Ben H. Guiot, M.D.
14810 Old St Augustine Rd., Ste. 207
Jacksonville, FL 32258
Phone (904) 217-7450 Fax (904) 217-7483

Patient Information Sheet

First Name: _____ Middle Initial: _____ Last Name: _____

Age: _____ Birth Date:_____ SS#:_____ Gender: M_____ F_____

Race: _____ Ethnicity: _____ Preferred Language: _____

Mailing Address: _____ City: _____ State: _____ Zip _____

Preferred Phone Number: _____ Alternate Phone Number: _____

Email Address : _____ Do you want appointment reminder? Yes ( ) No ( )

Employer: _____ Work Phone: (_____)_____

Emergency Contact: _____ Emergency Contact Phone: (_____)_____

Relationship: _____

Authorized Person/s to discuss your care: _____

Primary MD: _____ Referred by: _____

Primary Insurance / Insurance Information

Company: _____ Policy ID: _____
Group No.: _____

Secondary Insurance
Company: _____ Policy ID: _____
Group No.: _____

I understand that in order to have these services properly paid by my insurance company, that I am responsible for the accuracy of the above information. I authorize the release of medical records required for claim payment. I further assign all benefits payable to Ben H. Guiot, MD dba Neuro Spine Florida. Should my insurance fail to pay in full for these services, I assume full responsibility for the remaining balance due.

_____ _____
Patient/Responsible Party Signature Date

PATIENT NAME: _____ DOB: _____

What is the reason that you are here for today? **Today's Date: _____**

Rate Your Pain (0 = No pain, 10 = worst pain you can imagine)

Right Now:	0	1	2	3	4	5	6	7	8	9	10
At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

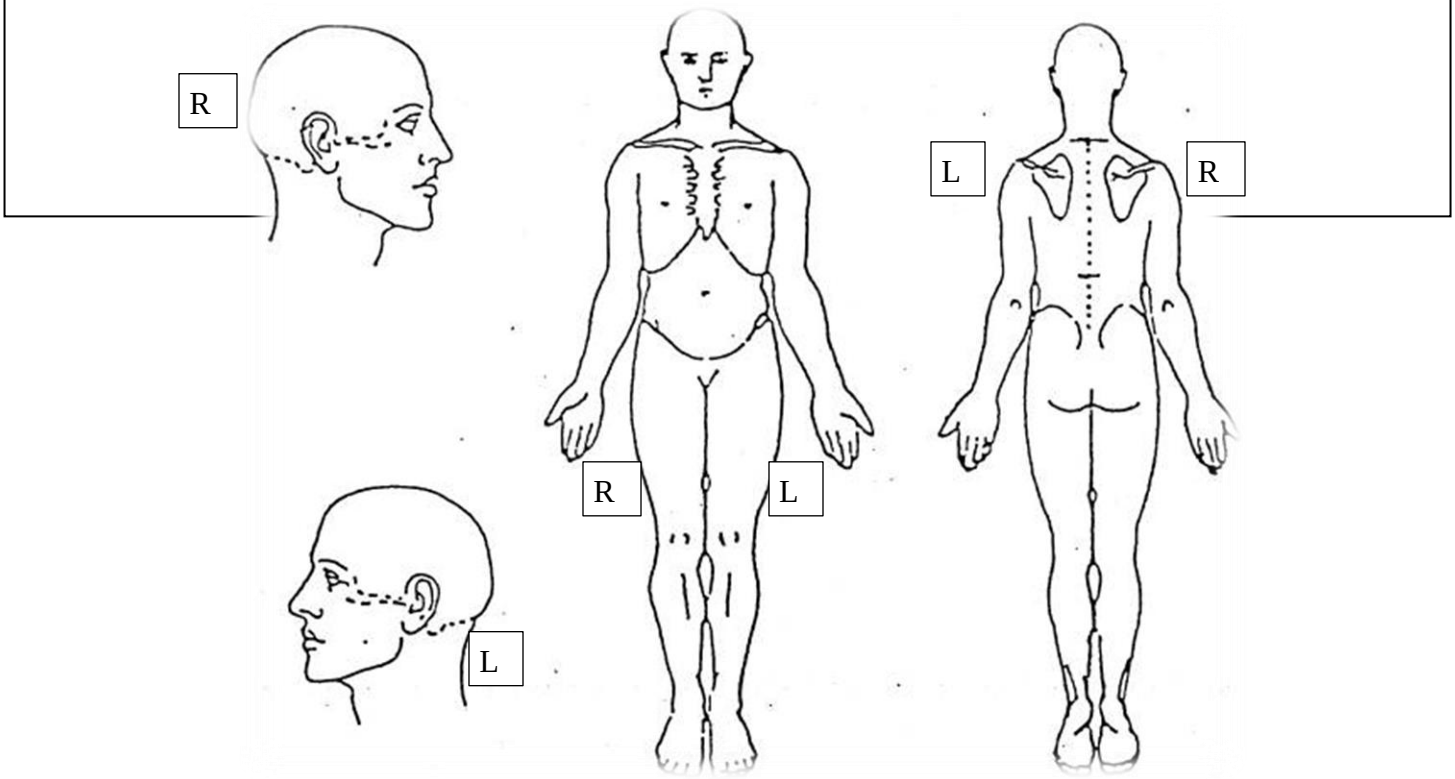
Pain Occurs ( ) Intermittent ( ) Constant ( ) Daily

What is the approximate date your condition commenced? _____

Pain Diagram

Please be sure to fill out this form out extremely accurately. Mark the areas on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain, and include all affected areas. You may draw on the face as well. Please note the letters "R" & "L" indicate right side or left side.

Aches (^^^^) **Numbness** (oooo) **Pins/Needles** (****) **Burning** (xxxx) **Stabbing** (////)



List any other helpful information describing your pain

PATIENT NAME: _____ DOB:_____

***YOUR* PAST MEDICAL HISTORY** *(Mark "None" if you did not have any of the listed conditions)*

Cardiac (Heart)
( ) None
( ) Heart Attack
( ) Chest Pain
( ) Hypertension/High Blood Press.
( ) Shortness of Breath
( ) Irregular Heart Rate
( ) High Cholesterol
( ) Valve Problems: Prolapse/Murmurs
( ) Other_____

Hematologic (Blood)
( ) None
( ) Anemia
( ) Clotting Problems
( ) Easy Bruising
( ) Other_____

Other Medical Problems
( ) Diabetes ( ) None
( ) Thyroid Problems
( ) Stress
( ) HIV/AIDS
( ) Depression
( ) Mental Illness
( ) Skin Problems/Discoloration
( ) Sleep Problems
( ) Gout
( ) Eye Problems
( ) Ear, Nose, Throat Problems
( ) Transfusion
( ) Other _____

Pulmonary (Lung)
( ) None
( ) Asthma
( ) Emphysema/COPD
( ) Bronchitis
( ) Chronic Cough
( ) Pneumonia
( ) Other _____

Gastrointestinal/Hepatic
( ) None
( ) Ulcers
( ) Gallbladder Problems
( ) Hepatitis A, B, or C
( ) Liver Disease
( ) Diarrhea
( ) IBS/GERD
( ) Reflux
( ) Vomiting
( ) Other_____

Renal(Kidney/Bladder)
( ) None
( ) Kidney Stones
( ) Chronic Infections
( ) Dialysis
( ) Kidney Failure
( ) Prostate Problems
( ) Other_____

Neurological Disease
( ) None
( ) Epilepsy/Seizures
( ) Stroke/TIA
( ) Parkinson's
( ) MS
( ) Dizzy/Fainting Spells
( ) Headaches
( ) Other_____

Cancer
Type _____

Treatment _____

PAST SURGICAL PROCEDURES ☐ NONE

TYPE	YEAR	TYPE	YEAR
_____		_____	
_____		_____	

Any other information you feel is necessary for our providers to treat you today?

_____

_____

_____

PATIENT NAME: _____ DOB:_____

SOCIAL HISTORY

Marital Status:
( ) Single ( ) Married ( ) Divorced ( ) Widowed

Number of Children: _____

Do you use nicotine products?

( ) No, never have
( ) Past Smoker, I stopped in _____(year)
How old were you when you started smoking? _____ years old
How long did you regularly smoke? _____ months/year(s)
How much did you use? _____packs/cans/cigars per day
( ) Yes, I do
_____ packs/cans/cigars per day
How old were you when you started smoking? _____ years old.

Do you drink alcoholic beverages?

( ) None
( ) Occasional 1-3/week
( ) Moderate 4-6/week
( ) Often 7 or more a week Amount per day _____

Drug use:

( ) None
( ) Only in the past
( ) Yes, I do

ALLERGIES ☐ NONE

Medication	Reaction	Other	Reaction
_____		_____	
_____		_____	

CURRENT MEDICATIONS ☐ NONE

NAME	DOSE	NAME	DOSE
_____		_____	
_____		_____	
_____		_____	

PHARMACY

Name: _____ City: _____

Phone Number: _____ Fax: _____

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS CONTAINING PROTECTED HEALTH INFORMATION

I hereby authorize Neuro-Spine Florida & Florida Neurosurgery to disclose or obtain the information described below.

Patient Information	Full Name_____ Date of Birth_____ Social Security Number:_____
Type of Authorization □ Self □ **Disclose** medical information **to**: □ **Obtain** medical information **from**:	Name_____ Address_____ Telephone Number_____
Purpose for Request	□ Continuity of Care □ Insurance □ Attorney □ Surgery Authorization □ At Request of the Patient □ Other_____
Requested Information	□ **Entire Medical Record** □ **Portions of Medical Record** from _____ to _____ [Dates]. □ **Other:**_____
Format	□**Paper** □**Electronic**

EXPIRATION DATE: This authorization will expire **thirty (30) days** from the date listed at the top of this form unless a different expiration date or expiration event is written here: _____.

REVOCATION: I understand that I have the right to revoke this authorization in writing any time, however I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy. Written notice should be directed to the Neuro Spine Florida's Privacy Officer.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

Signature: _____ □ Patient □ Personal Representative

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Financial Policy and Notice of Privacy Practices

These forms are available for your viewing online, or to be printed at the office per your request.

Acknowledgement

You will be asked to sign an acknowledgement of your receipt of the Financial Policy and Notice of Privacy Practices. We are required by law to make a good faith effort to provide you with our Financial Policy and Notice of Privacy Practices and obtain such acknowledgment from you. However, your receipt of care and treatment from Neuro-Spine Florida is not conditioned upon your providing the written acknowledgement.

Acknowledgement of Receipt

I hereby acknowledge that I have received and reviewed a copy of Neuro-Spine Florida's Financial Policy and Notice of Privacy Practices.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient/patient's representative Relationship to patient

For Office Use Only

_____
Date Received

_____
Signature