**Patient Information**

Patient Name (Last, First, Middle) | Social Security # | Date of Birth | Married | Single | Sex

Mailing Address | E-Mail Address

City, State, Zip Code | Primary Care Physician

Home Phone | Cell Phone

Primary Employer | Emergency Contact Name

Local Address | Emergency Contact Relationship to Patient

City, State, Zip Code | Emergency Contact Home Phone

Work Phone | Emergency Contact Work Phone

**Payment Responsible Party Information (if different from above)**

Name (Last, First, Middle) | Social Security # | Date of Birth | Married | Single | Sex

Mailing Address | Secondary Billing Address (if applicable)

City, State, Zip Code | City, State, Zip Code

Home Phone | Home Phone

Relationship of Insured Patient | Cell Phone

**Primary Insurance**

Name of Insurance Company | Policy Number

Name of Insured | Group Number

Mailing Address of Insurance Company | Copay Amount

City, State, Zip Code | Deductible

Relationship of Insured Patient | Effective Date | Expiration Date

**Secondary Insurance**

Name of Insurance Company | Policy Number

Name of Insured | Group Number

Mailing Address of Insurance Company | Copay Amount

City, State, Zip Code | Deductible

Relationship of Insured Patient | Effective Date | Expiration Date

**Referral Information**

Name of Referring Physician | City, State

How did you hear about us (if not referred by another physician)?

SIGNATURE OF PATIENT/ RESPONSIBLE PARTY | DATE

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** | |

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

Viera Family Medicine and Wellness

1341 Bedford Dr.

Melbourne, Fl 32940

321-622-8031

# RECEIPT OF PRIVACY PRACTICES AND ADVANCE DIRECTIVE INFORMATION WRITTEN ACKNOWLEDGEMENT FORM

I _____, have reviewed a copy of Stephen Giorgianni, D.O.'s notice of privacy practices. I understand that I may request a written copy of same by contacting the Office Manager.

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

_____accepted, or

_____denied.

_____. _____

Signature of Patient. Date

# CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician _____ (initials)
2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION** In consideration of services rendered, I hereby transfer and assign to Dr. Stephen Giorgianni. Do 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, workman's compensation carriers, welfare funds or the patient's employer. _____ (initials)
3. **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's 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. _____ (initials)
4. **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. _____ (initials)
5. **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. _____ (initials)
6. **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 for 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. _____ (initials)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I have received on this, or a prior occasion, the Notice of Privacy Practice and acknowledge that I have a copy of the notice or that I requested, and was given a copy.

Received Copy This Date: Yes No Previously Received Copy: Yes No

Patient /Legal Representative:_____ Witness:_____

Patient unable to acknowledge receipt of the Notice of Privacy: _____

Patient refused to Sign Acknowledgment: _____ Reason: _____

PATIENT'S SIGNATURE: _____ DATE: _____

SUBSCRIBER SIGNATURE (if different than patient): _____