Dina Casparro, DPM, INC
581 McCray Street Suite F | Hollister CA 95023 Phone 831.636.3338 | Fax 831.531.2507

TODAYS 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 #: (_____) _____-_____
CELL PHONE # (_____) _____-_____

E-MAIL:_____

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

OCCUPATION: _____
PRIMARY LANGUAGE: _____
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:**
☐ OTHER FORMS OF TOBACCO
☐ NEVER
☐ QUIT
WHAT YEAR? ____
☐ SMOKE
____ PACKS/DAY
FOR ____ YEARS

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 _____
_____
_____

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

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

YOUR MEDICAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

AIDS/HIV	Y	N		LIVER DISEASE	Y	N
ABNORMAL BLEEDING	Y	N		LUNG DISEASE	Y	N
ACID REFLUX	Y	N		MIGRAINE HEADACHES	Y	N
ANEMIA	Y	N		MITRAL VALVE PROLAPSE	Y	N
ARTHRITIS	Y	N		NEUROPATHY	Y	N
ARTIFICIAL JOINTS	Y	N		ORGAN TRANSPLANT	Y	N
ASTHMA	Y	N		OSTEOPOROSIS	Y	N
AUTOIMMUNE CONDITION	Y	N		PACEMAKER	Y	N
BACK TROUBLE	Y	N		PERIPHERAL VASCULAR DISEASE	Y	N
BLADDER INFECTIONS	Y	N		PNEUMONIA	Y	N
BLOOD CLOTS OR DVT	Y	N		POLI	Y	N
BLOOD TRANSFUSION	Y	N		RAYNAUDS DISEASE	Y	N
CANCER: IF YES WHAT TYPE	Y	N		RHEUMATOID ARTHRITIS	Y	N
				SEIZURES/EPLIEPSY	Y	N
CORONARY ARTERY DISEASE	Y	N		SICKLE CELL DISEASE	Y	N
DIABETES: (CIRCLE ONE) TYPE 1 OR TYPE 2	Y	N		SKIN DISORDER	Y	N
DIAYLSIS	Y	N		SLEEP APNEA	Y	N
FIBROMYALGIA	Y	N		STOMACH ULCERS	Y	N
GOUT	Y	N		STROKE		
HEART ATTACK	Y	N		SUBSTANCE ABUSE	Y	N
HEART DISEASE/FAILURE	Y	N		THYROID DISEASE	Y	N
HEPATITIS	Y	N		TIBERCULOSIS	Y	N
HERNIA	Y	N		VARICOSE VEINS	Y	N
HIGH CHOLESTEROL	Y	N		**OTHER CONDITIONS NOT LISTED:**	Y	N
HIGH BLOOD PRESSURE	Y	N				
KIDNEY DISEASE	Y	N				

PLEASE LIST ALL MEDICATIONS AND DOSAGE:

PLEASE PROVIDE **MEDICATION LIST,

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE

FAMILY HISTORY: DO YOU HAVE A FAMILY HISTORY OF:

MOTHER: CIRCLE ONE: DECEASED OR ALIVE

☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS ☐ STROKE

☐ OTHER _____

FATHER: CIRCLE ONE: DECEASED OR ALIVE

☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS ☐ STROKE

☐ OTHER _____

SIBLING: CIRCLE ONE: BROTHER OR SISTER.

CIRCLE ONE: DECEASED OR ALIVE

☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ CORONARY ARTERY DISEASE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS ☐ STROKE ☐ OTHER _____

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

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:

_____

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)

_____

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

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: _____