Dina Casparro, DPM

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PATIENT INFORMATION FORM

Date: ___ / ____ / _____

PATIENT NAME:_____
SOCIAL SECURITY #: _____/_____/_____
DATE OF BIRTH: ___/___/___ AGE: _____
SEX: MALE OR FEMALE
HOME ADDRESS: _____
CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE? YES NO
HOME PHONE #: (_____) _____-_____
WORK PHONE #: (_____) _____-_____
CELL PHONE # (_____) _____-_____
E-MAIL:_____

MARITAL STATUS:
☐ SINGLE ☐ MARRIED ☐ PARTNERED
☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

OCCUPATION: _____
PRIMARY LANGUAGE: _____
ETHNICITY: _____
PRIMARY CARE DOCTOR: _____
PHONE: _____

WHO REFERRED YOU TO US?_____

EMERGENCY CONTACT: _____
RELATIONSHIP: _____
PHONE #: (_____) _____-_____

INSURANCE INFORMATION
****PLEASE GIVE US YOUR CARD TO COPY**

PRIMARY INSURANCE COMPANY NAME:
_____

SECONDARY INSURANCE COMPANY NAME:
_____

WHO IS RESPONSIBLE FOR PAYMENT OR WHO IS THE INSURANCE POLICY HOLDER NAME?
_____
RELATIONSHIP TO PATIENT? _____
DOB: _____
SOCIAL SECURITY #: _____
PHONE #: (_____) _____-_____

SOCIAL HISTORY:

USE OF TOBACCO:
☐ NEVER
☐ QUIT
WHAT YEAR? ___
☐ SMOKE
___ PACKS/DAY
FOR ___ YEARS

USE OF CAFFEINE:
☐ NEVER
☐ MODERATE
☐ RARE
☐ DAILY
☐ OCCASIONALLY

USE OF **RECREATIONAL DRUGS**:
☐ NEVER
☐ QUIT – WHAT AGE? _____ TYPE _____
☐ CURRENT USE - TYPE?_____
☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF **ALCOHOL**:
☐ NEVER
☐ NO LONGER USE
☐ HISTORY OF ALCOHOL ABUSE
☐ CURRENT USE - TYPE?_____
☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

ALLERGIES:
☐ NONE KNOWN
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE
☐ OTHER _____
☐ MEDICATIONS _____
☐ ANESTHESIA _____
☐ FOODS _____

ARE YOU **PREGNANT**? _____ YES _____ NO

HAVE YOU HAD YOUR **FLU VACCINATION** FOR THE CURRENT SEASON? _____ YES _____ NO
IF NO, WHAT WAS THE REASON: _____ ALLERGY
_____ DECLINED _____ UNAVAILABLE

FOR PATIENTS **65 AND OLDER**:
DO YOU HAVE AN **ADVANCED CARE PLAN** OR SOMEONE TO MAKE DECISIONS ON YOUR BEHALF? ___ YES ___ NO
HAVE YOU HAD THE **PNEUMONIA VACCINATION**?
___ YES ____ NO

PREFERRED PHARMACY
NAME: _____
LOCATION: _____

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/_____

REASON FOR VISIT TODAY? _____**SHOE SIZE:** _____ **HEIGHT:** _____ **WEIGHT:** ___

YOUR MEDICAL HISTORY: **HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

ACID REFLUX	Y	N		FIBROMYALGIA	Y	N		NEUROPATHY	Y	N
ANEMIA	Y	N		GOUT	Y	N		OPEN SORES/ULCERS	Y	N
ARTHRITIS	Y	N		HEART ATTACK	Y	N		PNEUMONIA	Y	N
ASTHMA	Y	N		HEART DISEASE/FAILURE	Y	N		POLIO	Y	N
BACK TROUBLE	Y	N		HEPATITIS	Y	N		RHEUMATOID ARTHRITIS	Y	N
BLADDER INFECTIONS	Y	N		HIV+/AIDS	Y	N		SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N		AUTOIMMUNE CONDITION	Y	N		SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N		KIDNEY DISEASE	Y	N		SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N		LIVER DISEASE	Y	N		STOMACH ULCERS	Y	N
LUNG DISEASE	Y	N		HIGH BLOOD PRESSURE	Y	N		STROKE	Y	N
HIGH CHOLESTEROL	Y	N		MIGRAINE HEADACHES	Y	N		THYROID DISEASE	Y	N
DIABETES: (CIRCLE ONE) TYPE 1 OR TYPE 2	Y	N		MITRAL VALVE PROLAPSE	Y	N		TUBERCULOSIS	Y	N
CANCER – YES OR NO TYPE?										
OTHER CONDITIONS NOT LISTED ABOVE:										

PLEASE LIST ALL MEDICATIONS AND DOSAGE: DO YOU CONSENT TO US ACCESSING YOUR MEDICATION LIST ONLINE?
PLEASE CIRCLE - YES OR NO

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	**DATE**	**TYPE OF SURGERY**	**DATE**

FAMILY HISTORY: DO YOU HAVE A FAMILY HISTORY OF:

☐ DIABETES: TYPE 1 OR TYPE 2 ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE
☐ RHEUMATOID ARTHRITIS ☐ STROKE ☐ OTHER _____

HIPAA Privacy Rule

Receipt of Notice of Privacy Practices

Written Acknowledgment Form

Acknowledgment of receipt of Information Practices Notice (§164.520(a))

➔ I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgment

- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Others (please specify) _____

Informed Consent:

I understand that the information sent to me via email and/or via text message from person at Dina Casparro, DPM, INC will not be sent securely and will be unencrypted. I understand the risks associated with that including but not limited to, that my private health information may be read by an unintended third party. I have been notified of the risks. I understand said risks and I still prefer to receive protected health information via unsecured communications via email and text message. I understand that Dina Casparro, DPM, INC and its staff are not responsible for any unauthorized access of my protected health information communicated by way of unencrypted email and text and that I bear the risk.

Signature: _____

Printed Name: _____

Date: _____

NOTICE OF PATIENT RESPONSIBILITY

To Our Patients:

Some services provided in this office are considered non-covered by certain insurance companies, for example, custom orthotics and routine nail care.

Ultimately, it is the patients' responsibility to determine whether a particular service is covered by their insurance carrier, or not.

If you, the patient/guarantor chooses to receive non-covered services, it will be your responsibility to pay for those services at the time they are provided.

Should your insurance company pay at a later day the patient/guarantor will be reimbursed for over-payment.

➔ I, _____, am aware that I am responsible for any service deemed non-covered, not payable by my insurance company for the services provided.

Signature: _____

Date: _____