101 Dixie Drive
Oakdale, PA 15071
PHONE # 412-787-8380
FAX # 412-787-1099

1170 NILES CORTLAND RD
NILES, OH 44446
PHONE # 330-544-4141
FAX # 330-544-4134

Jeffrey T. Molinaro, DPM, FACFAS

DATE_____

LAST NAME_____ FIRST NAME_____ M.I._____

SS #(REQUIRED)_____ DOB_____ AGE_____ SEX: M_____ F_____

HOME PHONE #_____ CELL PHONE #_____

STREET ADDRESS_____

CITY, STATE, ZIP_____

PATIENT EMPLOYER/SCHOOL_____

EMPLOYER/SCHOOL ADDRESS_____

EMPLOYER/SCHOOL PHONE #_____

OCCUPATION_____

SINGLE_____ DIVORCED_____ WIDOWED_____ SEPARATED_____ MINOR_____ OTHER_____

MARRIED_____ SPOUSE'S NAME_____

EMERGENCY CONTACT_____ CONTACT PHONE #_____

RELATIONSHIP TO PATIENT_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

PRIMARY INSURANCE_____ POLICY HOLDER NAME_____

POLICY HOLDER DOB_____ POLICY HOLDER SS #(REQUIRED)_____

RELATIONSHIP TO PATIENT_____ POLICY HOLDER PHONE #_____

POLICY HOLDER ADDRESS_____

POLICY HOLDER EMPLOYER_____ EMPLOYER PHONE #_____

EMPLOYER ADDRESS_____

SECONDARY INSURANCE_____ POLICY HOLDER NAME_____

POLICY HOLDER DOB_____ POLICY HOLDER SS #(REQUIRED)_____

RELATIONSHIP TO PATIENT_____ POLICY HOLDER PHONE #_____

POLICY HOLDER ADDRESS_____

POLICY HOLDER EMPLOYER_____ EMPLOYER PHONE #_____

EMPLOYER ADDRESS_____

PARENT/GUARDIAN NAME_____ RELATIONSHIP TO PATIENT_____

DOB_____ SS #(REQUIRED)_____ PHONE #_____

ADDRESS_____

EMPLOYER_____ EMPLOYER PHONE #_____

EMPLOYER ADDRESS_____

WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU CAME TO BE TREATED FOR? RIGHT OR LEFT OR BOTH	HAVE YOU EVER BEEN TO A PODIATRIST BEFORE? CIRCLE YES / NO IF YES: NAME AND LAST VISIT	IS THERE ANY PERSONAL OR FAMILY HISTORY OF DIABETES? YES / NO IF YOURSELF: PILL OR INSULIN IF FAMILY MEMBER RELATIONSHIPTO YOU?

ANKLE PAIN	YES	NO
ATHLETE'S FOOT	YES	NO
BUNIONS	YES	NO
CORNS/CALLUSES	YES	NO
FLAT FEET	YES	NO
FOOT OR LEG CRAMPS	YES	NO
HEEL PAIN	YES	NO
INGROWN TOENAILS	YES	NO
PLANTAR WARTS	YES	NO
TIRED FEET	YES	NO
SWELLING IN ANKLES/ FEET	YES	NO
CRAMPS OR NUMBNESS	YES	NO

FAMILY PHYSICIAN:	PHONE #:

PHARMACY:	PHONE #:

ALLERGIES:

- o ADHESIVE TAPE
- o LOCAL ANESTHETICS
- o ANTICOAGULANT THERAPY
- o NOVOCAINE
- o ASPIRIN
- o PENICILLIN
- o CODEINE
- o SEAFOODS
- o DEMEROL
- o SULFA
- o IODINE
- o NO KNOWN ALLERGIES
- o OTHER
- o _____

MEDICATIONS/DOSAGE:

FAMILY HISTORY:

CANCER/HEART DISEASE/DIABETES/ARTHRITIS	RELATIONSHIP TO PATIENT

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JEFFREY T. MOLINARO, DPM, FACFAS

MEDICAL HISTORY:

- o ALLERGIES ANESTHETICS
- o AIDS/HIV
- o ANEMIA
- o ARTHRITIS
- o ARTIFICIAL HEART VALVES
- o ARTIFICIAL JOINTS
- o ASTHMA
- o BACK PROBLEMS
- o BLEEDING DISORDER
- o CANCER
- o CIRCULATORY PROBLEMS
- o DEPRESSION
- o EPILEPSY
- o FAINTING
- o GOUT
- o DIABETES PILL OR INSULIN
- o HEADACHES
- o HEART DISEASE
- o HEMOPHILIA
- o HEPATITIS A B C
- o JAUNDICE
- o HIGH BLOOD PRESSURE
- o KIDNEY PROBLEMS
- o LIVER DISEASE
- o LOW BLOOD PRESSURE
- o MRSA OR STAPH INFECTION
- o NEUROPATHY
- o RADIATION TREATMENT
- o RESPIRATORY DISEASE
- o RHEUMATIC FEVER
- o STROKE
- o TUBERCULOSIS
- o THYROID
- o ULCERS
- o VARICOSE VEINS
- o UNEXPLAINED WEIGHT LOSS

SOCIAL HABITS:		
DO YOU SMOKE? PACKS PER DAY? #	YES	NO
DATE QUIT:		
DO YOU DRINK? HOW OFTEN? PLEASE CIRCLE SOCIAL OR EVERYDAY	YES	NO

PAST MAJOR SURGICAL HISTORY:

HEIGHT:	WEIGHT:

TREATMENT CONSENT:

I HEREBY CONSENT AND GIVE MY PERMISSION TO THE DOCTOR (AND THE DOCTOR'S ASSISTANTS OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

DATE:

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT:

PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

JEFFREY T. MOLINARO, DPM, FACFAS

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____
NAME OF INSURANCE COMPANY(IES)
and assign directly to Dr. Jeffrey T. Molinaro all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Please sign if you have health insurance

Signature of Patient:_____ Date:_____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. Jeffrey T. Molinaro for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Please sign if you have Medicare or Medigap

Signature of Patient:_____ Date:_____

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Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize the Practice to release any or all information concerning my medical care or finances to any individual except as set forth above.

_____ I authorize the Practice to verbally release any or all information concerning my medical care or finances to the following individuals:

Name: _____Phone #_____

Relationship to Patient _____

Name: _____ Phone #_____

Relationship to Patient _____

Name: _____ Phone #_____

Relationship to Patient _____

Patient Signature X_____Date_____

Witness Signature X_____Date _____

Dr. Jeffrey T. Molinaro, DPM, FACFAS

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TREATMENT AUTHORIZATION

I,_____, acknowledge and accept any and **ALL** financial responsibility for any treatment received in this office in the event my insurance does not allow or denies payment. This includes nail care, orthotics, injections, surgery, post op visits, follow up visits and any other treatment performed by Dr. Jeffrey T. Molinaro whether in the office or at an outpatient facility.

I understand that I am also responsible for all co-payments, deductibles and any denied treatment as explained above.

_____ _____
patient signature date

_____ _____
witness date