Women's Health
LoCicero Health
GYNECOLOGY

Gynecology
New Patient Forms

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**

Email address: _____

Home phone: (_____) _____ **Cell phone**: (_____) _____

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

Social Security #: _____ **Driver License #:**_____

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: _____

Relationship to patient:_____

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 Health 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 Health 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 access 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.

Please ask the front office staff for your login information.

For office use only:

Username: _____

Temporary Password: _____
(This password will expire within 24 hours)

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

Women's Health LoCicero Health GYNECOLOGY

GYNECOLOGIC HISTORY QUESTIONNAIRE

Name:_____ DOB: _____ Date: _____

Chief reason for today's visit: _____

First day of last menstrual period: _____

Date of last pap smear: _____Results: _____

Type of birth control currently using: _____
(including vasectomy, tubal ligation, condoms, abstinence, or natural family planning methods)

Are you happy with this method of birth control? _____

Were you referred to our office? If so please tell us by who._____

OBSTETRICAL HISTORY

Are you currently pregnant? ☐Y ☐N If so, on what date was first positive pregnancy test? _____

Total number of times pregnant (include miscarriages and abortions): _____

Total number of live births (include dates and type of delivery): _____

_____

Total number miscarriages: _____ Total number abortions: _____

Any complications during your pregnancies? If so, please explain: _____

_____

Did you have a Caesarean Section? If so, when: _____

Any family history of inherited disorders (i.e. Tay Sachs, Spina Bifida, Down Syndrome, other genetic disorder)?

_____

GYNECOLOGICAL HISTORY

Age at first period: _____ How many days do your periods last? _____

How often do your periods come? ☐ Every 28-30 days ☐ More frequently ☐ Less frequently

How heavy is your menstrual flow? ☐ Light ☐ Moderate ☐ Heavy ☐ Extremely Heavy

Do you have bad cramps? ☐Y ☐N Do you have any PMS symptoms? ☐Y ☐N

Any bleeding between periods? ☐Y ☐N Any bleeding after intercourse? ☐Y ☐N

Any problems with urination (loss of urine while coughing, sneezing, etc.)? ☐Y ☐N

Check any of the following problems that you have had either in the past or currently:

☐ Gonorrhea ☐ Pelvic Inflammatory Disease (PID) ☐ Herpes ☐ Vaginal Infections

☐ History of physical or sexual abuse ☐ IUD Related problems

☐ Abnormal pap smears (what abnormality and when)? _____

MEDICAL HISTORY

How is your health in general? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke? ☐**Y** ☐**N** How much? _____packs per day How many years have you smoked?_____

Are you a past smoker? ☐**Y** ☐**N** When did you quit? _____ How many years did you smoke? _____

Do you drink alcohol? ☐**Y** ☐**N** How many alcoholic beverages do you have in a week? _____

Social drug use? ☐**Y** ☐**N** If so, what type of drugs do you use? _____

Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition? If so, what was the diagnosis and when? _____

_____

Have you ever been hospitalized for a medical illness? If so, please explain: _____

_____

What surgeries have you had? (please give year of surgery, including cosmetic): _____

_____

_____

Do you have any allergies to medications? ☐**Y** ☐**N** Do you have any other allergies? ☐**Y** ☐**N**

Please List: _____ Please list: _____

_____ _____

_____ _____

Do you have any history of a bleeding disorder? ☐**Y** ☐**N** Had a blood transfusion? ☐**Y** ☐**N**

Do you use medication on a regular basis? Please list name and dose of medication: _____

_____

Have you had a mammogram? ☐**Y** ☐**N** Date & result of last mammogram: _____

Do you have any problems with your breasts? (lumps, discharge, or pain)? _____

FAMILY HISTORY (Please check if anyone in your family has any of these conditions and tell us who has it)

☐ Breast Cancer ☐ Uterine Cancer ☐ Ovarian Cancer ☐Colon Cancer

☐ Diabetes ☐ Heart disease ☐ High Blood Pressure ☐ Stroke

☐ Osteoporosis ☐ Thyroid disease ☐ Autoimmune ☐ Other

SOCIAL HISTORY

Marital status: **M S D W P** Sexual Orientation? ☐**Heterosexual** ☐**Homosexual**

Occupation: _____ Religion: _____

Name: _____ DOB:_____ Today's date:_____

DO YOU HAVE or HAVE YOU EVER HAD:

General:	
Fatigue/Weakness	□ No □ Yes
Recent weight loss or gain	□ No □ Yes
Night sweats/ Chills	□ No □ Yes
Frequent infections/ large lymph nodes	□ No □ Yes
HIV/AIDS	□ No □ Yes
Viral Hepatitis (□HAV □HBV □HCV)	□ No □ Yes
Diagnosed with cancer if Yes, specify:_____	□ No □ Yes
Implants in the body: if Yes, specify:_____	□ No □ Yes
Respiratory:	
Shortness of breath	□ No □ Yes
Chronic cough	□ No □ Yes
Asthma	□ No □ Yes
COPD/Bronchitis/Emphysema	□ No □ Yes
Tuberculosis or TB contacts	□ No □ Yes
Sleep apnea/ snoring	□ No □ Yes
Other:	
Cardiovascular:	
Low or High Blood Pressure	□ No □ Yes
Chest pain or pressure	□ No □ Yes
Palpitations	□ No □ Yes
High cholesterol/ lipids	□ No □ Yes
Swollen feet or ankles: if Yes: □ Rt leg □ Lt leg □ Both legs	□ No □ Yes
Heart surgery if Yes, specify:_____	□ No □ Yes
Other:	
Gastrointestinal:	
Difficulty swallowing	□ No □ Yes
Loss of appetite	□ No □ Yes
Nausea / Vomiting	□ No □ Yes
Heartburning/GERD	□ No □ Yes
Gastric or Duodenal ulcers	□ No □ Yes
Abdominal pain/ Bloating	□ No □ Yes
Lactose or gluten intolerance	□ No □ Yes
Constipation	□ No □ Yes
Diarrhea	□ No □ Yes
Blood in stool	□ No □ Yes
Hemorrhoids	□ No □ Yes
Endocrine:	
Diabetes, type II / Prediabetes (if Yes, circle one)	□ No □ Yes
Thyroid Disease	□ No □ Yes
Hormone problems:(if Yes, specify:_____)	□ No □ Yes

Other:	
Muscles/Bones/Skin:	
Muscle pain/Cramps	□ No □ Yes
Arthritis/ Joint pain (if Yes, circle one)	□ No □ Yes
Neck or Back pain or stiffness	□ No □ Yes
Osteoporosis / Osteopenia (if Yes, circle one)	□ No □ Yes
Varicose veins	□ No □ Yes
Dermatitis / Eczema / Psoriasis (if Yes, circle one)	□ No □ Yes
Foot pain or ulcers	□ No □ Yes
Other:	
Neurological/Mental:	
Headaches	□ No □ Yes
Seizures / Epilepsy / Fainting (if Yes, circle one)	□ No □ Yes
Dizzy spells/ Vertigo	□ No □ Yes
Balance problems	□ No □ Yes
Stroke/ TIA	□ No □ Yes
Numbness /Tingling	□ No □ Yes
Confusion/ Memory loss	□ No □ Yes
Depression / Anxiety	□ No □ Yes
Insomnia	□ No □ Yes
ENT/Eyes:	
Double vision	□ No □ Yes
Seeing a halo around lights	□ No □ Yes
Glaucoma	□ No □ Yes
Cataracts	□ No □ Yes
Hearing loss	□ No □ Yes
Ringing in ears	□ No □ Yes
Reproductive:	
Eryctile dysfunction/ Low libido	□ No □ Yes
Breast lump/ pain/discharge	□ No □ Yes
STD (if Yes,specify:_____)	□ No □ Yes
Currently sexually active (how many partners: ___males __females)	□ No □ Yes
Other:	
Autoimmune disorders (Lupus, RA, ect.)	□ No □ Yes
Anemia	□ No □ Yes
Kidney disease, (if Yes,specify:_____)	□ No □ Yes
Blood in urine	□ No □ Yes
Frequent urinary infections	□ No □ Yes
Urinary incontinence	□ No □ Yes
Fecal incontinence	□ No □ Yes
Getting up at night to urinate (_____times)	□ No □ Yes
Weak urine stream	□ No □ Yes

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 individual's 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: _____

☐ Other: _____

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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.