



PA PODIATRY
THOMAS M. ROCCHIO, DPM
2200 W HAMILTON STREET SUITE 308 ALLENTOWN, PA 18104

Patient Registration

Please print clearly.

Patient Name: _____ Age: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M ___ F ___ Birth Date: _____ SS#: _____ Marital Status: S M D W Sep.

Employer: _____ Address: _____

Name of Spouse or Parent: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Family Physician: _____ Address: _____

Physician Phone: _____ Date last seen: _____

Pharmacy Name: _____ Address: _____

Pharmacy Phone: _____

Medications: _____

Allergies: _____

Allergic Reaction: _____

What is the reason for your visit? _____

Have you ever been treated by a podiatrist before? Yes ___ No ___

If yes, please list doctors name: _____ Last Visit: _____

How did you hear about our office? _____

Patient Name: _____

PLEASE CHECK ALL THAT APPLY TO YOUR PAST MEDICAL HISTORY

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Gout | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Stroke | <input type="checkbox"/> Circulatory Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other: _____ | |

What surgeries have you had? _____

INSURANCE INFORMATION

1. Insurance Co: _____ Member ID#: _____

Subscriber Name: _____ Relation: _____ Subscriber's DOB: _____

2. Insurance Co: _____ Member ID#: _____

Subscriber Name: _____ Relation: _____ Subscriber's DOB: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have/has insurance coverage and I assign directly to Thomas M Rocchio Podiatry LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Patient/Responsible Party	Relationship	Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits may be either to me or on my behalf to Thomas M. Rocchio Podiatry LLC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____	_____	_____
Patient/Responsible Party	Relationship	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I acknowledge that I have received a copy of PA Podiatry's Notice of Privacy Practices. This notice describes how PA Podiatry may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights I may have regarding my protected health information.

_____	_____	_____
Patient/Responsible Party	Relationship	Date