RETURN VIA EMAIL TO: CYNTHIA.DRORLANDO@GMAIL.COM

NAME _____ DATE OF BIRTH _____

ADDRESS _____ OCCUPATION _____

CITY, STATE, ZIP _____

HOME PHONE # _____ PREFERRED EMAIL _____

CELL # _____ ☐ I CONSENT TO RECEIVE BILLING STATEMENTS AND APPOINTMENT REMINDERS VIA EMAIL

MARITAL STATUS _____ SPOUSE'S NAME _____

EMERGENCY CONTACT (NAME/RELATIONSHIP) _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO US ? _____

PRIMARY MEDICAL INSURANCE ? _____

PRIMARY MEDICAL INSURANCE ID #: _____

SECONDARY MEDICAL INSURANCE ? _____

SECONDARY MEDICAL INSURANCE ID#: _____

NAME & ADDRESS OF YOUR MEDICAL DOCTOR / DATE OF LAST VISIT

_____

APPROX. **HEIGHT** _____ APPROX. **WEIGHT** _____

RECENT **BLOOD PRESSURE** READING _____ / _____

- **WHAT BRINGS YOU TO OUR OFFICE ?** _____

  _____

- **PLEASE LIST ANY SURGERY YOU HAD:**

Procedure	Date	Procedure	Date

- **PLEASE LIST ANY FOOT SURGERY YOU MAY HAVE HAD:**

Procedure	Date	Procedure	Date

NAME_____ DATE OF BIRTH_____

- **PLEASE NOTE YOUR MEDICAL HISTORY (CHECK ANY THAT APPLY):**

☐ HIGH BLOOD PRESSURE ☐ HEPATITIS ☐ HEART ATTACK
☐ INSULIN DEPENDENT DIABETES ☐ NON INSULIN DIABETES ☐ STROKE
☐ ANEURYSM ☐ BLOOD CLOTS ☐ ARTHRITIS
☐ VARICOSE VEINS

OTHER (PLEASE LIST) _____

_____ _____

- **PLEASE NOTE ANY PAST INJURIES OR TRAUMA**

_____

_____

- **SOCIAL HISTORY**: DO YOU:

SMOKE TOBACCO YES ☐ PACK/DAY? _____ NO ☐ QUIT ☐ HOW LONG AGO? _____
DRINK ALCOHOL YES ☐ NO ☐ RARELY ☐
DRINK CAFFEINE YES ☐ NO ☐

- **MEDICATIONS**: PLEASE LIST MEDICATIONS (INCLUDING ASPIRIN) CURRENTLY TAKING:

_____

_____

_____

- **ALLERGIES:** DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING:

☐ PENICILLLIN ☐ ERYTHROMYCIN ☐ SULFA ☐ CODEINE
☐ ASPIRIN ☐ CORTISONE ☐ ADHESIVE TAPE ☐ LATEX
☐ IODINE ☐ LOCAL ANESTHETICS

- **OTHER ALLERGIES TO MEDICATIONS** – PLEASE LIST:

_____

DATE: _____ SIGNATURE _____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) Date

_____ _____
Parent or Authorized Representative (if applicable) Signature

GUARANTEE AGREEMENT

I. Individual's Responsibility for Non-Covered Services.

In consideration of services rendered by Anthony Orlando, DPM to the undersigned patient, the undersigned promise(s) to pay to Anthony Orlando, DPM any co-payment, coinsurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are **NOT COVERED** by my health insurance plan for services rendered.

_____ _____
Initial **Date**

I. Assignment of Benefit Proceeds.

I hereby assign to Anthony Orlando, DPM all monies and/or benefits to which I am entitled from my insurer/HMO/third-party payor, government agencies, or those who are financially liable for my medical care.

_____ _____
Initial **Date**

III. Authorization to Release Records.

I hereby authorize Anthony Orlando, DPM to release to my insurer / HMO / third-party payor, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for precertification / prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, other than those services covered by Paragraph I above, which are not Medically Necessary or improperly billed.

_____ _____
Initial **Date**

_____ _____
Signature of Patient or Authorized Representative Date

Electronic Medication History

I allow Dr. Anthony Orlando to obtain my medication history electronically, understanding all information will remain confidential and part of my medical record.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Pharmacy Selection

I allow Dr. Anthony Orlando to electronically submit prescriptions to the following pharmacy on my behalf.

_____ _____

Pharmacy Name Pharmacy Phone

_____

Pharmacy Address

_____

Pharmacy City, State Zip

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature