VENICE PODIATRY

Louis S. Giannone, DPM

P: (941) 412 - 3000
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Date: _____

Please Print

NAME (*First, MI, Last*):			
DOB:	SEX: ☐ M ☐ F	SSN:	WHO REFERRED YOU TO US?
BILLING ADDRESS (*Street, City/State/Zip*):			
HOME NUMBER: CELL NUMBER:		EMAIL:	

Emergency Contact Information	
NAME:	
RELATIONSHIP:	PHONE NUMBER:

Insurance Information	
POLICY HOLDER NAME:	
DOB:	SSN:

Guardian Information (only if patient is a minor)	
NAME:	
REALTIONSHIP:	PHONE NUMBER:
BILLING ADDRESS (*Street, City/State/Zip*):	

MEDICAL CARE TEAM:

List all current doctors by first and last name, including specialty

FOR OFFICE USE ONLY:

Physician:	**Specialty:**	**(if not local physician, where?):**	**Date Last Seen:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please bring photo ID and all current medical insurance cards with your paperwork at time of appointment.

MEDICATIONS:

Please include all prescriptions, over-the-counter medications, and herbal supplements.

Name	Dosage	Frequency

PHARMACY	
NAME:	PHONE #:
ADDRESS:	

Medical History (please circle)

Abnormal bleeding
Alzheimer's Disease
Anemia
Arthritis
- Osteoarthritis
- Psoriatic arthritis
- Rheumatoid arthritis

Asthma
Back trouble
Bladder infection
Blood clots
Blood transfusion
Bronchitis/Emphysema
Cancer
Cataracts
Coronary Artery Disease
Crohn's Disease
Dementia
Diabetes (Type I or II)

Which physician orders your A1C?

DATE OF LAST A1C?

Edema
Fibromyalgia
Glaucoma
Gout
Hearing Aids
Heart attack
Heart disease/failure
Hepatitis
High blood pressure
High cholesterol
HIV+/AIDS
Kidney disease
Liver Disease
Mental illness
Migraine headaches
Mitral Valve Prolapse
Muscle weakness
Neuropathy
Open sores
Paralysis
Parkinson's Disease
Pneumonia
Pneumonia
Polio
Rheumatic Fever
Sickle Cell Disease
Skin disorder
Sleep apnea
Stomach ulcers
Thyroid disease
Thyroid disease
Tuberculosis
Other:
_____
_____
_____
_____

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Allergies (please circle)
None
Iodine
Medications: _____
Anesthesia: _____
Foods/Shellfish: _____
Other: _____

SURGICAL HISTORY:		HOSPITALIZATIONS:	
Type of Surgery	Date (*M/Y*)	Reason	Date (*M/Y*)
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Family History (please circle)	
Alzheimer's Disease	High blood pressure
Dementia	Thyroid disease
Diabetes	Other:
Cancer	_____
Coronary Artery Disease	_____
Heart disease	_____
Rheumatoid Arthritis	_____
Stroke	

Social History (please circle)	
MARITAL STATUS: Single Married Partnered Separated Divorced Widowed	
Are you a FULL TIME or PART TIME resident of Florida?	
SEASONAL ADDRESS (Optional):	
ALCOHOL USE: Never Socially Moderately History of Alcohol Abuse	
TOBACCO USE: Never Socially Moderately Quit	If you currently smoke, how much?
	If you quit, how long ago?
OCCUPATION:	
Retired	
If not retired, Employer? _____	

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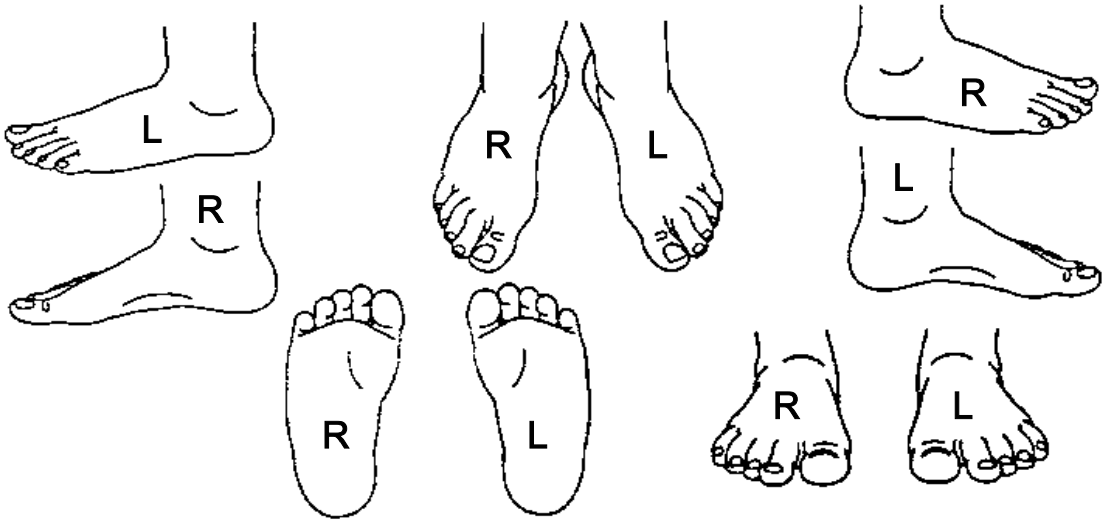
Vitals	
HEIGHT:	WEIGHT:
If applicable, HEMOGLOBIN A1C PERCENTAGE:	

Current Problem		
WHICH FOOT IS THE PROBLEM AFFECTING?		
HOW LONG AGO DID THIS PROBLEM BEGIN?		
Did the problem begin SUDDENLY or GRADUALLY?		
Since the time the problem began, has it IMPROVED, WORSENED, or STAYED THE SAME?		
HOW WOULD YOU DESCRIBE YOUR PAIN?		
No pain	Dull	Sharp
Aching	Itching	Stabbing
Burning	Radiating	Other: _____
WHAT MAKES THE PROBLEM FEEL BETTER?		
WHAT TREATMENTS HAVE YOU ALREADY HAD FOR THIS PROBLEM?		
Please mark the following diagram according to the location of the pain/problem.		



I authorize treatment of the person named above. I confirm that this form was completed to the best of my knowledge. I agree to pay all charges, co-pays, and coinsurance shown by statement promptly. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to VENICE PODIATRY, PLLC unless my account has been paid in full.

_____ _____

Signature Date

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Venice Podiatry, PLLC

Dr. Louis S. Giannone, DPM

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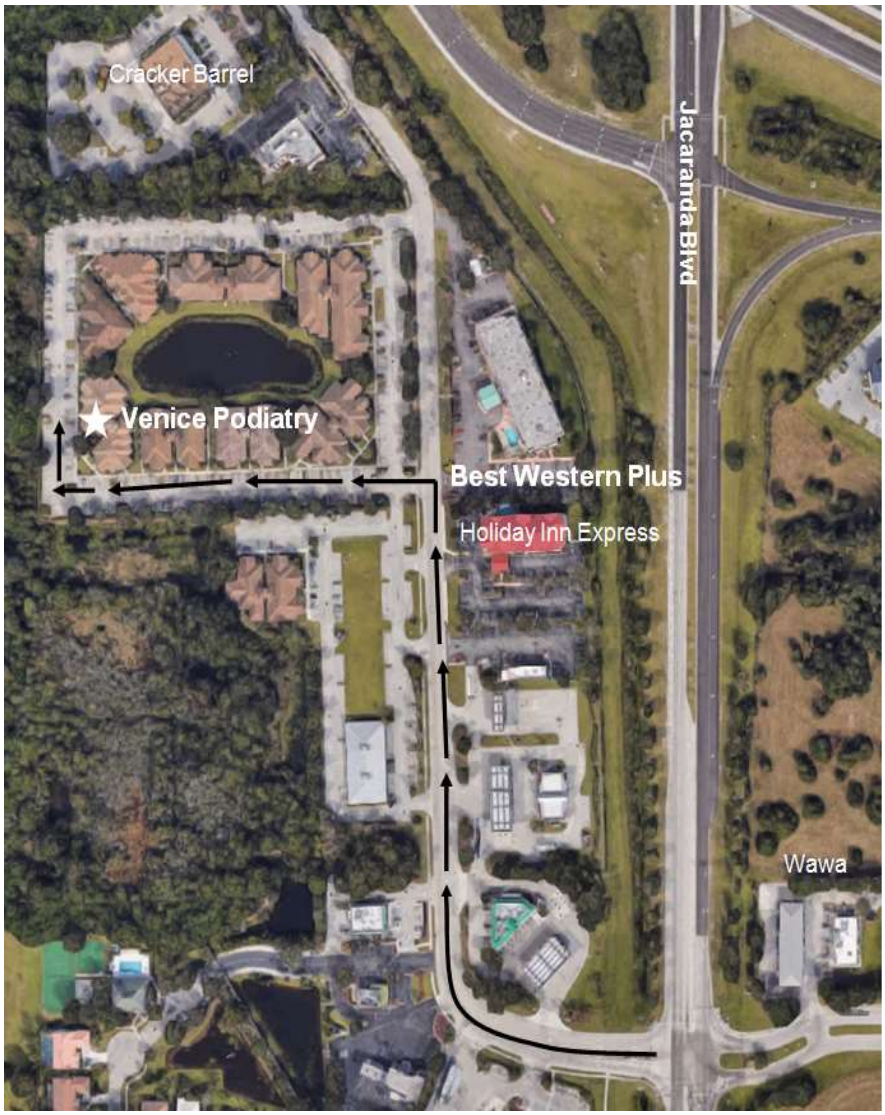

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