Louis A. DiToppa, DO, FAAFP

PATIENT INFORMATION

Full name: _____Today's date_____
Last First MI
Parent/Guardian (when patient is a child) _____

Gender; M / F **MARITAL STATUS:** Single/Married/Divorced/Widowed/Committed Relationship

Birthday: _____ SS#:_____ Occupation: _____

Address: _____
Street City State Zip

Contact Numbers (please mark preferred means of contacting you)

Email: _____

Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURED/POLICY HOLDER (Who provides the insurance coverage) _____

Primary Insurance
Name of Insurance Company: _____

Policy/ID#: _____ Group#: _____

Secondary Insurance
Name of Insurance Company:_____

Policy/ID#: _____ Group#: _____

Local Pharmacy & location: _____ **Mail Order** : _____

I authorize the release of any medical information necessary to process my claim and the payment of medical benefits to Louis A, DiToppa, DO, FAAFP and give permission to access my pharmacy history via the electronic health record company, AthenaHealth.

Signature of Patient or Responsible Party: _____ Date: _____

Louis A. DiToppa, DO, FAAFP
DiToppa Medical Center
1978 Lincoln Way
White Oak, PA 15131
Phone: 412-664-0720 Fax: 412-664-7134

Patient Name: _____

Please list all the current prescriptions you are taking or bring your prescription bottles with you. This information will be entered into your chart at your visit.

Medication	Dose	How many times a day?	Doctor

Circle the following non-prescription medications that you use:

Laxatives	Antacids	Aspirin	Ibuprofen/Naproxen
Decongestants	Allergy Pills	Nasal Sprays	Natural Hormones
Vitamins	Herbs	Supplements	Others _____

<u>MEDICATION ALLERGIES:</u> Please list any medication allergies you have had: Include antibiotic, pain medications, iodine, shell fish, etc.

Medication Name	What reaction?

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www.ditoppamedical.com

HEALTH HISTORY QUESTIONNAIRE

Patient Name:_____ Today's Date:_____

MEDICAL HISTORY

__HEART DISEASE	__CANCER	__RHEUMATIC FEVER	__ANEMIA
__STROKE	__BREAST LUMP	__TUBERCULOSIS	__BLEEDING DISORDER
__DIABETES	__CATARACTS	__HEPATITIS	__THYROID PROBLEMS
__HIGH BLOOD PRESSURE	__GLAUCOMA	__VENEREAL DISEASE	__LIVER DISEASE
__ASTHMA	__MIGRAINE HEADACHES	__HIV/AIDS	__ANXIETY/DEPRESSION
__EMPHYSEMA	__EPILEPSY	__ARTHRITS	__ALCOHOL/DRUG

OTHER PROBLEMS:_____

_____

HOSPITALIZATIONS: List all times in the hospital (for illness or surgery)

Date	Reason/Surgery	Comment

FAMILY MEDICAL HISTORY (Only list those with medical problems)

	Age	Diseases	Age at death
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Other			
Child			

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Patient Name: _____

LIFESTYLES AFFECTING HEALTH

Have you used any tobacco? Never _____ Yes _____ Year started _____ Year stopped _____

If using currently (# per day): Cigarettes: _____ Cigars _____ Snuff/chewing tobacco _____

Alcohol: Never_____ 0-6 drinks/weeks _____ 7-14 drinks/week _____ Over 14 drinks/week _____

Caffeine: Rarely _____ Drink/day _____ Type _____

Do you follow a special diet? Yes / No describe _____

Exercise: Yes / No Type _____

IV Drug Use: Yes / No

Hard of hearing or deaf in one or both ears: Yes / No

Legally Blind in one or both eyes: Yes / No

Are you a caregiver: Yes / No

Do you have a caregiver: Yes / No

Education: High School Trade School College (Bachelors Masters Doctorate)

Patient Health Literacy (Do you understand your medical needs): Yes / No

How did you hear about DiToppa Medical: _____

PATIENT CONSENT FORM **Louis A. DiToppa, DO, FAAFP**

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Louis A. DiToppa, DO, FAAFP to use and disclose protected health information (PH) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Louis A. DiToppa, DO, FAAFP describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent, Louis A. DiToppa, DO; FAAFP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Louis A. DiToppa, DO, FAAFP.

With this consent, Louis A. DiToppa, DO, FAAFP may call my home or other alternative location and leave a message on voice mail of in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Louis A. DiToppa, DO, FAAFP may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Louis A. DiToppa, DO, FAAFP may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Louis A. DiToppa, DO, FAAFP restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Louis A. DiToppa, DO, FAAFP to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If do not sign this consent, or later revoke it, Louis A. DiToppa, DO, FAAFP may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian **Date** **Relationship to Patient**

Your medical information cannot be released to ANYONE without your permission. This includes all family members, spouses, adult children and parents (when you are of legal age). If there is person/persons who may call our office on your behalf (now or in the future) please give us permission to speak with them below.

Name	Relationship

I give permission for the following people to call the office and discuss my medical care on my behalf. The office, Louis A. DiToppa, DO, FAAFP will not contact anyone unless prompted by the patient.

Signed: _____ **Date:** _____