Anthony Baldizzi, MD
175 2nd Avenue North
St. Petersburg, FL33701

PLEASE PRINT

DATE: ______________________________

LAST NAME: ____

FIRST NAME: ____

ANY POSSIBILITY OF PREGNANCY? YES NO

REASON FOR VISIT:____

____

DO YOU HAVE ANY ALLERGIES? YES NO

IF SO, PLEASE LIST____

____

* DO YOU SMOKE? YES NO PLEASE CIRCLE
PACKS PER DAY____________ HOW LONG?_____________

PLEASE LIST ALL MEDICATION YOU ARE TAKING WITH DOSAGE (INCLUDING ANY "OVER THE COUNTER" MEDICINE)

MEDICATIONS:

____

____

____

PATIENTS MAY USE ANY PHARMACY THEY WISH.
PLEASE INFORM US IF YOU HAVE A PREFERENCE.

THANK YOU.

Anthony Baldizzi, MD
175 2nd Avenue North
St. Petersburg, FL33701

Date: ________________

Name: ____
Last First MI

Address: ____Apt/Suite__________

____
(city) (state) (zip code)

Date of Birth: _____/______/_________ SS Number: _______-_______-__________

Phone:______________________Alternative Phone:___________________________

Email:____

Current Marital Status (Circle): Single Married Divorced Widowed

Employer: _____________________________________

Work Phone Number: _________________________

Emergency Contact: ________________________________

Emergency Contact Number: _______________________

CONSENT TO TREAT

I hereby authorize Anthony Baldizzi, MD and associate practitioners to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostics procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: ____ Date: __________________