



Neurology 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 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

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 made 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
Diphtheria.....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

Ringin 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

Record of Disclosures of Protected Health Information

<u>Date</u>	<u>Disclosed To Whom Addressed or Fax No.</u>	<u>Description of Disclosure</u>	<u>By Whom Disclosed</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LoCicero Medical Group

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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 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.
