# David A. Scalzo, D.P.M., P.C
# & Associates


Podiatric Medicine/Surgery
203 Foote Ave., Duryea, PA 18642
Phone: (570) 457-4560 – Fax (570) 457-4562


Date: ____________________

Name: ________________________________________________________________________
(First, Middle Last)

Date of Birth: ________________ Age ________ Sex M F Social Security # ________________________

Race/Ethnicity: ____________________ Language: ____________________

Height: ________________ Weight: ________________ Shoe Size: ______________

Address: ______________________________________________________________________

______________________________________________________________________________

Email address ____________________________________
Phone: Home: __________________ Cell: ____________________ Work: __________________

Marital Status: Married Single Separated Divorced Widow

Do you use tobacco? Yes No
Do you use recreational drugs? Yes No
Do you drink alcohol? Yes No If yes, how often? ____________________
Are you pregnant? Yes No
Are you employed? Yes No Employer? ________________________________

Occupation? ___________________________________________________________________

Number of hours spent on your feet: __________ Steel Tipped Boots? Yes No

Primary Care Physician: ______________________________________________________

Date you last saw your doctor: _______________________________________________

Endocrinologist: _____________________________________________________________

Cardiologist: ________________________________________________________________

Pharmacy: (Name & City) ______________________________________________________

If Rite-Aid Pittston is it (Main St. or Laurel St.) ____________________________

What is the reason for your visit Today? ______________________________________

______________________________________________________________________________

Name:________________________________________

Are you allergic or have you ever had a reaction to any of the following?
(Please circle all that apply.)

| | | | | |
|---|---|---|---|---|
| Radiographic Contrast/Dye | Band Aids/Tape | Lidocaine | Sulfa Drugs | Anesthesia |
| Codeine | Novocain | Iodine | Penicillin | Aspirin |
| Latex | Other:________________________ | | | |

Do you have or have you ever been treated for any of the following? (Circle all that apply)

| | | | |
|---|---|---|---|
| Type I Diabetes (Juvenile)<br>Recent A1C________ | Type II Diabetes<br>Recent A1C____ | Psychiatric Disorder | Seasonal Allergies |
| Retinopathy | Circulation Problems | High Cholesterol | Chronic Kidney Disease |
| Heart Attack | Hypertension | Thyroid Disease | Kidney Problems |
| Amputation | Epilepsy | Lung Disease | Anemia |
| Neuropathy | Arthritis | GERD | Osteoporosis |
| Asthma | Gout | Back Pain | Hepatitis |
| Blood clot | Stomach Ulcer | Bunion | HIV/ AIDS |
| Stroke | Cancer | Ulcer/Wound | |

Do you have any family history (**M**other, **F**ather, **S**ister, and **B**rother) of any of the following?
(Please circle all that apply.)

| | | | |
|---|---|---|---|
| Arthritis – M F | Diabetes – M F | Hypertension - M F | Bleeding Disorders – M F |
| Foot Deformities - M F | Osteoporosis - M F | Cancer – M F | Heart Disease - M F |
| Stroke - M F | Other: ________________________ | | |

Do you use any of the following assistive devices?

Walker Cane Crutches Wheelchair Braces

Have you ever had foot surgery? Yes No

If yes, please list type and date of surgery.________________________________________

________________________________________

Please list all other surgeries and dates. ________________________________________

________________________________________

Patient Name:______________________________________________

I authorize the doctors and staff of David A. Scalzo to discuss the details of my treatment/ condition in person or by telephone with the following individuals only:

| Name | Phone | Relationship |
| --- | --- | --- |
| | | |
| | | |
| | | |

Patient/Guardian Signature ____________________________ Date: ____________________

I give my permission for David A. Scalzo to leave a message on my answering machine regarding any medical related issues concerning my treatment by the doctors. YES NO

Medication List: See Attached ____

**Patient Medication List**

| Medication | Dosage | Frequency |
| --- | --- | --- |
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Patient Name____________________________________________

**Primary** Insurance Name:____________________________________________

Insured's Name:____________________________________________

Insured's Date of Birth:____________________ Social Security # ____________________

Relationship to patient: ____________________________________________

**Secondary** Insurance Name:____________________________________________

Insured's Name:____________________________________________

Insured's Date of Birth:____________________ Social Security # ____________________

Relationship to patient: ____________________________________________

## Assignment and Release

I, the undersigned, certify that I ( or my dependent) have/has insurance coverage and I assign directly to David A. Scalzo all insurance benefits, if any, otherwise payable to me for services rendered. 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

X______________________________ ______________________________ ____________________

**Signature of Responsible Party** **Relationship** **Date**

## Medicare Authorization

I request that payment of authorized Medicare benefits may be made to David A. Scalzo for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other "health insurance" is indicated on 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 to the insurer or agency shown. In Medicare assigned cases, the physicians 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 non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

X______________________________ ______________________________ ____________________

**Signature of Responsible Party** **Relationship** **Date**

## HIPPA

I acknowledge that I was provided a copy of the David A. Scalzo Notice of Privacy Practices. This notice describes how David A. Scalzo may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information as well as the rights I may have regarding my protected health information.

X______________________________ ______________________________ ____________________

**Signature of Responsible Party** **Relationship** **Date**

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# & Associates

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Date: ______________________________

I ________________________________________ authorize Dr. David A. Scalzo and Associates
(PRINT NAME)

To electronically access my Insurance/Pharmacy in order to retrieve my current medication for my continuation of care.

________________________________________
Signature