Ivan A. Guerrero, M.D.

Yesenia Baez, A.R.N.P

Northeast Florida Infectious Diseases

6817 Southpoint Parkway, Suite 802

Jacksonville, FL 32216

Ph: 904-646-1987 Fax: 904-646-1501

www.NEFID.net

PATIENT DEMOGRAPHICS

Name: ______________________________ DOB: ______________

Address: ______________________________Zip: ________

SSN#: ______________________ E-mail: ______________________

Home Phone: __________________ Cell Phone: ______________________

Marital Status: __Single __Married __Divorced __Legally Separated __Widowed __Significant Other

Employer: ______________________ Occupation: ____________________

Work Phone: ______________________ May we call you at work? ____________

Who can we speak to about your health care? ______________________________

Relation: ______________ Phone #: ______________________________

Emergency Contact: ______________________ Phone: ______________

Primary Care Physician: ______________________ Phone: ______________

Pharmacy Name: ______________________ Phone: ______________

Primary Insurance: ______________________ Group#: ______________

Policy/ID/Member #: ______________________ Authorization #: ____________

Secondary Insurance: ______________________ Group#: ______________

Policy #: ____

How did you hear about us? ______________________________________

Were you recently hospitalized? _____ Hospital Name: ______________________

If you are Worker's Comp: Case Worker's Name & Phone #: ______________________

______________________________ Injury Date: ______________

I hearby authorize Northeast Florida Infectious Diseases, Ivan Guerrero, MD, PA to furnish information to insurance carriers, case managers and related health care personnel concerning my illness and treatment.

I understand that I am responsible for all charges for treatment recieved, and agree to pay the outstanding balance upon demand.

Patient Signature: ______________________________ Date: ______________

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MEDICATION LIST

Patient Name:____ DOB: _______________________

Allergies & Reactions:____

____

Name of Medication	Dosage	Frequency

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Name: ____ DOB: ____________________

Your answers will help your health care provider better understand your medical concerns and conditions. Thank you!

What is the reason for your visit today? ____

Demographics:

___ Hispanic
___ Non-Hispanic
___ Decline to answer

___ American Indian or Alaska Native
___ Asian
___ Black or African American

___ Native Hawaiian or Pacific Islander
___ White
___ Other

Medical History: Have you ever had any of the following:

Cardiovascular Disease:
___ Heart Attack (MI)
___ Congestive heart failure
___ Atrial fibrillation
___ Pacemaker
___ Hypertension
___ Peripheral vascular disease

Endocrine/Metabolic:
___ Diabetes
___ Thyroid disorder
___ High cholestrol

Gastrointestinal Disease:
___ Reflux
___ Ulcers
___ Crohn's Disease
___ Ulcerative colitis
___ Diverticulitis

Hematology/Cancer:
___ Anemia
___ Blood clots
___ Cancer of ______________________
____
____

Infectious Disease:
___ Hepatitis B
___ Hepatitis C ____ Treated
___ Tuberculosis
___ HIV
___ STD
___ C.Diff (clostridium difficile)

Kidney Disease:
___ Chronic Kidney Disease, Stage _____
___ Dialysis, ____ times weekly
___ Kidney stones
___ UTI ___ recurrent

Musculoskeletal Disease:
___ Arthritis
___ Gout
___ Fibromyalgia

Neurologic Disease:
___ Seizure disorder
___ Stroke/TIA
___ Chronic headaches/Migraines
___ MS
___ ALS

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Name: ____ DOB: ____________________

Skin:

___ Cellulitis
___ MRSA skin infection
___ Boils

Psychiatric Disease:

___ Anxiety
___ Depression
___ other mental illness

Surgical History:

___ Appendectomy
___ Splenectomy
___ Tonsillectomy
___ Cornary artery bypass
___ Heart valve replacement
___ Joint replacement
Specify joint(s): ____________________
____
____
___ Transplant ______________________
____
___ Gallbladder
___ Hysterectomy
___ Breast
___ Colon
___ Hernia

Respirtory Disease:

___ COPD ___ Covid 19 When? ______________
___ Asthma
___ Pneumonia
___ Sinusitis

Have you had the Flu vaccine this year?

___ Yes ___ No

Pneumonia vaccine?

___ Yes ___ No

Covid 19 vaccine?

___ Yes ___ No ___ Booster(s)

___ Other: _________________________________
____
____

Family History:

___ Heart attck before 60 years old
___ Cancer
___ Diabetes
___ Stroke
___ Hypertension
___ Other: _________________________________
____
____

Social History:

Occupation: ____

___ Tobacco/Vape use? Type & amount per day: ___________________________________
___ Former tobacco/Vape user? Quit date: _______________________________________
___ Alcohol use? Type & amount per week: _______________________________________
___ Recreational drug use? Type & amount per week: ______________________________
___ History of injectable drug use? Yes or No
___ Hobbies (hunting, fishing, boating, running, etc): ______________________________

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Name: ______________________________ DOB: ______________

Please tell us if you have experienced any of theses in the last 30 days:

General:

___ Fever
___ Chills
___ Weight loss
___ Fatigue
___ Weakness
___ Dizziness
___ Sweats

Eyes:

___ Change in vision
___ Blurry or double vision
___ Drainage

Ears, Nose Throat:

___ Sore throat
___ Earache
___ Ringing in ears
___ Sinus congestion/pain
___ Diffculty/painful swallowing
___ Oral ulcers

Genitourinary:

___ Frequent urination
___ Painful urination
___ Urinary urgency

Neurological:

___ Seizure
___ Numbness/tingling
___ Headache

Neck:

___ Pain
___ Swollen glands

Respiratory:

___ Cough ____ Productive?
Color: ______________________
___ Shortness of breath
___ Chest pain

Cardiovascular:

___ Chest pain
___ Palpitations/irregular heart beat

Gastrointestinal:

___ Nausea
___ Vomiting
___ Abdominal pain
___ Diarrhea, Frequency: ______________

Skin:

___ Rash
___ Draining wound
___ Itching

Women Only:

Are you pregnant? ___ yes ___ no
Date of last menstration: ______________

Recent International Travel? Where were you and when did you return? ________________

Do you have any pets? What kind? ______________________________

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Medication Refills:

Your pharmacy must call or fax medication refill requests to our office.
Allow 2 business days for the medication to be refilled.

Cancellation Policy:

In the event that it is necessary for you to cancel or reschedule your appointment, please you call our office with a ***minimum of 24 hours advanced notice***. This will provide us time to make that opening available to another patient.

If a 24 hour notice is not recieved, or you do not show for your scheduled appointment, you will be charged a **$50** fee which is not payable by your insurance company or worker's compensation.

There is no charge for appointments cancelled with 24 hours advanced notice.

Payment Policy:

Payment is due at the time of service.
You are responsible for any balance not covered by your insurance company.
This includes your copayments, coinsurance and deductible.
***You are responsible for obtaining any prior-authorizations/referrals from your insurance company*.**

Medical Forms Policy:

All medical forms completed by this office have a $50 fee that is not payable by insurance companies or workers compensation. This includes FMLA forms.
Forms can be picked-up five (5) business days after drop off.

Medical Records Policy:

You may request a copy of your medical records and will available for $1.00 per page.
Lab results will not be available until it is reviewed with you by a member of our medical staff.
A request from another provider must be accompied by a written release signed by the patient.
All request take a minimum of five (5) business days to complete.

Returned Checks:

Any returned checks will be subject to an additional $35 collection fee.

Insurance Authorization:

I authorize the use of my information on all my insurance submissions.
I authorize my insurance company to send payments directly to Ivan Guerrero, MD.
I permit a copy of this authorization to take place of the orginial.

My signature is acknowledgement and understanding of the office policies stated above:

Patient Signature: ______________________________ Date: ________________

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Authorization to Release/Request Records

Patient Name: ________________________________ DOB: ____________________________

Address: ____

____

I request and authorize ____
(Doctor's or facility name)

Phone: __________________________________ Fax: ________________________________

to release/request health care information on the above named patient to Northeast Florida Infectious Diseases, Ivan Guerrero, MD.

This request applies to:

□ All healthcare information

□ Healthcare information in reference to the following treatment, condition or date only:

____

____

□ I authorize release/request of my STI results, HIV/AIDS testing, Hepatitis C testing whether positive or negative, to the persons listed above.

□ I authorize the release/request of records regarding drug, alcohol or mental health treatment to the persons listed above.

□ I authorize Northeast Florida Infectious Disease to release my treatment records from their office to the above named physician/faciltiy.

________________________________ ________________________

Patient Signature Date

____

Office Staff Witness

This authorization expires one year from patient signature date