101 Dixie Drive
Oakdale, PA 15071
PHONE # 412-787-8380
FAX # 412-787-1099

1170 NILES CORTLAND RD
NILES, OH 44446
PHONE # 330-544-4141
FAX # 330-544-4134

Jeffrey T. Molinaro, DPM, FACFAS

PATIENT INFORMATION FORM

TODAY'S DATE: ___/____/____

PATIENT NAME: ______________________________ ________________________________ ___________
LAST FIRST MIDDLE

DATE OF BIRTH:_____ /_____ /_____ AGE: ______ SS#__________________________ SEX: M F

ADDRESS: _____________________________________CITY/STATE: ____________________ ZIP: _________

HOME PHONE #: (______) ______-________ PRIMARY LANGUAGE: ________________
CELL PHONE #: (_______) ______-_______ RACE:_____________________________
E-MAIL: ______________________________ ETHNICITY:__________________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ MINOR

EMERGENCY CONTACT: ____________________RELATIONSHIP: _____________ PHONE #:(____) _____-______

EMPLOYER/SCHOOL: _____________________________________ OCCUPATION: _______________________
EMPLOYER ADDRESS: ____EMPLOYER #:(____) ______-________

FINANCIAL RESPONSIBILITY: (PARENT/GUARDIAN/SPOUSE)

WHO IS RESPONSIBLE FOR PAYMENT? NAME:____
RELATIONSHIP TO PATIENT? ___________________DOB:______________SS#:_________________
ADDRESS: _______________________CITY/STATE: _____________ ZIP: _______ PHONE #:(____) _____-______
EMPLOYER: ____EMPLOYER #:(____) _____-______
EMPLOYER ADDRESS: ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:____
MEMBER ID #: _________________ GROUP #:_______________
POLICY HOLDER NAME:_________________________DATE OF BIRTH: ___________SS #: ______________
RELATIONSHIP TO PATIENT? _____________________PHONE #: (____) _____-______
ADDRESS: ___________________________________ CITY/STATE: ___________________ ZIP: ____________
EMPLOYER: ____EMPLOYER #:(____) _____-______
EMPLOYER ADDRESS: ____

SECONDARY INSURANCE COMPANY NAME: ____
MEMBER ID #: _________________ GROUP #:_______________
POLICY HOLDER NAME:____________________________DATE OF BIRTH: ___________SS #: ______________
RELATIONSHIP TO PATIENT? ________________________PHONE #: (____) _____-______
ADDRESS: ______________________________________CITY/STATE: ___________________ ZIP: _____________
EMPLOYER: ____EMPLOYER #:(____) _____-______
EMPLOYER ADDRESS: ____

PATIENT NAME: ________________________
DATE OF BIRTH: ___/___/____

PLEASE COMPLETELY FILL OUT THIS FORM

PRIMARY CARE DOCTOR: ____**PHONE #: (____) ____-_____**
LOCAL PHARMACY: _________________________**LOCATION:** _____________**PHONE #: (____) ____-_____**

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

____
____
____
____

ALLERGIES: ☐ NONE KNOWN
☐ ANESTHESIA ☐ ADHESIVE TAPE ☐ 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______________________

YOUR MEDICAL HISTORY:

HEIGHT: _________________ WEIGHT: _________________ SHOE SIZE:_________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

◯ ABNORMAL BLEEDING	◯ DIABETES: 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 INFECTION	◯ OTHER CONDITIONS

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: ___/___/____

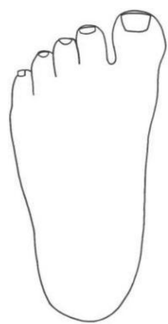
CURRENT PROBLEM

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

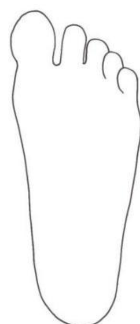
WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? RIGHT OR LEFT____________________________________

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

LEFT FOOT



TOP OF FOOT



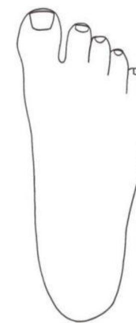
BOTTOM OF FOOT

OUTSIDE OF FOOT

INSIDE 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 US?____

PATIENT NAME: ______________________
DATE OF BIRTH: ___/___/____

PATIENT INFORMATION FORM

__________(Initial) 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.

__________(Initial) I have received or viewed on the Doctor's website a copy of the Notice of Privacy Practices from Jeffrey T. Molinaro, DPM, FACFAS.

Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy rules implemented through the Health Care Portability Act of 1996 (HIPPA), in order for your physician or staff of the practice to discuss your condition or finances with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

PLEASE CHECK ONE:

__________ I do not authorize the practice to release any or all information concerning my medical care or finances to any individual except as set forth above.

__________ I authorize the practice to verbally release any or all information concerning my medical care or finances to the following individuals:

NAME(S) ________________________________ RELATIONSHIP______________ PHONE #: (____) _____-_______

NAME(S) ________________________________ RELATIONSHIP______________ PHONE #: (____) _____-_______

NAME(S) ________________________________ RELATIONSHIP______________ PHONE #: (____) _____-_______

____
PATIENT SIGNATURE DATE

____
IF OTHER THAN PATIENT AND RELATIONSHIP TO PATIENT DATE

PATIENT NAME: ___________________________
DATE OF BIRTH: ___/___/____

Patient Financial Policy

-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.

-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 this office.

-There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.

____

PATIENT SIGNATURE DATE

____

IF OTHER THAN PATIENT AND RELATIONSHIP TO PATIENT DATE

____

WITNESS SIGNATURE (OFFICE STAFF) DATE