Name_____ DOB_____ Todays Date _____

Reason for today's visit:

_____

_____

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

Asthma	Atrial Fibrillation	Anemia	Anxiety
COPD	Colon Cancer	Coronary Heart Disease	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
Sleep Apnea	Arthritis	Covid	

Other:_____

_____

List of <u>ALL</u> Surgical Procedures/Tests:

_____

_____

Colonoscopy: Date of last one:_____ Facility:_____ Doctor:_____Findings:_____

EGD/Upper Endoscopy: Date of last one:_____ Facility:_____ Doctor:_____Findings:_____

Cologuard: Date of last one: _____ Doctor:_____Findings:_____

Cardiac Cath: Date:_____ Doctor:_____

Cardiac Cath with stents: Date_____ Doctor:_____

Mammogram Date:_____ Facility:_____ Doctor:_____Findings:_____

Pap Smear Date:_____ Facility:_____ Doctor:_____Findings:_____

Pacemaker/Defibrillator Date:_____Manufacturer_____

Received Covid 19 Vaccination: _____ Date:_____Manufacturer_____

List of all Medications: Include blood thinner such as aspirin. Name, dosage, and frequency:

_____

_____

_____

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: Former Never Smoked Current how long_____ how much _____ quit _____

Alcohol use: Yes No how much _____

Drug use: Yes No

Regular Exercise: Yes No **Height** _____ **Weight** _____

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

Current Pain: yes/no If yes, where:_____ Pain scale 1 minimal to 10 maximum _____

Describe pain: (eg. Dull, sharp, stabbing)_____

Circle any of the following that you have CURRENTLY:

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 CPAP/BiPap

---

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

Wounds/Cysts/Abscess: (Current) Location of wound_____ How long _____ days/months

Drainage: yes/no **Warm to touch:** yes/no **Pus:** yes/no **Swelling:** yes/no

Currently on Antibiotic: Yes / No **Pain:** Yes / No **Describe**: _____

Derm: New skin lesion Rash Itching Skin Cancer (Type)_____

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

Psych: Depression Anxiety Memory Loss Thoughts of Suicide Confusion

---

Endo: Cold Intolerance Heat Intolerance Unusual Weight Change

---

Heme: Abnormal Bruising Bleeding Enlarged Lymph Nodes

MS: Back Pain Sciatica Arthritis

John F. Guarino M.D., P.A.
Matthew C. Tufts 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: _____

Insurance Primary: _____ Insurance Secondary: _____

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

Emergency Contact: _____ Phone #:_____

Employer Name_____ Phone #_____

Primary Doctor: _____ Referring Doctor: _____

Cardiologist_____ Pulmonologist_____

Cancer Specialist _____ Hosp Preference_____

Pharmacy/Location _____ Employer/ Profession _____

John F. Guarino M.D., P.A.
Matthew C. Tufts 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

List the names of Individuals that may have access to your Medical Records:

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 business days prior to that scheduled date. We will obtain any pre-certification or authorization for you, if necessary. A 24 business hour notice is required to reschedule an office visit. A 48 business hour notice is required to reschedule a procedure or surgery. Cancellations charges may apply if timely notice is not given to our office. Credit Card processing charge of 3% will apply if payment is made with any credit/debit card.

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 $50.00 charge for all returned payments.
There is a $25.00 charge for office visit cancellations with less than 24- business hour notice.
There is a $50.00 charge for endoscopy cancellations with less than 48- business hour notice.
There is a $100.00 charge for surgery cancellations with less than 48- business hour notice.

Advanced Beneficiary Notice of Noncoverage (ABN). If you are having a colonoscopy and your insurance carrier does not pay, you will be responsible. The intended screening colonoscopy could become subject to your deductible and co-insurance. The estimated cost is $250-$450, depending on your health insurance.

I have read, understand, and agree to the above HIPAA, Healthcare Advanced Directives, financial policies, and disclosures.

_____ **_____**

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