Frank Lavernia MD

Internal Medicine & Diabetes

____ New Patient

____ Existing Patient Date: ______________________

Last Name: _________________________________ First Name: _____________________________________ M.I.: _____

Local Address: ____________________________________ City: __________________________ St.: ______ Zip:_______

Permanent
Address: ____ City: __________________________ St.:______ Zip:________

Sex: M___ F ____ Marital: Single ___ Married ___ Status: Widowed ___ Divorced ___

Home Phone: ________________________ Work Phone: __________________________ Cell: ________________________

Date of Birth: ________________________ Social Security # : ____

Name of work place: ____ Occupation: ______________________________

Country of Birth: ___________________________________ Race/Ethnic Background: ______________________________

Emergency Contact: ____ Phone: ___________________________________

Referred by: ____

Reason for Visit: ____

Insurance Information: ____ Policy #: ________________________________

I, the undersigned, have insurance coverage with _________________________ and assign directly to the above signed Physician all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payment of benefits or facilitate my care. If I am enrolled in an HMO or PPO insurance and my membership has lapsed, or the services for my visit are not covered benefit or I have a different Primary Care Physician, I understand that I will be financially responsible for the charges incurred.

Signature: ____ Date: ___________________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: ____

PATIENT NAME: ____

DATE OF BIRTH: ____

MEDICAL RECORD # (IF AVAILABLE) _________________________________

PLEASE SEND MEDICAL RECORDS FOR THE ABOVE MENTIONED PATIENT
AS SOON AS POSSIBLE TO:

FRANK LAVERNIA, M.D.
Internal Medicine and Diabetes
4855 W Hillsboro Blvd.   Suite B-6
Coconut Creek, FL 33073

I AUTHORIZE AND REQUEST THE ABOVE MENTIONED FACILITY TO PROVIDE ANY AND ALL INFORMATION CONCERNING MY TREATMENT.

____   _____________

PATIENT SIGNATURE   DATE

Frank Lavernia MD
Internal Medicine & Diabetes

History and Physical

Name: ______________________________________
Date: _____________ Date of Birth: _____________
Chief Complaint: ______________________________
Drug Allergies: ______________________________
Medications: ________________________________
____
____

Hospitalization and Surgery
Date: ______________________________________
Date: ______________________________________
Date: ______________________________________
Date: ______________________________________
Date: ______________________________________
Last Colonoscopy Date: _______________________

Abdominal Pain ____
Allergies ____
Anemia ____
Appetite Change ____
Arthritis ____
Asthma/Bronchitis ____
Back Pain ____
Bone Fracture/Injury ____
Bowel Habit Change ____
Cancer ____
Chest Pain ____
Convulsions/Seizures ____
Diabetes ____
Diarrhea/Constipation ____
Diphtheria ____
Diverticulitis ____
Dizziness/Fainting ____
Ear Infections ____
Ear Ringer ____
Eye Infection/Disorder ____
Fatigue ____
Foot Pain/Disorder ____
Gall Bladder ____
Gout ____
Hair Loss ____

Hair Loss ____
Headaches ____
Heart Disease ____
Heart Murmur ____
Hemorrhoids ____
Hernia ____
High Blood Pressure ____
High Cholesterol ____
Indigestion ____
Infections ____
Jaundice/Hepatitis ____
Kidney Stones ____
Leg Pain ____
Memory Loss ____
Mental Illness ____
Muscle Weakness ____
Nausea/Vomiting ____
Nervousness/Depression ____
Nose Bleeding ____
Numbness/Tingling ____
Osteoporosis ____
Pneumonia ____
Prostate Disease ____
Rashes/Hives ____
Sexual Dysfunction ____

Sinus Trouble ____
Stools Blood/Dark ____
Stroke ____
Swallowing Difficulty ____
Throat ____
Thyroid Disease ____
Tremor ____
Ulcers ____
Urethral Discharge ____
Urination Change ____
Urine Blood In ____
Varicose Veins ____
Venereal Disease ____
Vision ____
Weight Loss ____
Childhood Diseases Chickenpox ____
Polio ____ Mumps ____ Measles ____
Rubella ____ Rheumatic Fever ____
Scarlett Fever ____ Tuberculosis ____
Herpes ____
Females Pregnant: Yes____ No____
Irregular/Painful Period ____
Date of Last Period _______________
Menopausal Symptoms ____
Date of Lat Pap Smear _____________
Date of Last Mammogram ___________
Number of: Pregnancies ____ Births___

Family History
Mother – Alive ____ Dead ____ - Health Problems ______________________________
Father – Alive ____ Dead ____ - Health Problems ______________________________
Siblings – Health Problems ____
____

Social History Married ____ Single ____ Number of Children __________ Healthy? Yes ____ No ____
Reason: ____
Alcohol Intake ____________________ Caffeine _________________________ Do you Exercise? Yes ____ No ____
Smoking: Yes____ No____ If yes, how many years? ______________________________