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JEFFREY T. MOLINARO, DPM, FACFAS
JEFFREYMOLINARODPM.COM

PATIENT INFORMATION

DATE: ___/___/___

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

DATE OF BIRTH: ___/___/_____ AGE: _____ SS# _____ SEX: ___M___ F

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #:(____) _____ - _____ CELL PHONE #:(____) _____ - _____ E-MAIL: _____

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED WIDOWED MINOR

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ EMPLOYER #: (____) _____ - _____

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

I AUTHORIZE THE PRACTICE TO SPEAK WITH THE FOLLOWING PEOPLE IN REGARDS TO MY DIAGNOSIS AND/OR TREATMENT OPTIONS OR ANY OTHER RELATED HEALTHCARE ISSUES:

NAME: _____ RELATIONSHIP _____ PHONE: (____) _____ - _____

NAME: _____ RELATIONSHIP _____ PHONE:(____) _____ - _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

MEMBER ID #: _____ GROUP #: _____

THIS INFORMATION MUST BE COMPLETED IF THE POLICYHOLDER IS NOT THE PATIENT

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____ SS#: _____

RELATIONSHIP TO PATIENT? _____ PHONE #: (____) _____ - _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ EMPLOYER #:(____) _____ - _____

SECONDARY INSURANCE COMPANY NAME: _____

MEMBER ID #: _____ GROUP #: _____

THIS INFORMATION MUST BE COMPLETED IF THE POLICYHOLDER IS NOT THE PATIENT

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____ SS#: _____

RELATIONSHIP TO PATIENT? _____ PHONE #: (____) _____ - _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ EMPLOYER #:(____) _____ - _____

FINANCIAL RESPONSIBILITY: EXAMPLE MINOR CHILD OF SEPARATED PARENTS

NAME: _____ RELATIONSHIP TO PATIENT? _____

DOB: _____ SS#: _____ PHONE #: (____) _____ - _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

EMPLOYER: _____ EMPLOYER #: (____) _____ - _____

EMPLOYER ADDRESS: _____

PATIENT NAME: _____

DATE OF BIRTH: ___/___/___

JEFFREY T. MOLINARO, DPM, FACFAS

YOUR MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

PRIMARY CARE DOCTOR: _____ PHONE #: (____) ____ - ____

LOCAL PHARMACY: _____ LOCATION: _____ PHONE #: (____) ____ - ____

PLEASE LIST ALL **MEDICATIONS** YOU ARE CURRENTLY TAKING (NAME-DOSAGE- HOW OFTEN DO YOU TAKE?)

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> ABNORMAL BLEEDING	<input type="checkbox"/> DIABETES: PILL OR INSULIN	<input type="checkbox"/> NEUROPATHY
<input type="checkbox"/> ACID REFLUX	<input type="checkbox"/> FIBROMYALGIA	<input type="checkbox"/> OPEN SORES
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> GOUT	<input type="checkbox"/> RADIATION TREATMENT
<input type="checkbox"/> ANXIETY	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> RESPIRATORY DISEASE
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HEART DISEASE/FAILURE	<input type="checkbox"/> RHEUMATIC FEVER
<input type="checkbox"/> ARTIFICIAL JOINT	<input type="checkbox"/> HEPATITIS <small>CIRCLE A B C</small>	<input type="checkbox"/> SKIN DISORDER
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> STOMACH ULCERS
<input type="checkbox"/> BACK TROUBLE	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> STROKE
<input type="checkbox"/> BLADDER INFECTIONS	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> THYROID DISEASE
<input type="checkbox"/> BLOOD CLOTS	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> TUBERCULOSIS
<input type="checkbox"/> BLOOD TRANSFUSION	<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> VARICOSE VEINS
<input type="checkbox"/> CANCER	<input type="checkbox"/> MIGRAINE HEADACHES	<input type="checkbox"/> WEIGHT LOSS
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> MRSA/STAPH INFECTIONS	<input type="checkbox"/> OTHER CONDITIONS

ALLERGIES: NONE KNOWN
 ADHESIVE TAPE ANESTHESIA ASPIRIN BEE STINGS CODEINE IODINE
 LATEX NSAIDS PENICILLINS SHELLFISH SULFA FOODS _____
 OTHER _____ MEDICATIONS _____

FAMILY HISTORY:
DO YOU HAVE A FAMILY HISTORY OF & WRITE WHO (PARENTS, MATERNAL/PATERNAL GRANDPARENTS) ADOPTED
 DIABETES: TYPE 1 OR TYPE 2 _____ CANCER _____ HEART DISEASE _____
 HIGH BLOOD PRESSURE _____ STROKE _____ THYROID DISEASE _____
 CORONARY ARTERY DISEASE _____ ARTHRITIS _____ OTHER _____

SOCIAL HISTORY:
USE OF TOBACCO NEVER QUIT - HOW LONG AGO? _____ SMOKE ___ PACKS/DAY
USE OF ALCOHOL NEVER RARE OCCASIONAL DAILY TYPE _____

SURGERIES:
TYPE OF SURGERY

PATIENT NAME: _____

DATE OF BIRTH: ___/___/___

JEFFREY T. MOLINARO, DPM, FACFAS

PATIENT FINANCIAL POLICY

-AS OUR PATIENT, YOU ARE RESPONSIBLE FOR ALL AUTHORIZATIONS/REFERRALS NEEDED TO SEEK TREATMENT IN THIS OFFICE.

-UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE BY YOU, OR YOUR HEALTH INSURANCE CARRIER, PAYMENT FOR OFFICE SERVICES ARE DUE AT THE TIME OF SERVICE. WE WILL ACCEPT VISA, MASTERCARD, DISCOVER, CASH OR CHECK.

-YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. AS A COURTESY, WE WILL FILE YOUR INSURANCE CLAIM FOR YOU IF YOU ASSIGN THE BENEFITS TO THE DOCTOR. IN OTHER WORDS, YOU AGREE TO HAVE YOUR INSURANCE COMPANY PAY THE DOCTOR DIRECTLY. IF YOUR INSURANCE COMPANY DOES NOT PAY THE PRACTICE WITHIN A REASONABLE PERIOD, WE WILL HAVE TO LOOK TO YOU FOR PAYMENT.

-WE HAVE MADE PRIOR ARRANGEMENTS WITH CERTAIN INSURERS AND OTHER HEALTH PLANS TO ACCEPT AN ASSIGNMENT OF BENEFITS. WE WILL BILL THOSE PLANS WITH WHICH WE HAVE AN AGREEMENT AND WILL ONLY REQUIRE YOU TO PAY THE COPAY/COINSURANCE/DEDUCTIBLE.

-IF YOU HAVE INSURANCE COVERAGE WITH A PLAN WITH WHICH WE DO NOT HAVE A PRIOR AGREEMENT, WE WILL PREPARE AND SEND THE CLAIM FOR YOU ON AN UNASSIGNED BASIS. THIS MEANS YOUR INSURER WILL SEND THE PAYMENT DIRECTLY TO YOU. THEREFORE, ALL CHARGES FOR YOUR CARE AND TREATMENT ARE DUE AT THE TIME OF SERVICE.

-ALL HEALTH PLANS ARE NOT THE SAME AND DO NOT COVER THE SAME SERVICES. IN THE EVENT YOUR HEALTH PLAN DETERMINES A SERVICE TO BE "NOT COVERED," OR YOU DO NOT HAVE AN AUTHORIZATION, YOU WILL BE RESPONSIBLE FOR THE COMPLETE CHARGE. WE WILL ATTEMPT TO VERIFY BENEFITS FOR SOME SPECIALIZED SERVICES OR REFERRALS; HOWEVER, YOU REMAIN RESPONSIBLE FOR CHARGES TO ANY SERVICE RENDERED. PATIENTS ARE ENCOURAGED TO CONTACT THEIR PLANS FOR CLARIFICATION OF BENEFITS PRIOR TO SERVICES RENDERED.

-YOU MUST INFORM THE OFFICE OF ALL INSURANCE CHANGES AND AUTHORIZATION/REFERRAL REQUIREMENTS. IN THE EVENT THE OFFICE IS NOT INFORMED, YOU WILL BE RESPONSIBLE FOR ANY CHARGES DENIED.

-FOR MOST SERVICES PROVIDED IN THE HOSPITAL, WE WILL BILL YOUR HEALTH PLAN. ANY BALANCE DUE IS YOUR RESPONSIBILITY.

-PAST DUE ACCOUNTS ARE SUBJECT TO COLLECTION PROCEEDINGS. ALL COSTS INCURRED INCLUDING, BUT NOT LIMITED TO, COLLECTION FEES, ATTORNEY FEES AND COURT FEES SHALL BE YOUR RESPONSIBILITY IN ADDITION TO THE BALANCE DUE TO THIS OFFICE.

-THERE IS A SERVICE FEE OF \$35.00 FOR ALL RETURNED CHECKS. YOUR INSURANCE COMPANY DOES NOT COVER THIS FEE.

BY SIGNING, I AGREE TO THE FOLLOWING FINANCIAL STATEMENTS AND YOUR UNDERSTANDING OF OUR FINANCIAL POLICIES IS AN ESSENTIAL ELEMENT OF YOUR CARE AND TREATMENT. IF YOU HAVE ANY QUESTIONS, PLEASE DISCUSS THEM WITH OUR OFFICE STAFF.

NOTICE OF PRIVACY PRACTICES

_____(INITIAL) I HAVE SEEN A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM JEFFREY T. MOLINARO, DPM, FACFAS ON THE WEBSITE OR IN THE OFFICE.

I HAVE READ AND UNDERSTOOD THIS INFORMATION. I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT, VERIFYING CONSENT TO THE ABOVE STATED TERMS.

PATIENT SIGNATURE

(IF OTHER THAN THE PATIENT STATE THE RELATIONSHIP TO PATIENT)

DATE

SIGNATURE OF WITNESS

DATE