASON FOR TODAY'S VISIT:

1._____

2._____

3._____

Routine check-up
No Symptoms_____

FAMILY HISTORY:
IF LIVING:

	AGE	HEALTH
Father		
Mother		
Brother/Sister		
Husband/Wife		
Son/Daughter		

IF DECEASED:

	AGE AT DEATH	CAUSE
Father		
Mother		
Brother/Sister		
Husband/Wife		
Son/Daughter		

HAS ANY BLOOD RELATIVE EVER HAD: WHO

Cancer	no yes
Tuberculosis	no yes
Diabetes	no yes
Heart trouble	no yes
High blood Pressure	no yes
Bleeding Tendency	no yes
Stroke	no yes

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.