**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

**CUBANO MD PSYCHIATRY**

**Adult Psychiatry Evaluation Form**

Name _____ DOB _____ Date _____

Marital Status _____ Occupation _____

Who currently lives in your household _____

Who referred you here, or where did you hear about us? _____

***Present History***

Describe the reason for your visit today.

_____

_____

_____

_____

_____

Are you currently depressed? Yes No

Have you had past episodes of depression? Yes No

Describe any **current** symptoms that you have regarding the following:

Sleep _____

Appetite _____

Mood/crying spells _____

Irritability/mood swings _____

Anxiety/Panic attacks _____

Energy/Motivation _____

Interest in normal activities _____

Worrying excessively _____

Libido _____

Concentration/Memory _____

Hearing voices or seeing things _____

Paranoia _____

Thoughts of not being alive _____

No need to sleep for days _____

Acting impulsively _____

Hyperactivity or fidgety _____

Forgetting to do tasks _____

Repetitive or compulsive behavior _____

Phobias or fears _____

Alcohol or illegal drug use _____

Grunts, tics, or jerks _____

Problems caring for yourself _____

Do you presently have suicidal thoughts? Yes No

Have you ever had suicidal thoughts? Yes No

Have you ever attempted suicide? Yes No

Do you or have you had homicidal thoughts? Yes No

Do you have any blood relatives who have committed suicide? Yes No

Do you own any guns or knives? Yes No

**(For office use only)**

Accompanied by: _____

Accompanied by: _____

HPI: _____

Please list the current stresses in your life:

_____

Please list your **current psychiatric** medications.

Medication _____ Dose _____ How long? _____ Side effects _____

Medication _____ Dose _____ How long? _____ Side effects _____

Medication _____ Dose _____ How long? _____ Side effects _____

Medication _____ Dose _____ How long? _____ Side effects _____

Medication _____ Dose _____ How long? _____ Side effects _____

Medication _____ Dose _____ How long? _____ Side effects _____

***Past Psychiatric History***

**Psychiatrist or therapist/counselor? Please list and describe.**

| *Date(s) seen? By Whom?* | *For what problem?* | *Treatment used (meds, ECT, therapy)?* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Have you ever been hospitalized in the past for any psychiatric reasons?**

| *Date(s)* | *Where and for what?* | *Treatment used (meds, ECT, therapy)?* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please circle all psychiatric medications that you have tried in the past. Please indicate dosage, dates, and reason for discontinuation (side effects) if it applies.**

| *Medication* | *Dosage* | *Date(s) Start-End* | *Reason for discontinuation (side effect/efficacy)* |
|---|---|---|---|
| Abilify | | | |
| Ambien | | | |
| Adderall | | | |
| Anafranil | | | |
| Antabuse | | | |
| Ascendin | | | |
| Atarax | | | |
| Ativan | | | |
| Buspar | | | |
| Campral | | | |
| Celexa | | | |
| Chloralhydrate | | | |
| Clonidine | | | |
| Clozaril | | | |
| Cogentin | | | |
| Concerta | | | |
| Cymbalta | | | |
| Dalmane | | | |
| Depakote | | | |
| Dexedrine | | | |
| Doral | | | |
| Effexor | | | |
| Elavil | | | |
| Fanapt | | | |
| Geodon | | | |
| Halcion | | | |
| Haldol | | | |
| Klonopin | | | |
| Invega | | | |
| Lamictal | | | |

| | | | |
|---|---|---|---|
| Latuda | | | |
| Lexapro | | | |
| Librium | | | |
| Lithium | | | |
| Lunesta | | | |
| Luvox | | | |
| Marplan | | | |
| Mellaril | | | |
| Methadone | | | |
| Miltown | | | |
| Nardil | | | |
| Norpramine | | | |
| Orap | | | |
| Pamelor | | | |
| Parnate | | | |
| Paxil | | | |
| Prosom | | | |
| Pristiq | | | |
| Prolixin | | | |
| Remeron | | | |
| Restoril | | | |
| Risperdal | | | |
| Ritalin | | | |
| Saphris | | | |
| Serax | | | |
| Seroquel | | | |
| Serzone | | | |
| Soma | | | |
| Sonata | | | |
| Stelazine | | | |
| Strattera | | | |
| Suboxone/Subutex | | | |
| Symmetrel | | | |
| Tegretol | | | |
| Thorazine | | | |
| Tofranil | | | |
| Topomax | | | |
| Traxene | | | |
| Trazodone | | | |
| Trileptal | | | |
| Valium | | | |
| Vibryd | | | |
| Vistraril | | | |
| Vivitrol | | | |
| Wellbutrin | | | |
| Xanax | | | |
| Zoloft | | | |
| Zyprexa | | | |

Any other psychiatric medications you have taken?

_____

_____

_____

***Medical History***

Please list any medical problems or diagnoses that you have? _____

_____

_____

***Past Medical Care***

Do you have a primary care doctor? Name _____ Last seen? _____

Address _____

Phone Number _____ Fax Number _____

Please give the name of any other medical doctor from whom you receive regular treatment

Name _____ Specialty _____

Name _____ Specialty _____

**Medical/Surgical Hospitalizations:**

Date Reason _____

Date Reason _____

Date Reason _____

Date Reason _____

**Please list all current medications.**

| ***Medication*** | ***Dosage*** | ***Times per day*** | ***For what condition*** | ***Prescriber*** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are you allergic to any medications/food? Yes No

Medication/Food_____ Reaction _____

Medication/Food_____ Reaction _____

**Please circle if you currently or have recently experience any of these physical symptoms.**

| | | | | | |
|---|---|---|---|---|---|
| Fever | Headache | Constipation | Hot/Cold flashes | Chills | Chest pain |
| Acid reflux | Decreased sex drive | Night sweats | Shortness of breath | Joint pains | Problems reaching orgasm |
| Unexplained weight loss/gain | Heart palpitations | Muscle pains or tension | Easy bruising or bleeding | Weakness in arms/leg | Cough |
| Pain or difficulty urinating | Rashes | Numbness in arms/legs | Sore throat | Dental problems | Episodes of passing out |
| Nausea or vomiting | Changes in vision | Problems walking | Diarrhea | Changes in hearing | |

**For Women**

Last menstrual period? _____ Usually regular? Yes No

Do you use any birth control? Yes No If yes, please list: _____

Have you been pregnant before? Yes No If yes, how many times? _____

Miscarriages? Yes No Elective abortions? Yes No

Any depression or unreal thoughts around pregnancies? Yes No

***Substance Use History***

**How often have you used the following substances?**

| *Substance* | *Last time used?* | *Approximately how often (times per day, week, month or year)?* | *How much is used in a sitting if/when you use?* |
|---|---|---|---|
| **Tobacco** | | | |
| ***Alcohol*** | | | |
| ***Marijuana or K2/"spice"*** | | | |
| ***Cocaine*** | | | |
| ***Opiates (e.g. Heroin, morphine, Percocet, oxycodone, Tylenol #3, Dilaudid/hydromorphone)*** | | | |
| ***Tranquilizers/sedatives (e.g. Xanax, Ativan, Klonopin, Valium)*** | | | |
| ***PCP or LSD*** | | | |
| ***Mushrooms*** | | | |
| ***Others*** | | | |

***Family History***

**Please list blood relatives who have been diagnosed with the following conditions.**

Alcoholism _____

Anxiety disorders _____

Bipolar disorder _____

Cancer _____

Depression _____

Diabetes _____

Drug abuse _____

Heart disease/high blood pressure/arrhythmias _____

Osteoporosis _____

Seizures _____

Schizophrenia _____

Strokes _____

Suicides _____

Thyroid disease _____

***Social History***

Where do you currently live? _____
Who lives with you? _____
Where were you born and raised? _____
Were you raised by your biological parents? Yes No
If no, describe _____

Do you have siblings? Yes No If so, how many? _____
Significant religious/cultural beliefs _____
Primary emotional sources of support _____
What do you do in your free time to relax? _____

Have you ever been a victim of a violent crime? Yes No
Have you ever been physically, emotionally, or sexually abused? Yes No
If Yes, please explain: _____

Please list any significant losses or deaths in your life:
Date _____ Description _____
Date _____ Description _____
Date _____ Description _____
Date _____ Description _____

Highest level of education _____

Current job/occupation _____
What jobs have you had in the past? -

Are you currently married? Yes No If yes, how long? _____
Are you having marital or relationship problems? Yes No
If yes, describe _____
Do you have children? Yes No
If Yes, what are their ages? _____
If you have children, do they have any significant psychiatric or medical problems? Yes No
If Yes, please describe _____

Previous marriages? Yes No # of times? _____

**SIGNATURE:** _____ **DATE:** _____
**Patient or Guardian**

**(For office use only)** _____

Name: _____ Today's Date: _____

# REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

**Const. (Health in General)** ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

**Ears, Nose, Mouth & Throat** ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

**C-V (Heart & Blood Vessels)** ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

**Resp. (Lungs & Breathing)** ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

**GI (Stomach & Intestines)** ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

**GU (Kidney & Bladder)** ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

**MS (Muscles, Bones, Joints)** ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

**Integ. (Skin, Hair & Breast)** ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

**Neurologic (Brain & Nerves)** ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

**Psychiatric (Mood & Thinking)** ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

**Endocrinologic (Glands)** ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

**Hematologic (Blood/Lymph)** ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

**Allergic/Immunologic** ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

## Patient Health Questionnaire (PHQ-9)

**Patient Name:** _____ **Date:** _____

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems? | | | | |
| a. Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| b. Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| c. Trouble falling/staying asleep, sleeping too much | ☐ | ☐ | ☐ | ☐ |
| d. Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| e. Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| f. Feeling bad about yourself or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| g. Trouble concentrating on things, such as reading the newspaper or watching television. | ☐ | ☐ | ☐ | ☐ |
| h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual. | ☐ | ☐ | ☐ | ☐ |
| i. Thoughts that you would be better off dead or of hurting yourself in some way. | ☐ | ☐ | ☐ | ☐ |
| 2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
| | ☐ | ☐ | ☐ | ☐ |

A. Notifier:

B. Patient Name: C. Identification Number:

# Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D._____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.**