Patient Registration Form

The Giardina & Glubo Podiatry team welcomes you to our office. Medicare, Medicaid and other insurance companies require us to collect this information about you.

First Name | Middle Name | Last Name | Generation (Sr., Jr., III)

Birth Date | Your Age today | Gender: ☐ M ☐ F | Social Security #

Street Address 1 | Street Address 2 | City | State | Zip Code

Home Phone | Work Phone | Cell Phone | Email

Ethnicity: Hispanic or Latino Yes ☐ No ☐ Language: English: Yes ☐ No ☐ Other _____

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐

Additional Needed Information

Marital Status: single ☐ divorce ☐ legally separated ☐ married ☐ partner ☐ unknown ☐ widowed ☐

Employment Status: full time ☐ part time ☐ not employed ☐

If employed, employer Name:

Occupation:

Legal Representative: Have you given Giardina & Glubo, DPM, PA permission to release your health care information to a designative representative? Yes ☐ No ☐

Name of Legal Representative:

Address, if different from the patient's address:

Legal representative phone number, if different from patient's phone number:

Other Information

Who may we thank for referring you to our practice?_____

Your Primary Physician(PCP): _____Date last seen: _____ /_____ /_____

Your Previous Podiatrist Name: _____Date last seen _____ /_____ /_____

Your Emergency Contact Name: Phone #:

How would you like to be contacted by our office? Contact Preferences: Telephone ☐ email ☐ text ☐

Name of Pharmacy: _____ Phone: _____

Pharmacy Address: _____

Main Concern/Reason for Seeing the Podiatrist Today:

Bunions ☐ Hammertoes ☐ Plantar Fasciitis ☐ Shin Splints ☐ Ingrown Toe Nail ☐ Flat Feet ☐ Gout ☐

Other: _____

Your Name:		Visit Date:	
Currently, do you smoke?		Yes ☐ No ☐	
If yes, has your doctor counseled you to stop smoking?		Yes ☐ No ☐	
What is your current height and weight?	Height:	Weight:	Shoe Size:
What do you think was your last Blood Pressure? BP: _____/_____			G&G BP reading: _____/_____ At least once a year
Did you have a Flu Vaccination this year or last year?		Yes ☐ No ☐ Not Sure ☐	
If yes, the Date _____/_____/_____ Approximate			

Please list all the medicines that you are now taking below:

Name of Medicine *(Example: Lisinopril)*	Dosage *(Example: 10 mg one time a day)*

Are you allergic to the following?

Novocaine ☐ Penicillin ☐ Sulfa ☐ Adhesive ☐ Tape ☐ Iodine ☐ Latex ☐ I do not have any allergies ☐

Other: _____

If you have checked any above please describe allergic reaction: _____

For our wonderful Medicare patients - please answer just a few more questions

Do you have a living will (advance directive)	Yes ☐ No ☐
Have you had a Pneumonia Shot in the last ten years?	Yes ☐ No ☐
If yes, the Date _____/_____/_____ Approximate	
If no, why not?	

If you have Diabetes, please tell us the following:

What was your last Hemoglobin A1C result in the last year? Results: _____ *We need to collect your A1c at least once a year*	Date of your test _____/_____/_____

Please check if you Have or Ever Been Treated for the Following Medical Conditions:

Alzheimer's ☐	Arthritis ☐	Asthma ☐	Cancer ☐	Cardiovascular ☐
Deep Vein Thrombosis- DVT ☐	Diabetes ☐	Epilepsy ☐	Heart Disease ☐	Hearing Disorder ☐
Hepatitis ☐	High Blood Pressure ☐	High Cholesterol ☐	HIV/AIDS ☐	Kidney Disease ☐
Liver Disease ☐	Low Back Pain/Sciatica ☐	Lung Disease ☐	Lyme's Disease ☐	Poor Circulation ☐
Osteoporosis ☐	Peripheral Neuropathy ☐	Psychiatric Disorder ☐	Seizures ☐	Stroke ☐
Stomach Ulcer ☐	Thyroid Disease ☐	Vascular Disease ☐	Vertigo ☐	None ☐
Other Please List:				

Surgical History - What surgeries have you had within the last 5 years?

Surgical Procedure	**Date of Surgery**

I have not had any surgeries ☐

Family History for Mother and/or Father Only

Alzheimer's ☐ Mother ☐ Father ☐	Arthritis ☐ Mother ☐ Father ☐	Cancer ☐ Mother ☐ Father ☐	Diabetes ☐ Mother ☐ Father ☐	Heart Disease ☐ Mother ☐ Father ☐	High Blood Pressure ☐ Mother ☐ Father ☐
Poor Circulation ☐ Mother ☐ Father ☐	Vascular Disease ☐ Mother ☐ Father ☐	None ☐ Other:			

Your Billing Information

Please bring your insurance cards, your driver's license with you and any required podiatry referral forms. Insurance copays are collected at the time of your visit. We accept cash, check, money order and credit card.

Billing Patient Insurance Authorization

I hereby authorize Giardina & Glubo, DPM, PA to apply for benefits on my behalf for services rendered. I request that payment from my insurance company to be made directly to Giardina & Glubo, DPM, PA. I understand that Giardina & Glubo, DPM, PA will bill insurance where applicable for all clinical services. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I consent to release medical information for conditions or diagnoses regulated by Federal statutes. I may revoke this authorization at any time, in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Yes, bill my insurance ☐ No, you may not bill my insurance ☐

Patient /Responsible Signature:

Relationship: Self ☐ Parent ☐ Guardian ☐ Legal Representative ☐

Date of Birth: _____ /_____ /_____ Signature Date: _____ /_____ /_____

I authorize the following person/people access to my medical records and/or to call on my behalf for medical, account, or billing questions.	
Patient Signature:	**Date:**
Name:	Phone:
Authorized person's email address:	
Name:	Phone:
Authorized person's email address:	

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

Patient Name: _____ Date: _____ /_____ /_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that Giardina & Glubo, DPM, PA may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Giardina & Glubo, DPM, PA has a detailed document called the '*Notice of Privacy Practices*'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Giardina & Glubo, DPM, PA will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Giardina & Glubo, DPM, PA to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Giardina & Glubo, DPM, PA has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) Date: _____ /_____ /_____

Relationship to Patient if signed by another party Date: _____ /_____ /_____

The signature on file for billing and release of health care information is valid for one year. All information released is in compliance with HIPAA as stated in our Notice of Privacy Practices. You may obtain a copy of the Notice of Privacy Practices, including any revisions by contacting: Giardina & Glubo, DPM, PA at 410.242.7066 and www.ggpodiatry.com. Thank you for completing our form(s). Medicare, Medicaid and other insurance companies require us to collect this important information about you.