Ronald P. Ciccone, M.D., P.C.
Integrative Family Medicine

1. CONSENT TO TREATMENT
I consent to be treated by Integrative Family Medicine. While I am a patient, I permit my doctor(s), staff, volunteers and all persons caring for me to treat me in ways they judge to be beneficial to me.

I understand that this care may include laboratory tests, diagnostic procedures, examinations, medical treatment, administration of drugs and specialist consultation. I understand that no guarantees have been made to me about the outcome of this care.

2. RELEASE OF INFORMATION
I hereby authorize release of any information acquired in the course of my examination or treatment which may be needed for the payment of hospital/professional charges, to include history obtained, x-ray and physical findings, prognosis and diagnosis (including psychiatric, alcohol and drug abuse, acquired immunodeficiency syndrome (AIDS) and or tests and their results relative to infection with h u m a n immunodeficiency virus (HIV). I also authorize release of information to any family/referring consulting physician requesting it for my follow-up care.

3. PERSONAL VALUES
I understand that the Integrative Family Medicine and its staff are not responsible for the loss of or damage to any money, articles or personal property if these items shall be with me while on the premises. I accept full responsibility for any items that I have in my possession.

4. BILLING INFORMATION
I understand that I will receive a bill for services in the event of hospitalization or treatment rendered by the hospital. In addition, I may also receive a separate bill(s) from the treating physician as well as from other physicians in specialty areas such as anesthesiology, cardiology, neurology, radiology and the emergency room. I also understand that all professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. The patient is responsible for all fees, regardless of insurance coverage. I acknowledge that interest or a fee at the provider's current rate may be charged on all balances owing to the provider that are past due.

SIGNATURES

_____ _____
Patient Date

Patient unable to sign because: _____

_____ _____ _____
Person authorized to sign for patient Relationship to patient Date

_____ _____
Witness Date

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Medical Information Release Form:

(HIPAA RELEASE FORM)

Name: _____ Date: __/__/__

By signing below, I have acknowledge that I have received the Notice of Privacy. This notice describes how medical information about me may be used and disclosed, and how I can get access to this information.

[ ] I authorize the release of information inclusive of diagnosis, records and claims information.

[ ] Excluded information (if any): _____

This information may be release to:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

The below individuals are authorized to pick up any written prescriptions, medication samples or supplements on my behalf:

_____

_____

Messages

Please call: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Signed: _____ Date: __/__/__

Ronald P. Ciccone M.D.

Medical Director, Integrative Family Medicine

(Please Print) **Patient Information**

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip _____

Home Telephone # ( ) _____ Cell # ( ) _____

Birthdate _____ SS# _____ E-mail _____

Male ( ) Female ( ) Married ( ) Single ( ) Occupation: _____ Referred by: _____

Primary Care Physician _____ Phone Number ( ) _____

Employer _____ Employer Phone: ( ) _____

Employer Address _____

Emergency Contact _____ Emergency Phone: ( ) _____

Pharmacy _____ Pharmacy Phone: ( ) _____

(Please Print) **Primary Insurance Information**

Insurance Company _____ Phone ( ) _____

Street Address _____

City _____ State _____ Zip _____

Policy Holders Last Name _____ First _____ MI _____

Date of Birth of Policy Holder _____ Relationship to Patient _____

ID or Policy Number _____ Group Name or Number _____

Policy Holder's Social Security Number _____

(Please Print) **Secondary Insurance Information**

Insurance Company _____ Phone ( ) _____

Street Address _____

City _____ State _____ Zip _____

Policy Holders Last Name _____ First _____ MI _____

Policy Holder's Date of Birth _____ Relationship to Patient _____

ID or Policy Number _____ Group Name or Number _____

Policy Holder's Social Security Number _____

1. I hereby authorize direct payment of medical benefits to Ronald P Ciccone MD for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.
2. I hereby authorize Ronald P Ciccone MD to release any medical or incidental information that may be necessary for medical care or in processing applications for financial benefit.
3. I certify that the information given by me in applying for payment is correct and request that payment of authorized benefits be made on my behalf.

NEW PATIENT PACKET RECEIVED [ ]

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

(If Patient Under 18 Years of Age)

7/29/2010

Ronald P. Ciccone, M.D., P.C.
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Patient Name: _____

Date: _____

Patient History

Please list any medicine, drugs or vitamins that you take:

Do you take birth control pills? ☐Yes ☐No Which one? _____

Have you had an alcoholic drink in the last 48 hours? ☐Yes ☐No

Please list allergies and other sensitivities:

List any medications or liquids that cause you a bad reaction:

List any operations or serious illness that you've had which required hospitalization. (Include any pregnancies.)

Month/Year	Illness or Operation

HAVE YOU EVER HAD ANY OF THE FOLLOWING	YES
TB (Tuberculosis) SKIN TEST:	☐
TETANUS (lockjaw) SHOTS:	☐
MUMPS OR SHOTS FOR MUMPS:	☐
MEASLES OR SHOTS FOR MEASLES:	☐
GERMAN MEASLES OR SHOTS:	☐
PAP SMEAR: DATE:_____	☐
CHEST X-RAY: DATE:_____	☐
COMPLETE MEDICAL EXAM: DATE:_____	☐
EKG (Electrocardiogram): DATE:_____	☐
BLOOD TESTS: DATE:_____	☐
PNEUMOVAX (Pneumonia) SHOT: DATE:_____	☐
FLU SHOTS:	☐

HAVE YOU HAD ANY PROBLEMS WITH:

	YES	NO		YES	NO
Liver or Hepatitis	☐	☐	Sex	☐	☐
Lumps	☐	☐	Sinuses	☐	☐
Moles	☐	☐	Hearing	☐	☐
Swelling	☐	☐	Seeing	☐	☐
Stiff Joints	☐	☐	Smelling	☐	☐
Dizziness	☐	☐	Racing Heart	☐	☐
Balance	☐	☐	Extra Heart Beat	☐	☐
Appetite	☐	☐	Digestion	☐	☐
Sleeping	☐	☐	Weight Gain/Loss	☐	☐
Breathing	☐	☐	Mood /Feelings	☐	☐
Pains, Aches	☐	☐	Menstruation	☐	☐
Rash	☐	☐	Akle Swelling	☐	☐
Broken Bones	☐	☐	Varicose Veins	☐	☐
Anemia	☐	☐	Weakness	☐	☐
Asthma	☐	☐	Frequent Colds	☐	☐
Hay Fever	☐	☐	Urine/Kidney/		
Bleeding Tendencies	☐	☐	Bladder	☐	☐
Cancer/Tumor	☐	☐	Rheumatism	☐	☐
Diabetes	☐	☐	Arthritis	☐	☐
Epilepsy	☐	☐	Stroke	☐	☐
Glaucoma	☐	☐	Tuberculosis	☐	☐
Gout	☐	☐	Ulcer	☐	☐
Heart Trouble	☐	☐	Stomach Trouble	☐	☐
High Blood Pressure	☐	☐	Hernia	☐	☐
Headaches	☐	☐	Hemorrhoids	☐	☐
Do You Smoke	☐	☐	Thyroid Disease	☐	☐
*How much:*_____			Venereal Disease	☐	☐
Drink Alcohol	☐	☐	Bowel Movement	☐	☐
*How Much:*_____			Drink Coffee/Tea	☐	☐
			*How much:*_____		

Will Dr. Ciccone be your Primary Care Physician?

☐ Yes ☐ Not Sure ☐ No

If no, who is your Primary Care Physician?

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Family History

Patient Name:_____ Date:_____

	AGE	IF LIVING, STATE OF HEALTH	IF DECEASED, CAUSE OF DEATH	AGE
FATHER				
MOTHER				
SISTER/S				
BROTHER/S				

Family History Details

	YES	NO	RELATION		YES	NO	RELATION
ALCOHOLISM				LIVER PROBLEMS			
ALLERGIES / HAYFEVER				NERVOUS DISEASE			
ARTHRITIS				RHEUMATIC FEVER			
ASTHMA				SEIZURES			
BLEEDING DISEASE				STOMACH PROBLEMS			
BLOOD DISEASE				STROKE			
CANCER				SUICIDE			
CONVULSIONS				TUBERCULOSIS			
DIABETES				THYROID PROBLEMS			
DRUG ADDICTION				VENEREAL DISEASE			
GOITER				WEIGHT GAIN/LOSS			
GOUT				OTHER			
HEART PROBLEMS				OTHER			
HIGH BLOOD PRESSURE							
KIDNEY PROBLEMS							
LEUKEMIA							

Medical Symptoms Questionnaire

Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past ***30*** days.

Point Scale

0 - *Never* or *almost never* have the symptoms
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(does not include near or far-sightedness) Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation Total _____

MOUTH / THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain Total _____

(PLEASE COMPLETE 2ND SIDE OF FORM)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal / stomach pain

Total _____

JOINTS / MUSCLES

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating / drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY / ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

GRAND TOTAL _____