VENICE PODIATRY

Louis S. Giannone, DPM

P: (941) 412 - 3000
F: (941) 412 - 3005

Please arrive 15 minutes early

Date: _____

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

FOR OFFICE USE ONLY:

Physician:	**Specialty:**	**(City, State)**	**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	Dementia	Kidney disease	Stomach ulcers
Alzheimer's Disease	Diabetes (Type I or II?)	Liver disease	Thyroid disease
Anemia	Edema	Mental illness	Tuberculosis
Arthritis Osteoarthritis Psoriatic arthritis Rheumatoid arthritis	Endometriosis	Migraine headaches	Other: _____
Asthma	Fibromyalgia	Mitral Valve Prolapse	_____
Back trouble	Gout	Muscle weakness	_____
Bladder infection	Hearing Aids	Neuropathy	_____
Blood clots	Heart attack	Open sores	
Blood transfusion	Heart disease/failure	Paralysis	
Bronchitis/Emphysema	History of falling	Parkinson’s Disease	
Cancer (Type?)	Hepatitis	Pneumonia	
Coronary Artery Disease	High blood pressure	Pneumonia	
Crohn's Disease	High cholesterol	Skin disorder	
	HIV+/AIDS	Sleep apnea	

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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 & indicate paternal, maternal, or sibling)	
Alzheimer's Disease	Stroke
Dementia	High blood pressure
Diabetes (Type I or II?)	Thyroid disease
Cancer (Type?)	Other:
Coronary Artery Disease	_____
Heart disease	_____
Rheumatoid Arthritis	_____
	_____

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	
DRUG USE: Never Socially Moderately History of Drug 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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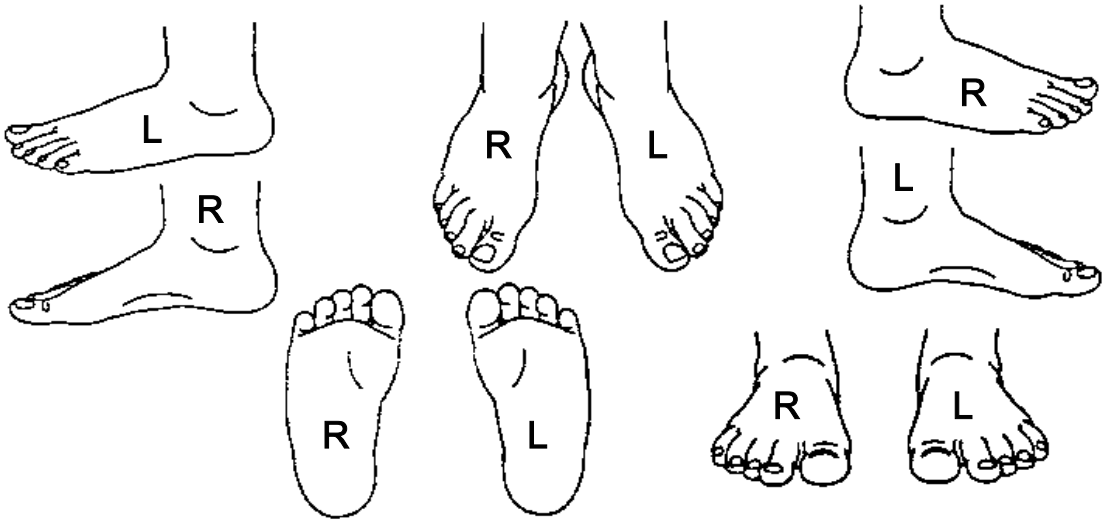
Vitals	
HEIGHT:	WEIGHT:
If applicable, Hemoglobin A1C Percentage:	

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 of Patient/Guardian Date

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