

**Ben H. Guiot, M.D.**

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Phone (904) 217-7450 Fax (904) 217-7483

**Patient Information Sheet**

First Name:  Middle Initial: 

Last Name: 

Age:  Birth Date:  SS#: 

Gender: Male Female

Race:  Ethnicity:  Preferred Language: 

Mailing Address: 

City: State: Zip: 

Preferred Phone Number: 

Alternate Phone Number: 

Email Address : 

Employer: Work Phone: 

Emergency Contact:  Emergency Contact Phone: 

Relationship: 

Authorized Person/s to discuss your care: 

Primary MD:  Referred by: 

**Patient Name:  DOB: **

**Primary Insurance / Attorney Case Information**

Company: Attorney Name: 

Group No.:  Policy ID: 

**Secondary Insurance**

Company:  Policy ID: 

Group No.:

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

****

Pain Occurs  Intermittent  Constant  Daily

**What is the approximate date your condition commenced?** 

**ALLERGIES**  **NONE**

**Medication & Reaction:**

****

**CURRENT MEDICATIONS**  **NONE**

**NAME & DOSE:**



**Pharmacy: **

**Patient Name:  DOB: **

**PAST SURGICAL PROCEDURES**  **NONE**

**TYPE & YEAR**

****

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

****

**Name & relationship of whom we can share your medical information with if needed?**

****

I understand that to have these services properly paid by my Insurance / Attorney, 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 Neuro Spine Florida / Florida Neurosurgery. Should my Insurance / Attorney fail to pay in full for these services, I assume full responsibility for the remaining balance due.

 

Patient/Responsible Party E-Signature Date

**Patient Name:  DOB: **

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

Cardiac (Heart) Hematologic (Blood) Other Medical Problems

**None**  **None**  **None**

Heart Attack  Anemia  Thyroid Problems

Chest Pain  Clotting Problems  Diabetes

Hypertension/High Blood Press.  Easy Bruising  HIV/AIDS

Shortness of Breath  Other  Depression

Irregular Heart Rate  Mental Illness

High Cholesterol  Skin Problems/Discoloration

Valve Problems: Prolapse/Murmurs  Sleep Problems

Other  Gout

Eye Problems

Ear, Nose, Throat Problems

Transfusion

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulmonary (Lung) Gastrointestinal/Hepatic Renal(Kidney/Bladder)

**None**  **None**  **None**

Asthma  Ulcers  Kidney Stones

Emphysema/COPD  Gallbladder Problems  Chronic Infections

Bronchitis  Hepatitis A, B, or C  Dialysis

Chronic Cough  Liver Disease  Kidney Failure

Pneumonia  Diarrhea  Prostate Problems

Other  IBS/GERD  Other

Reflux

Vomiting

Other

Neurological Disease Cancer

**None**  **None**

Epilepsy/Seizures Type & Treatment:

Stroke/TIA Click or tap here to enter text.

Parkinson’s

MS

Dizzy/Fainting Spells

Headaches

Other

**Patient Name:  DOB: **

**SOCIAL HISTORY**

**Marital Status:**

Single  Married  Divorced  Widowed

**Number of Children:** Click or tap here to enter text.

**Do you use nicotine products?**

No, never have

No, I stopped in Click or tap here to enter text. (year)

How old were you when you started smoking? Click or tap here to enter text. years old

How long did you regularly smoke? Click or tap here to enter text. months/year(s)

How much did you use? Click or tap here to enter text. packs/cans/cigars per day

Why did you stop smoking?

Afraid of Health Hazards  Can’t Afford

Depressed You  Institutional Influence

Yes, I do

Click or tap here to enter text. packs/cans/cigars per day

How old were you when you started smoking? Click or tap here to enter text. years old.

Have you thought about quitting?  Yes  No

Are you ready to quit?  Yes  No

**Do you drink alcoholic beverages?**

None

No, I stopped in Click or tap here to enter text.

Yes, I do

Amount per day/week/month Click or tap here to enter text.

**Drug use:**

None

Only in the past

Any history of IV drug use?  Yes  No

Yes, I do

Any IV drug use?  Yes  No

Types of drugs used Click or tap here to enter text.

**Do you exercise?**

No

Yes If yes, type Click or tap here to enter text. How often Click or tap here to enter text.



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**AUTHORIZATION FOR 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: Click or tap here to enter text.  Date of Birth: Click or tap here to enter text. |
| **Authorization to disclose/obtain:** | I, Click or tap here to enter text. give Neuro Spine Florida / Florida Neurosurgery authorization to disclose and/or obtain any/all necessary medical records deemed necessary for my care. |
| **Purpose for Request** | Continuity of Care Insurance Attorney Surgery Authorization  At Request of the Patient  Other: Click or tap here to enter text. |
| **Requested Information** | **Injection Procedures/Reports**  **Office Notes/Consultation Reports**  **Operative Reports**  **Physical Therapy Reports**  **Radiology Reports**  **Entire Medical Record**  **Other:** Click or tap here to enter text. |

**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: Click or tap here to enter text.

**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 / Florida Neurosurgery’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: Click or tap here to enter text. Patient PersonalRepresentative



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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 / Florida Neurosurgery 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 / Florida Neurosurgery’s Financial Policy and Notice of Privacy Practices.

Click or tap here to enter text. Click or tap here to enter text.

Signature of patient or patient’s representative Date

Click or tap here to enter text. Click or tap here to enter text.

Printed name of patient/patient’s representative Relationship to patient

**For Office Use Only**

Click or tap to enter a date.

Date Received

Click or tap here to enter text.

Signature