

DOUGLAS N. DELORENZO, D.P.M.
Patient Registration

Patient Name			Gender	Male ____ Female ____
Birthdate		Age	SS#	
CURRENT ADDRESS				
Address			City, State, Zip	

COMMUNICATION				
Home Phone #		Work Phone #		Extension
Cell Phone #		SMS or Text?	Yes ____ No ____	
Who may we leave a message with?	Patient Only ____ Patient and/or Spouse ____ Anyone answering the phone ____			
Email				

GOVERNMENT REQUIRED INFORMATION Check One in EACH Section				
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> Other: _____			
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Decline to Answer		Ethnicity	<input type="checkbox"/> Not hispanic or latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer
Do you Smoke ?	Yes ____ No ____	If yes, How Much?		
Do you Drink Alcohol?	Yes ____ No ____	If yes, How Much?		
Do you use Recreational drugs?	Yes ____ No ____	If yes, How Much?		

INFORMATION			
Marital Status	M ____ S ____ W ____ D ____	Employer	
Occupation		Employer Phone/Address	

Pt. Height:	Pt. Weight:	Flu Shot: Yes ____ No ____ ; If Yes, when? ____
List all Allergies:		
List all Medications:		
List all Surgeries:		
List all hospitalizations:		

Who may we thank for referring you? _____

PRIMARY INSURANCE

Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Relationship to patient	
			Date of Birth

SECONDARY INSURANCE

Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Relationship to patient	
			Date of Birth

EMERGENCY CONTACT

Name	Relationship	Phone #

Primary Care Physician		Date last seen:	
PCP Address		PCP Phone:	
Preferred Pharmacy		Pharm. Phone:	
Pharmacy Address			

Dr. Douglas N. DeLorenzo is authorized to release medical information regarding my health to the following people:	

I have read a copy of the regulations.

NOTICE OF PRIVACY PRACTICES in accordance with the new HIPAA

Physician's release and agreement: I hereby authorize payment directly to Dr. Douglas N. DeLorenzo benefits due to me from my Insurance Company otherwise payable to me. I further authorize the release of any medical information required by my Insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the part who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. If I fail to pay any outstanding balances, I will also incur any charges associated with the collection of these fees.

I understand I will be responsible for any fees incurred because I did not provide accurate insurance information. This includes not getting authorizations when required.

Patient's Signature: _____ **Date:** _____

Patient Name (Print:) _____