Antonio Cubano MD, PA
725 Primera Blvd., Suite 140, Lake Mary, FL 32746
407-732-7266 • 407-732-7310

PATIENT INFORMATION

Date: _____
First Name: _____ Last: _____ M.I.: _____
Address: _____
City/State/Zip: _____ SSN: _____
Marital Status: SMDW Sex: M F Date of Birth: _____/_____/_____ Age: _____
Primary Phone: _____ Secondary Phone: _____
Employer: _____ Email Address: _____
Employer address: _____

SPOUSE/GUARDIAN

Spouse/Guardian: _____ Date of Birth: _____/_____/_____
Employer Name _____ SSN: _____
Address (if different): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ Phone: _____

INSURED OR RESPONSIBLE PARTY (POLICY HOLDER) INSURANCE INFORMATION

Policy Holder Name: _____ Relationship to Patient: _____
Name of Insurance Company: _____
Member ID: _____ Group Number: _____ Effective Date: _____
SSN: _____ Date of Birth: _____/_____/_____
Employer: _____ Work Phone: _____

SECONDARY INSURANCE (Medicare supplement or secondary plans)

Policy Holder Name: _____ Relationship to Patient: _____
Name of Insurance Company: _____
Member ID: _____ Group Number: _____ Effective Date: _____
SSN: _____ Date of Birth: _____/_____/_____
Employer: _____ Work Phone: _____

CONSENT AND AUTHORIZATION FORM

I, _____, consent to evaluation and treatment by Antonio Cubano MD PA for myself, or my child.

Print Name

PRIMARY CARE PHYSICIAN

Insurance plans and managed care organizations encourage the exchange of information between this office and your Primary Care Physician (PCP) in order to coordinate medical and psychiatric care. *Please make a selection below.*

☐ I give consent for information regarding my treatment to be shared with my PCP/Referring Physician/Pediatrician/Therapist as follows:

Name of PCP: _____ PCP Phone: _____

Located at: _____

Name of Therapist: _____ Therapist Phone: _____

Located at: _____

☐ I do not wish to have information regarding my treatment with this practice released to my PCP.

INSURANCE CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof, to any insurance company or third party payor for utilization management, audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay Antonio Cubano MD PA its usual charges for all services received, including any balances not covered by my insurance carrier(s). I understand that it is the patient's responsibility to obtain any prior authorization or doctor's referral. I understand that failure to meet this requirement may result in a significant loss of benefits. I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Antonio Cubano MD PA, and direct that payment of proceeds be made directly to Antonio Cubano MD PA. Because we reserve appointment time for you, we charge a fee up to and including our full normal fee, for missed appointments not cancelled at least 24 hours in advance.

My signature below represents that I have read and understand the terms and statements above.

This consent and authorization form will remain in effect for the duration of my treatment unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

_____ _____

Patient's Signature Date Parent/Guardian's Signature Date

I have witnessed the completion of this authorization form. _____

Employee Signature Date

Acknowledgement of Notice of Privacy Practices and Office Policies and Procedures

I understand I may request a copy of the Notice of Privacy Practices and Office Policies and Procedures. I understand that I may ask questions to Antonio Cubano MD PA, if I do not understand any information contained in the Notice of Privacy Practices and Office Policies and Procedures.

_____

Patient/Guardian's Signature Date

Third Party Access

I authorize Antonio Cubano MD PA to disclose current healthcare information with the family/others listed below.

_____ _____

Spouse Parent

_____ _____

Sibling Other

_____ _____

Patient Signature Date Employee Signature Date

Patient Name:	MR #

Cubano MD Psychiatry

725 Primera Blvd Suite #140

Lake Mary, FL 32746

Parent-Report Questionnaire

Date ___/___/___

Demographics:

Child's Name (last, first, mi) _____

Sex: M F Date of birth: ____/_____/_____ Race: _____

Address _____

City_____ State_____ Zip code _____

Phone Number Home _____ Cell phone_____

Insurance: _____ ID #: _____ Group #: _____

Primary cardholder name and DOB: _____ _____/_____/___

Person completing this form _____ Relationship to child _____

Who lives in the same household as the child?

Name	Sex	Age	Relationship to child

Father's occupation: _____

Highest education received: _____

Mother's occupation: _____

Highest education received: _____

Child's current grade: _____ Special Ed: Yes No

Name of school: _____

Has your child ever repeated any grades: _____ If yes, which and why:

_____

Patient Name:	MR #

Developmental History:

1. Length of pregnancy: _____
2. Where any medications used during pregnancy? Yes No If yes, what?_____
3. Any complications of delivery?
    a. _____ Premature rupture of membranes
    b. _____Twins or Triplets?
    c. _____Forceps used?
    d. _____High blood pressure
    e. _____Hemorrhage
    f. _____Other
4. How much did the baby weight at birth? _____
5. Did the baby start breathing right away? Yes No Don't know
6. Did the baby cry? Yes No Don't know
7. Where there any problems with the baby after he/she was born?
    a. _____ Incubator
    b. _____Trouble breathing
    c. _____Jaundice
    d. _____Seizures
    e. _____Trouble feeding
    f. _____Other
8. When did the baby leave the hospital? _____

Patient Name:	MR #

9. Any problems after the baby came home?

    a. _____Colic, excessive irritability/crying

    b. _____Sleepiness, too quiet, lethargy

    c. _____Poor feeding

    d. _____Slept too little

    e. _____Too floppy

    f. _____Too stiff

10. When did the baby smile interactively? _____

11. At what age was the baby able to sit by him/herself _____

12. At what age did the baby start to walk by him/herself? _____

13. When did the baby said his/her first word? _____

14. When did the baby start to speak in short sentences like: "I want milk"?_____

15. Did the baby had trouble learning to speak? _____

16. Is the child toilet trained? _____ If yes, how old when trained? _____

17. How old was the child when she/he was able to:

    a. Ride a tricycle? _____

    b. Ride a bicycle without training wheels? _____

    c. Get dressed by him/herself? _____

    d. Tie shoelaces? _____

18. What hand does the child prefer to use? Right Left

19. Anything else significant occur during the child's developmental years?

_____

Patient Name_____ MR#_____

Has your child ever had any serious injuries?

No Yes If yes, describe and give dates below:

Type	Date	Comments

Is your child currently taking any medication?

No Yes If yes, please list

Name	Dose	Date Started	Reason

Girls only (circle appropriate number and describe):

Has your daughter had her 1st period? No Yes

If yes, at what age _____

Are periods regular? No Yes

Date of last menstrual cycle_____

Is there any change in symptom severity with periods? No Yes

If yes, please describe_____

Is there a possibility that your daughter is pregnant? No Yes

Neuropsychiatric History

Has your child ever:

1. made involuntary body movements or sounds (tics)? No Yes

Age of first tic(s)____ yrs Please describe:_____

_____

_____

2. had recurrent disturbing thoughts or worries (obsessions)? No Yes

Age of 1st obsessions: ____ yrs Please describe:_____

_____

_____

Patient Name_____ MR#_____

3. had repetitive or excessive habits (compulsions)? No Yes
   Age of 1st compulsions: ____yrs Please describe:_____
_____
_____

4. had problems with attention, concentration, hyperactivity? No Yes
   Age of 1st symptoms: _____yrs Please describe: _____
_____
_____

5. had diagnosed with a learning disability? No Yes
   Age of 1st symptoms: _____yrs Please describe: _____
_____
_____

6. had other emotional or behavioral problems? No Yes
   Age of 1st symptoms: ____yrs Please describe: _____
_____
_____

Have you ever sought professional treatment for your child for any of the above problems?

No Yes If yes, give details below:

Problem (Diagnosis)	Start Date	Stop Date	Type (See scale below)	Inpatient, Outpatient or Day Hospital?	Benefit (See scale below)

Therapy Type Scale

1=Drug Therapy, 2=Talk Therapy, 3=Behavior Therapy, 4=Other (specify)

Benefit Rating Scale

Good, Fair, Poor

Patient Name_____ MR#_____

Medical History:

Does your child have any history of the following:

Illness	No	Yes	At what Age(s)	✓ if still present	Comments
Allergies (describe)					
Asthma					
Chicken Pox					
Complications at Birth					
Convulsions, Seizures, Epilepsy					
Head Injury					
High Blood Pressure					
Loss of Consciousness					
Low Blood Pressure					
Measles					
Other Serious Illness_____					
Other Serious Illness_____					
Respiratory Illness					
Rheumatic Fever					
Sleep Problems					
Urogenital Problems					
Vision Problems (e.g. Lazy eye)					
Dizziness or Fainting					

Medical Procedures:

Has your child ever had surgery (an operation)?

No Yes If yes, describe and give dates below:

Type	Date	Comments

Patient Name_____ MR#_____

Medication History

Has your child ever been treated for emotional or psychiatric problems with medication?

No Yes

If yes, Please complete information in the table below:

Medications	No	Yes	Dose	Start Date	Stop Date	Diagnosis	Benefit (Scale Below)	Side Effects
Anti-Depressants								
Amitriptyline (Elavil)								
Bupropion (Wellbutrin)								
Clomipramine (Anafranil)								
Desipramine (Norpramin)								
Fluoxetine (Prozac)								
Fluvoxamine (Favaran)								
Imipramine (Tofranil)								
Nortriptyline (Pamelor)								
Paroxetine (Paxil)								
Sertraline (Zoloft)								
AntiAnxiety/Sleep Drugs								
Clonazepam (Klonopin)								
Lorazepam (Ativan)								
Buspirone (Buspar)								
Anti-Parkinsonian								
Diphenbydramine (Benadryl)								
Benztropine (Cogentin)								

Patient Name_____ MR#_____

Medications	No	Yes	Dose	Start Date	Stop Date	Diagnosis	Benefit (Scale Below)	Side Effects
Anti-Psychotics								
Clozapine (Clozaril)								
Fluphenazine (Prolixin)								
Haloperidol (Haldol)								
Pimozide (Orap)								
Thiordazine (Mellaril)								
Mood Stabilizers								
Lithium								
Stimulants								
Amphetamine (Dexedrine)								
Methylphendate (Ritalin)								
Pemoline (Cylert)								
Miscellaneous								
Clonidine (Catapres)								
Hydroxyzine (Atarax)								
Naltrexone								
Dilantin (Phenytoin)								
Valproic Acid (Depakene)								
Other:								
Other:								

Benefit Rating Scale
Good, Fair, Poor

Patient Name_____ MR#_____

Family History

Is your child adopted? No Yes

Have any of the child's blood relatives had a serious emotional, behavioral or neurological problem? (For example, hyperactivity, learning disability, abnormal movements) No Yes

If yes, fill in the table below:

Name	Age	Relationship	Father's Side	Mother's Side	Suspected Diagnosis	Received Therapy?

How would you describe family life? 1=Stable 2=Unstable

Has the child experienced any of the difficulties listed in the table below?

No Yes

If yes, check all that apply.

(✓)			Child's Age	Durations
	1.	Death of a parent		n/a
	2.	Death of other loved ones/close friend.		n/a
	3.	Separation from patent or family		
	4.	Parents' separation/divorce		n/a
	5.	Loss of Home		
	6.	Family finance problems		
	7.	Physical abuse		
	8.	Sexual abuse		
	9.	Parent with substance abuse problem		
	10.	Conflicts with parents		
	11.	Removal of child from home		
	12.	Victim of crime or violence		n/a
	13.	Unwanted pregnancy		n/a
	14.	School problems		
	15.	Illness in self		
	16.	Illness in family (specify _____)		
	17.	Other(_____)		

For office use only:

Reviewed by_____ Date reviewed_____

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number _____

Score _____

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	____	____	____	____
2. I did not feel like eating, I wasn't very hungry.	____	____	____	____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	____	____	____	____
4. I felt like I was just as good as other kids.	____	____	____	____
5. I felt like I couldn't pay attention to what I was doing.	____	____	____	____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	____	____	____	____
7. I felt like I was too tired to do things.	____	____	____	____
8. I felt like something good was going to happen.	____	____	____	____
9. I felt like things I did before didn't work out right.	____	____	____	____
10. I felt scared.	____	____	____	____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	____	____	____	____
12. I was happy.	____	____	____	____
13. I was more quiet than usual.	____	____	____	____
14. I felt lonely, like I didn't have any friends.	____	____	____	____
15. I felt like kids I know were not friendly or that they didn't want to be with me.	____	____	____	____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	____	____	____	____
17. I felt like crying.	____	____	____	____
18. I felt sad.	____	____	____	____
19. I felt people didn't like me.	____	____	____	____
20. It was hard to get started doing things.	____	____	____	____

Antonio Cubano MD PA
Vanderbilt Assessment-Parent

To be completed by parent

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child ____ was on medication ____ was not on medication ____ not sure

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5

23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (e.g., teams)	1	2	3	4	5

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Staff Use Only

Total Symptom Score for questions 1-18: _____

Average Performance Score for questions 19-26: _____

Adapted from Vanderbilt Rating Scales developed by Mark L. Wolraich.