1250 YOUNGSTOWN WARREN ROAD UNIT 1A
NILES, OH 44446
PHONE # 330-544-4141
FAX # 330-544-4134

101 DIXIE DRIVE
OAKDALE, PA 15071
PHONE # 412-787-8380
FAX # 412-787-1099

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?

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

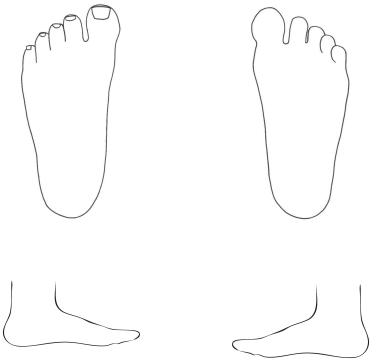
CURRENT PROBLEM WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? **LEFT OR RIGHT**_____

ANKLE OR FOOT 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
NUMBNESS	YES	NO
PLANTAR WARTS	YES	NO
TIRED FEET	YES	NO
SWELLING IN ANKLES/ FEET	YES	NO

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.

LEFT FOOT

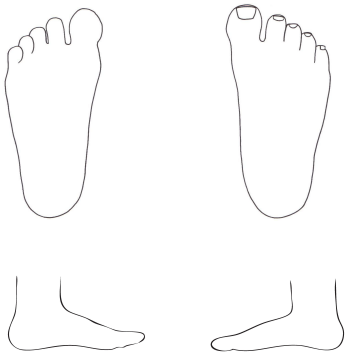
TOP OF FOOT **BOTTOM OF FOOT**



INSIDE OF FOOT **OUTSIDE OF FOOT**

RIGHT FOOT

BOTTOM OF FOOT **TOP OF FOOT**



OUTSIDE OF FOOT **INSIDE OF FOOT**

HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING
☐ BURNING ☐ RADIATING ☐ ITCHING ☐ STABBING

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ NO ☐ YES (DESCRIBE) _____
IF YES, WAS IT A WORK-RELATED INJURY? ☐ NO ☐ YES

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

WHO REFERRED YOU TO THE OFFICE?_____

PATIENT CONSENT FOR TREATMENT

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS. I HEREBY CONSENT AND GIVE MY PERMISSION TO THE DOCTOR (AND THE DOCTORS ASSISTANCE OR DESIGNATED REPLACEMENT) TO ADMINISTER AND PERFORM SUCH PROCEDURES UPON ME AS THE DOCTOR DEEMS NECESSARY.

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

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