Office of Dr. Dino DiTrolio

Patient Registration Form Today's Date:_____

Personal Information

Patients First Name: _____ Patients Last Name: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male / ☐ Female

Social Security #: _____-_____-_____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ White / ☐ Asian / ☐ African American / ☐ Hispanic / ☐ Latino / ☐ Pacific Islander / ☐ Native American

Ethnicity: ☐ Hispanic or Latino / ☐ Non-Hispanic or Latino

What is your preferred language? ☐ English / ☐ Spanish / ☐ Mandarin / ☐ Italian / ☐ Other:_____

Home Address:_____ City:_____ State:_____Zip Code:_____

Employment Information

You are currently: ☐ Employed / ☐ Unemployed / ☐ Student / ☐ Pre-school child / ☐ Retired

If you are employed, please provide the follow information regarding your employer;

Employer Name:_____

Work Address:_____

Work Phone #:(_____) _____-_____

Personal communication and Emergency Contact Information

Home Phone #: (_____) _____-_____ Cell Phone #:(_____) _____-_____

May we leave a message on your phone? ☐ Yes / ☐ No, if yes, ☐ cell / ☐ home / ☐ work

May we send you an email, fax or text documents or messages? ☐ Yes / ☐ No

Email:_____@_____._____ Fax#: (____) _____-_____

Emergency contact name:_____

Emergency contact phone #: (_____) _____-_____

The emergency contact is my: ☐ spouse / ☐ parent / ☐ child / ☐ friend / ☐ sibling / ☐ other_____

How were you referred you to our office?

☐ Medical Doctor / ☐ Relative / ☐ Friend / ☐ Co-Worker / ☐ Internet / ☐ Our Office Web site / ☐ Insurance

Who may we thank for referring you?:_____

Is this visit due to an automobile accident: ☐ Yes / ☐ No

Is this visit due to a worker's compensation issue: ☐ Yes / ☐ No

If yes, please provide us with a copy of your insurance card and information.

Insurance and Guarantor Information - Please provide your insurance card or cards and photo ID

Do you have health Insurance: ☐ Yes / ☐ No, If yes, please continue below.

Name of Insurance Company:_____

Are you the primary policy holder? ☐ Yes / ☐ No, If No please complete below

The primary policy holder is my: ☐ Spouse / ☐ Parent / ☐ Domestic Partner

If you are NOT the primary policy holder, please provide the following;

Primary policy holders full name:_____

Primary policy holders date of birth: _____/_____/_____

Primary policy holders address: Same as mine: ☐ Yes / ☐ No

If No, please provide address: _____

Do you have a secondary insurance: ☐ Yes / ☐ No

If Yes, are you the secondary policy holder? ☐ Yes / ☐ No, If No, please complete below,

Secondary policy holders full name:_____

Secondary policy holders date of birth: _____/_____/_____

Secondary policy holders address: Same as mine: ☐ Yes / ☐ No

If No, please provide insured's address: _____

Primary Medical Doctor

Who is your Primary Medical Doctor?_____

Primary Doctors Address:_____

What is his or her office phone number? (_____) _____-_____

When was the last time you saw him or her?_____

Pharmacy Information

What **local** pharmacy do you use?_____

What street, town and state is your **local** pharmacy in? _____, _____, _____

May we electronically request your RX history from your pharmacy? ☐ Yes / ☐ No

By signing below, I authorize Whitestone Podiatry PC (Whitestone) to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Whitestone, and it may include prescriptions back in time for several years, and may include, if applicable, prescriptions to treat HIV, substance abuse and psychiatric conditions. I understand that my prescription history will become part of my Whitestone medical record. I also give permission for Whitestone to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Allergy Questions

Do you have any material, medication or food allergies? ☐ Yes / ☐ No

If Yes, what is your allergy? (check all that apply)

☐ epinephrine / ☐ aspirin / ☐ codeine / ☐ penicillin / ☐ cortisone / ☐ iodine / ☐ sulfa / ☐ tetracycline

☐ erythromycin / ☐ Demerol / ☐ morphine/ ☐ latex / ☐ Levaquin / ☐ Cipro/ ☐ seafood/ ☐ adhesive

☐ Other:_____ ☐ Other:_____ ☐ Other:_____ ☐ Other:_____

Current Prescription Medication

Are you currently taking any prescription or over-the-counter medications? ☐ Yes / ☐ No

If Yes, Please complete below;

Name of Medication	Name of Medication
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems

Do you **CURRENTLY** have any of the following problems? ☐ Yes / ☐ No , If Yes please check all that apply:

General Health:	☐Fever	☐Chills	☐ Weakness	☐ Weight loss
Allergic:	☐Coughing	☐Wheezing	☐Hives	☐Recurrent Infection
Cardiovascular:	☐Swelling of legs	☐Leg pain	☐Ulcers on legs	☐Chest pain
Endocrine:	☐Excess Urination	☐Increase Thirst	☐Sweats	☐Weight Loss
Eyes:	☐Blurred Vision	☐Cataract	☐Tingling	☐Unsteady Gait
Hematologic:	☐Swollen Glands	☐Lumps	☐Blood Clots	☐Bruises Easily
Musculoskeletal:	☐Joint Pain	☐Muscle Cramps	☐Back pain	☐Paralysis
Neurological:	☐Numbness	☐Burning	☐Tingling	☐Unsteady Gait
Psychiatric:	☐Memory Loss	☐Depression	☐Nervousness	☐Anxiety
Skin:	☐Itching	☐Lumps	☐ Nail Changes	☐Rashes

Medical Conditions

Do you have any medical conditions? ☐ Yes / ☐ No

If Yes, please check all that apply, **even if you are taking medication for the condition**

☐ Alzheimer's or memory loss	☐ anemia	☐ anxiety
☐ atrial fibrillation	☐ back problems	☐ bleeding disorder
☐ cancer, type_____	☐ COPD	☐ congestive heart failure
☐ coronary artery disease	☐ diabetes	☐ GERD
☐ glaucoma	☐ hearing loss	☐ heart valve problem
☐ hearts attack or MI	☐ heart problem	☐ hepatitis
☐ high cholesterol	☐ HIV or AIDS	☐ hypertension
☐ kidney disease	☐ liver disease	☐ migraines
☐ Parkinson's	☐ peripheral arterial disease	☐ peripheral neuropathy
☐ prostate problem	☐ psoriasis	☐ Raynaud's
☐ rheumatoid arthritis	☐ seizure disorder	☐ skin cancer
☐ stroke or TIA	☐ thyroid problem	☐ vision problems
☐ other_____	☐ other_____	☐ other_____

Surgeries

Have you had any surgeries? ☐ Yes / ☐ No

If Yes, please check all that apply,

☐ appendix	☐ back	☐ bariatric
☐ bladder	☐ bypass legs	☐ bypass heart
☐ cataract	☐ colon	☐ gall bladder
☐ heart valve	☐ kidney	☐ liver
☐ Organ transplant, organ_____	☐ prostate	☐ replacement hip
☐ replacement knee	☐ thyroid	☐ vein striping
☐ other_____	☐ other_____	☐ other_____

Social and Immunization History

Smoking

Do you currently smoke cigarettes? ☐ Yes / ☐ No

If yes, how many packs per day do you smoke? ☐ Less than 1 / ☐ 1 pack / ☐ > 1 pack per day

Have you smoked in the past? ☐ Yes / ☐ No

If yes, when did you quit? ☐ This year / ☐ 1-5 years ago / ☐ More than 5 years ago

Do you drink alcohol regularly? ☐ Yes / ☐ No

If yes, how much? ☐ Socially / ☐ 1 drink per week / ☐ 1 drink per day / ☐ 1 or more per day

Flu & Pneumonia Vaccine

Have you had a flu shot this year? ☐ Yes / ☐ No

If yes, when,_____

Have you had a pneumonia (pneumococcal pneumonia) vaccine? ☐ Yes / ☐ No

If yes, when,_____

Podiatric Problem

Can you describe what type of foot, ankle or leg problem are you having?

_____

_____

Which of foot, ankle or leg is the problem on: ☐ left / ☐ right / ☐ both

Where in particular is the problem?_____

When did the problem begin? ☐ today / ☐ ___days ago / ☐ ___ weeks ago / ☐ __months ago/ ☐ __ years ago

Do you remember a particular injury or cause? ☐ Yes / ☐ No

If yes, explain;_____

Did the problem begin ☐ suddenly or ☐ gradually

Have you had any prior treatment for this problem? ☐ Yes / ☐ No

If yes, explain;_____

If painful, how would you describe the pain?: ☐ dull ☐ sharp ☐ aching ☐ burning ☐ shooting ☐ throbbing

other, _____

AUTHORIZATION OF TREATMENT / ASSIGNMENT OF BENEFITS / REFERRAL POLICY

I, _____ hereby authorize Whitestone Podiatry PC (the practice) to administer such procedures and treatment as deemed necessary in the diagnosis and treatment of my feet, ankles and lower legs. I also authorize the practice to apply to and bill my insurance company on my behalf for medical services and or supplies rendered by the practice. I request payment from my insurance company or Medicare to be made directly to the practice. I certify that the information I have reported with regard to my insurance and medical status is correct and accurate and authorize the release of all necessary medical and insurance information for myself and any and all dependents for any and all claims to my insurance company or Medicare. I permit a copy of this to be used in place of the original. This authorization may be revoked at any time by me with written notice to the practice. Most insurance plans require that patient's authorization be obtained only once, and then maintained as part of the patient's permanent chart record. The plan will accept an unsigned authorization only if it is fully documented that the patient cannot sign for him or herself and there is no one who can sign for them.

Please note that it is your responsibility to know if a referral is required for office visits, surgery or treatment. If required, it is your responsibility to have the referral at the time of visit and keep track of how many visits are remaining on any given referral. Failure to obtain a referral (if needed) will shift the responsibility for payment at the time of visit to you, not the insurance plan. We cannot call your doctor to request a referral on your behalf. If you have a co-pay, it is due at the time of the visit. If you fail to pay your co-pay at the time of the visit, a $5.00 surcharge will be applied for each month until the balance is paid. We do not bill for co-pay.

Regardless of your insurance plan, you are financially responsible for payment. If the claim we submit is not paid by your insurance plan within 90 days, we consider the claim as "not covered" by your plan, and you will become financially responsible. Should your account go to collection, you agree to pay any and all expenses, including collection fees or percentages.

Acknowledgement of Practices Notice of Privacy Practices

By signing my name below, I acknowledge that I am aware that a copy of the Notice of Privacy Practices (NPP) is available to me (copy located in waiting room) and I have had the opportunity to read, if I so chose, and understand the Notice of Privacy Practices (NPP) and agree to its terms. I may request and receive a printed copy of the NPP upon request.

MEDICARE PATIENTS ONLY: I request that payment of authorized medical and surgical benefits and supplies be made to Whitestone Podiatry PC on my behalf or any covered dependants. I authorize any holder of medical information about me to release it to the Center for Medicare and Medicaid Services (CMS) and its agents. Any information needed to determine benefits shall be included.

SELF-PAY PATIENTS: As a self paying patient I understand that I am responsible for and will pay for all medical/podiatric services at the time of the visit.

I have read, understand and agree to the above.

_____/_____/_____
Today's Date

_____
Patient's Name (Please Print)

_____
Patient's Signature

_____
If under 18 years old, Patient's or Guardians Name (Please Print)

_____
If under 18 years old, Patient's or Guardians Signature