Name_____ DOB_____ Todays Date _____

Circle any of the following that you may have or have had in the past:

Asthma	Atrial Fibrillation	Anemia	Anxiety
COPD	Colon Cancer	CAD	Crohn's
Depression	Diabetic type II	Diabetic type I	Diverticulitis
Hx DVT	GI Bleeding	GERD	Hyperlipidemia
Hypertension	Hypothyroidism	Hyperthyroidism	Hepatitis A, B, C
Kidney Disease	Kidney Stone	Heart Attack	Seizure Disorder
Breast Cancer	Prostate Cancer	Stomach Cancer	HIV

OTHER:

_____

_____

List of Surgical Procedures:

_____

_____

_____

_____

Colonoscopy Date of last one:_____

Esophagogastroduodenoscopy Date of last one:_____

Cardiac Cath:_____

Cardiac Cath with stents:_____

Pacemaker or Defibrillator (Please give receptionist a copy of this card):_____

List of all Medications: Name, dosage, and frequency: **Include all over the counter medications & Vitamins**

_____

_____

_____

Medication Allergies:

_____

_____

_____

Family History of any of these diseases in your immediate family? If so, please list family members:

Colon/Rectal Cancer _____

Cancer of Breast _____

Cancer of Pancreas_____

Cancer of the Stomach_____

Cancer of Esophagus_____

Diabetes_____

Heart Attack _____

Stroke _____

Other_____

Social History: (Circle one)

- Smoker: Current, Former, Never Smoked — how long_____ how much _____ quit _____
- Alcohol use: Yes No — how often _____
- Drug use: Yes No
- Regular Exercise: Yes No

Height _____ Weight _____

Female only: Date of last menstrual period _____ (approx.)

Date of Hysterectomy_____

Current Problems: (circle any of the following problems)

General: Fever Fatigue Weight Loss Glasses Dentures Bridge Loose Tooth

_____

GI: Abdominal Pain Nausea Vomiting Diarrhea Constipation Change in Bowel Habits
Blood in stool / Toilet Paper Gas/Bloating Indigestion Heartburn Dysphagia Gas

_____

Breast: Left Breast Lump Right Breast Lump Nipple Discharge Breast Pain
Abnormal Mammo Breast Enlargement

_____

Cardiac: Chest Pain/ Discomfort Racing Skipping Heart Beat Palpitations
Swelling of Hands or Feet Syncope/Fainting

_____

Respiratory: Cough Shortness of Breath Coughing up Blood Wheezing

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Vascular: Varicose Veins Leg Swelling Leg Redness Leg Coolness
Pain in Legs with Walking Resting Leg Pain Blue Toes

GU: Incontinence Blood in Urine Urinary Frequency Urinary Urgency
Painful Urination

Wound: Redness Discharge Pain Opening of wound Bleeding of wound

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Derm: New skin lesion Rash Itching Skin Cancer

Neuro: Paralysis Seizures Frequent Headaches Tremors Fainting
Dementia Alzheimer's

Psych: Depression Anxiety Memory Loss Thoughts of Suicide Confusion

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Endo: Cold Intolerance Heat Intolerance Unusual Weight Change

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Heme: Abnormal Bruising Bleeding Enlarged Lymph Nodes

MS: Back Pain Sciatica Arthritis

John F. Guarino M.D., P.A.
Maria F. Castilla M.D.
4245 Kings Highway, Unit A
Pt. Charlotte, FL 33980
Phone 941-391-5102
Fax 941-391-6937

WELCOME TO OUR PRACTICE

We would like to welcome you and your family to our practice. It is very important to us that you and your family are happy with your experiences with us.

PREPARATION FOR YOUR APPOINTMENT

Bring your completed patient forms, any medical records you feel are important, any recent x-rays, a medication list, your photo ID and your insurance cards.

PATIENT INFORMATION

Name:_____

Address:_____

Home Phone:_____Cell Phone:_____

Date of Birth:_____Social Security #:_____

Email Address:_____

Spouse's Name:_____Spouse's Date of Birth:_____

Emergency Contact:_____Phone #:_____

Primary Doctor:_____Referring Doctor:_____

Cardiologist_____ Pulmonologist_____

Cancer Specialist _____

Pharmacy/Location _____

John F. Guarino M.D., P.A.
Maria F. Castilla M.D.
4245 Kings Highway, Unit A
Pt. Charlotte, FL 33980

NOTICE OF PRIVACY PRACTICES - HIPAA

The privacy of your protected health information is important to us. We have offered or provided you with a copy of our Notice of Privacy Practices. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. I was offered or I have received Dr. John Guarino M.D. P.A'.s Privacy Notice.

RELEASE OF AUTHORIZATION

Name of Individuals that may have access to your Medical Records: (please print)

HEALTHCARE ADVANCED DIRECTIVES

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. By law, health maintenance organizations (HMOs) are required to provide their patients with written information concerning healthcare advanced directives. I was offered or I have received the healthcare advanced directive pamphlet.

FINANCIAL POLICY

You may discuss your financial responsibility with our billing specialist. We may notify you of your financial responsibility prior to your scheduled surgery or procedure and this will be due 2 days prior to that scheduled date. We will obtain any pre-certification or authorization for you, if necessary.

Self Pay Patient
I understand that I am financially responsible for all charges related to my healthcare. These fees are discussed prior to my treatment, and are due up front unless other arrangements have been made. I was given a copy of the "Self Pay Policy" and I agree to the terms of the policy.

Insured Patient
I authorize my insurance benefits to be paid directly to John F. Guarino MD PA.
I understand that charges that are not covered by my insurance company including my deductible, my co-insurance, and my co-payments, are my financial responsibility.
I authorize John F Guarino M.D., P.A. to release pertinent medical information to my insurance company when requested.

There is a $25.00 charge for all returned payments.

I have read, understand, and agree to the above HIPAA, Healthcare Advanced Directives, and Financial Policy.

_____ _____

Patient name (Please Print) **Patient Signature/Date**