LoCiceroHealth

Primary Care New Patient Forms

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

Last Primary Care 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

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

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

Past surgeries or serious injuries:	Date:
Blood or Plasma transfusion	□ No □ Yes

Allergies:	Reaction:
Medications: □ No □ Yes	
Food: □ No □ Yes	
Pollen/Dust/Other: □ No □ Yes	

Family history:	
	Family member:
Cancer	
Diabetes type-2 (in adults)	
High blood pressure	
Coronary artery disease	

Current medications:	Dose:	Times per day:

Habits:
Alcohol use: □ Never □ Socially □ Heavy □ Dependent
How many drinks a day _____ ; How many drinks a week ____
Smoking: □ Never □ Quit □ Smoking
Smoked __packs/day for__years. Quit ___years ago
Currently smoking __packs/day. Smoking for ___years
Illicit drugs: □ None □ Former □ Current
Which drug? □ Cocaine □ Other:_____
Medical Marijuana: □ No □ Yes

For Females:	
Number of Pregnancies	
Number of Deliveries	C-sec ____ Vaginal____
Last menstrual period	
Abnormal bleeding	□ No □ Yes, _____
Painful periods	□ No □ Yes, _____

	Preventive care:	Date:	
	Last Physical Exam		□ Normal □ Abnormal, details_____
□ Never done	Colonoscopy		□ Normal □ Abnormal, details_____
□ Never done	Eye exam		□ Normal □ Abnormal, details_____
□ Never done	Pneumonia vaccine		□ I wish to receive if indicated
□ Never done	Shingles vaccine		□ I wish to receive if indicated
□ Never done	Influenza vaccine		□ I wish to receive if indicated
□ Never done	Tetanus vaccine/DTP		□ I wish to receive if indicated
□ Never done	HPV (Papillomavirus)		□ I wish to receive if indicated
□ Never done	COVID-19 vaccine		□ I wish to receive if indicated
□ Never done	STD screening		□ I would like to be screened for STD
	For Females:		
□ Never done	DEXA/Bone density:		□ Normal □ Abnormal, details_____
□ Never done	PAP smear/ HPV		□ Normal □ Abnormal, details_____
□ Never done	Mammogram:		□ Normal □ Abnormal, details_____

Do you have any special needs during medical visits? □ No □ Yes_____

Are you using assisting devices? Wheelchair / cane / walker

Medical alert bracelet?_____

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.