Alvarado Podiatry Center

Donald Triolo, D.P.M.

6699 Alvarado Road, Suite 2201

San Diego, CA 92120

Tel: (619) 583-8160 / FAX: (619) 583-8170

www.drtriolo.com

ATTENTION NEW PATIENTS

- Please arrive 15 min. before the appointed time for your first visit.
- Please fill out all of the paperwork completely and bring it in with you to your appointment.
- Please bring your insurance card(s) and photo I.D.
- We also need to know the medications you are taking.(If you carry a list, bring it with you and we will make a copy.)
- We require 24 hour notice if you need to reschedule or cancel your appointment.
- Please bring with you any records, lab tests or x-rays (including CAT scan or MRI reports) from previous treatments for the same condition. You can have the records faxed to us at (619) 583-8170.

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PATIENT INFORMATION: Date of Birth_____

Referred by_____

Last Name_____ First Name_____ MI___ Sex (Circle) M F

Soc. Sec. #_____ Home Phone (____)_____ Cell Phone (____)_____

Street Address_____ City_____ State____ Zip_____

Employer Name_____ Occupation_____ Work Phone (____)_____

Spouse's Name_____ Other family members seen_____

RESPONSIBLE PARTY: (if different from above)

Name_____ _____ Phone (____)_____

Street Address_____ City_____ State____ Zip_____

INSURANCE INFORMATION: (Present your insurance card(s) to the receptionist)

Policy Holder's Information:

Primary insurance_____ Copay Amount_____
Name_____ Date of Birth_____
Soc. Sec. or ID#_____ Group#_____
Employer_____ Phone (____)_____
Secondary insurance_____ Copay Amount_____
Policy Holder's Information:
Name_____ Date of Birth_____
Soc. Sec. or ID#_____ Group#_____
Employer_____ Phone (____)_____

Emergency Contact:

Name_____ Relationship To Patient_____ Phone_____
Street Address_____ City_____ State_____

HEALTH HISTORY

Have you ever had:

Yes	No		Yes	No	
____	____	Angina or chest pain	____	____	Irregular heart beat
____	____	Asthma or wheezing	____	____	Known occupational exposure to Loud noises or chemical compounds (e.g. Benzene)
____	____	Bleeding tendency (including family history)	____	____	Lung disease, TB
____	____	Cancer (including family history)	____	____	Metal implants, clips, rods, etc.
____	____	Diabetes: NIDDM_____ IDDM_____	____	____	Migraines
____	____	Emphysema	____	____	Pacemaker
____	____	Epilepsy or convulsions	____	____	Stroke
____	____	Heart Disease			** Mental illness, drug addiction, HIV or AIDS, please discuss with the Physician.
____	____	Hepatitis Type:_____	____	____	Other illness_____ _____
____	____	High blood pressure			

Explanation of the above "Yes" answers: _____

_____

List any past surgeries you have had: _____

List any medications you are currently taking: _____

List any allergies: _____

Do you drink alcoholic beverages? _____ How much? _____

Do you or have you ever smoked? _____ How much? _____

How many years? _____ Have you quit? _____ If yes, when? _____ Do you chew tobacco? _____

Who is you primary care physician? _____ Last date seen? _____

Female – Are you are pregnant? _____ How many months? _____

I authorize insurance payment of medical benefits to DONALD TRIOLO, DPM. If payment for services is denied for any reason, I will be responsible for payment of services rendered. I understand that penalties for past due accounts or returned checks may apply. Co-pays must be made on the day of service.

I affirm that this information is true and accurate.

Patient or authorized person's signature: _____ Date:_____