Via Health

1341 Bedford Drive, Ste B Melbourne, FL 32940

Phone (321)622-8031 Fax (321)610-7487

Patient Information

Patient Name (Last, First,Middle)_____ Date of Birth_____

Mailing Address_____ City,State,Zip_____

Home Phone_____ Cell Phone_____Work Phone_____

Social Security#_____ E-Mail_____ Marital Status_____

Emergency Contact_____Phone_____ Relationship_____

Primary Insurance

Name of Insurance_____ Member ID_____

Name of Insured_____ DOB_____ Relationship_____

Secondary Insurance

Name of Insurance_____ Member ID_____

Name of Insured_____ DOB_____ Relationship_____

Tertiary Insurance

Name of Insurance_____ Member ID_____

Name of Insured_____ DOB_____ Relationship_____

Referral Information

How did you hear about us?_____

Signature of Patient/Representative_____ Date_____

Patient Name:_____ Date of Visit:_____

Date of Birth:___/___/____

Preferred Pharmacy & Address_____

Imaging Center:_____ Lab Facility:_____

Please Circle all symptoms that apply to you.

Constitutional:

Fatigue/Weight Gain/Weight Loss/ Loss of Appetite/ Diminished Activity

Eyes:

Eye pain/ Eye Redness/ Eye Itchiness/ Eye Swelling/ Eye Discharge

HENT (Head, Ears, Nose, Throat):

Ear Pain/Ear Discharge/ Hearing Loss/Sinus Pressure/ Drooling/ Facial Swelling/Congestion/Sore Throat/ Hoarseness/ Foul smelling Breath/ Mouth Lesions

Breasts:

Lumps/Tenderness/Swelling/Leaking

Cardiovascular:

Chest Pain/Rapid Heart Beat

Respiratory:

Wheezing/ Cough/ Chest Tightness/Pain with Respiration/ Noisy Breathing/ Rapid Respirations/ Difficulty Breathing

Gastrointestinal:

Nausea/Constipation/Difficulty Swallowing/ Vomiting/ Blood in Stool/ Diarrhea/ Abdominal Pain/ Mucus in Stool

Genitourinary:

Increased Frequency/ Blood in Urine/ Voiding Urgency/ Painful Urination/ Testicular Pain/ Swelling/Redness/ Itching/Masses/Discharge

Skin:

Pain/ Itchiness/ Dry Skin/ Flaking/ Redness/ Rash/ Hives/ Skin Lesions/ Skin Growths/ Skin Lumps/ Insect Bites

Neurological:

Numbness (anywhere)/ Weakness/Tingling/ Burning/ Shooting Pain/ Headaches/ Dizziness/ Loss of Consciousness

Musculoskeletal:

Limited Motion/ Joint Swelling/ Previous Injuries/ Trauma/ Myalgia/ Tissue Swelling

Endocrine:

Increased Thirst/ Increased Drinking/ Temperature Intolerance

Psychiatric:

Anxiety / Depression/ Insomnia/ Loss of Interest

Allergic:

Sneezing, Running Nose, Watery Eyes

Dr.Stephen Giorgianni
1341 Bedford Dr. Unit B Melbourne, Fl 32940
321-622-8031

Name:_____
DOB:_____
Phone #: _____
Date:_____

Surgical History:

Procedure	Surgery Date

Medication: Please list more on the back of this page

Medication	How Often do you take?	Medication	How often do you take

Are you Allergic to any Medications? If any please list.

Drug/Allergens	Reactions	Onset date

Vaccines:	Yes or No	Date
Flu (influenza)		
Shingles		
Pneumonia (pneumovax)		
Tetanus (Tdap)		

Routine Screenings:	Yes or No	Results & Date
Mammogram		
Colonoscopy		
Pap Smear		
Physical Exam		
Prostate Exam		

Family History:

Relation	Problem/Disease	Onset Age/ Died at what age

Social History:

Advance directive	Yes or No
Do you smoke?	Never Current Former
Smoking- How Much?	Packs- per day-
Smoking since at what age?	
Chewing Tobacco	Yes or No
Alcohol Intake	None Occasional Moderate Heavy
Illicit Drugs	Yes or No
Occupation	

Marital Status	
Education	
Diet	Regular Vegetarian Gluten Free Diabetic
Caffeine Intake	None Occasional Moderate Heavy
Exercise Level	None Occasional Moderate Heavy
General Stress Level	Low Medium Heavy
Seat Belt Used Routinely	Yes or No
Sunscreen Used Routinely	Yes or No

Past Medical History:

Problem	**Check if Yes**	**Problem**	**Check if yes**
Allergies		**Blood clots**	
Anemia		**DVT**	
Anxiety		**COPD**	
Aortic Aneurysm		**CVA**	
Arrhythmia		**Cancer (Please Specify)**	
Arthritis		**Cardiomyopathy**	
Asthma		**Congestive Heart failure (CHF)**	

Coronary Artery Disease		**Has Pacemaker**	
Depression		**Heart Attack**	
Diabetes		**Heart Disease**	
Dialysis		**Hepatitis**	
Diverticulitis		**Hiatal Hernia**	
GERD/Reflux		**Hyperlipidemia**	
GI Problems		**Hypertension**	
Gout		**HIV/AIDS**	

Kidney Disease		**Seizures/Epilepsy**	
Liver Disease		**Stroke/TIA**	
Migraines		**Thyroid**	
Osteoporosis		**UTI**	
Pulmonary Embolism		**Ulcers**	

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CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT RESPONSIBILITY

CONSENT TO MEDICAL TREATMENT The undersigned consents to the medical treatment, as may be deemed necessary or advisable in the judgement of the physician or other provider.

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION In consideration of services rendered, I hereby transfer and assign to Stephen M. Giorgianni, DO and Viera Family Medicine and Wellness all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

FINANCIAL AGREEMENT The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

MEDICARE/MEDICAID Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the office treating me.

USE OF COPIES I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the office.

PAYMENT RESPONSIBILITY I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibility to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME, NOT TO EXCEED 60 DAYS.

PATIENT NAME _____

AUTHORIZED REPRESENTATIVE_____

SIGNATURE_____ **DATE**_____

Via Health

1341 Bedford Drive, Suite B

Melbourne, FL 32940

(321)622-8031

Receipt of Privacy Practices and Advance Directive Information Written Acknowledgement Form

I have received a copy of Via Health's notice of privacy practices. I understand that I may request a personal copy of same by contacting the Office Manager.

I further acknowledge that I have been offered Advanced Directive information that I have either:

_____ accepted

_____ denied.

Patient Name_____

Authorized Representative_____

Signature_____ **Date**_____