PODIATRY / WOUND CARE

Dr. John Savidakis Jr.
2701 Park Drive, Suite #6
Clearwater, FL 33763

(727) 796-1490
Fax: (727) 797-5611

WELCOME TO OUR OFFICE

Today's Date : ____/____/_____ (Please use black ink.)

PATIENT INFORMATION: ___Male ___Female **DIABETIC**: ___Yes ___No

Name : ____________________________________ Date of Birth: ___/____/____ Age: ___

Address : _______________________________ Email address: _____________________

_________________________ __________ ___________- ______
City State Zip Code

Home Phone : __________________________ Cell Phone: __________________________

Social Security Number : ____

Marital Status: __ Single __ Married __ Widowed __ Divorced __ Separated

Employer :_______________________________ Occupation: _________________________

Work Phone: ____________________________

Guardian's Name and Phone (if patient is a minor) __________________________________

Emergency Contact : ______________________ Relationship ________ Phone ____________

Referred By : ____

Primary Care Physician : ______________________________ Date Last Seen : ___________

Your Pharmacy : ____

Insurance: Please provide the office with your Insurance card(s) and photo ID.
The office will photo copy these for our records.

Name: ______________________________________ Date of Birth : ____/____/_____

Today's Date : __________________

PAST MEDICAL HISTORY (Please list all medical conditions which you have and are being treated for):

____

____

____

____

____

PAST SURGICAL HISTORY (Please list any surgeries that you have had):

____

____

____

____

FAMILY HISTORY (Please list any relevant medical family history):

____

SOCIAL HISTORY:

Tobacco: __ Never __Currently smoke __packs/day and have done so for ___ years
__ Previously smoked __ packs/day for __ years. Stopped in _________.

Alcohol: __ Never __ Rarely __ Moderate __ Daily Drinks per day: ___

Caffeine: __ Never __ 1-3 servings daily __ 3-4 servings daily __ More than 6 daily

Are you in: __ Good health __ Fair health __ Poor health
If there was one thing you could change about your health, what would that be ?

____

My Medication List

Name:____ Date of Birth:___/___/___

Today's Date:_______________ Height:___________ Weight:_____________

Please list all medications you are currently taking. Include all prescription and over-the-counter medications, herbal products, and nutritional supplements.

Name of Medication	**Strength/Dose**	**How often do you take?**													

Do you have any allergies? __Yes __No / If yes, what type of reaction did you have?

__ Aspirin _____________ __ Latex ________________________ __ Silver__________________

__Codeine_____________ __ Local Anesthesia______________ __ Sulfa Drugs_____________

__Foods_______________ __ Penicillin ___________________ __ Tape or band aids________

__ Iodine______________ __ Pollen______________________ __ Other__________________

Name: ____________________________________ Date of Birth : ____/____/_____

Today's Date : _______________ Shoe Size: _____

PODIATRIC HISTORY: What is the reason for today's visit?

____

____

____

____

When did this problem start? ____

Since your pain / problem began, has it: __ stayed the same __ become worse __improved

Where is the pain / problem located? ____

How would you describe your pain? (circle all that apply):

No pain Sharp Dull Aching Burning Radiating Itching Stabbing

Other (describe): ____

How would you rate your pain on a scale from 0 to 10 : (please circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

What makes your pain or problem feel worse? ___________________________________

What makes your pain or problem feel better? ___________________________________

Have you ever had treatment before? (explain) __________________________________

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status, address, or insurance information.

I hereby give permission to **Dr. Savidakis** to evaluate and treat my foot / leg condition and to take medical pictures as deemed necessary.

I authorize payment of benefits to either myself or **Dr. Savidakis** as agreed upon at the time of treatment for services rendered.

____ ____________________

Signature of patient or guardian Date

Dr. John Savidakis 2701 Park Drive, Ste 6 Clearwater, FL 33763

Do I Need a Test for PAD ?

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry oxygen to your arms, legs, brain, or kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50.

PAD may result in leg discomfort with walking, poor healing of leg / foot wounds, difficulty controlling blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk for stroke and heart attack.

Answers to the following questions will determine if you are at risk for PAD, and if a simple vascular exam will help us better assess your vascular health status.

Name: ___________________________________ Date: _________________

Circle "Yes" or "No" :

1. Do you have foot, calf, buttock, hip, or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk or exercise which is relieved by rest? Yes No
2. Do you experience any pain at rest in your lower leg(s) or feet? Yes No
3. Do you experience foot or leg pain that often disturbs your sleep? Yes No
4. Are your toes or feet pale, discolored, or bluish in color? Yes No
5. Are your feet or hands cold to the touch? Yes No
6. Do you have any skin wounds or ulcers on your feet, toes, or legs that are slow to heal? Yes No
7. Has your doctor ever told you that you have diminished or absent foot pulses or poor circulation in your feet / leg(s)? Yes No
8. Have you suffered any injury to your feet or leg(s)? Yes No
9. Do you have an infection in your feet or leg(s) that may be gangrenous (black skin tissue)? Yes No

Patient Signature: _______________________________

Physician Signature: _______________________________ Date: _____________

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PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and /or minor surgical Treatment by **Dr. John Savidakis Jr.** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records for treatment.

AUTHORIZATION AND ASSIGNMENT

I request that the payment of authorized Medicare / Insurance benefits be made either to me or on my behalf for any services furnished by **Dr. John Savidakis Jr.** I authorize any holder of medical information about me to release to CMS/Insurance carriers and its agents any information needed to determine these benefits or benefits related to services.

I hereby authorize **Dr. John Savidakis Jr.** to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s)/Medicare to make payment directly to **Dr. John Savidakis Jr.** for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me.

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services.

I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with:

___ Spouse ___ Children ___ Other ____

Please list the family members or significant others, if any, whom we may inform about your medical condition, in case of an emergency:

Name: ____ Phone number: ______________________

Name: ____ Phone number: ______________________

PRIVACY NOTICE

I have received a copy of **Dr. John Savidakis Jr.'s** office privacy notice as required by HIPAA.

Signature: ____ **Date:** ______________________________

Patient Name (Print): ________________________________ **SSN:** ______________________________

Witness : ____ **Relationship:** ______________________