

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 (519)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: _____			
___	___	High blood pressure	___	___	Other illness _____ _____

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 your primary care physician? _____ Last date seen? _____

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

I authorize insurance payment of medical benefits to DONALD TRIOLO, DPM. If payment for services is denied due to lack of prior authorization. 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:** _____