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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Last Name	PATIENT INFORMATION:		Date of Birth				
Soc. Sec. # Home Phone () Cell Phone () Street Address City State Zip Employer Name Occupation Work Phone () Spouse's Name members seen RESPONSIBLE PARTY: (if different from above) Name Phone () 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 Phone Phone Emergency Contact: Emergency Contact: Emergency Contact: Relationship Phone Phone Street		Referred by					
Street Address City State Zip Employer Name Occupation Work Phone () Spouse's Name 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	Last Name	First Name		MI	Sex (Circle) M F		
Address City State Zip	Soc. Sec. #	Home Phone ()		Cell Phone ()		
Employer NameOccupation	Street						
Name Occupation Work Phone () 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 Ocopay Amount Name Order Order Ocopay Amount Soc. Sec. or ID# Group# Employer Phone Ocopay Amount Secondary insurance Copay Amount Policy Holder's Information: Name Ocopay Amount Soc. Sec. or ID# Group# Employer Ocopay Amount Policy Holder's Information: Name Ocopay Amount Policy Holder's Information: Name Ocopay Amount Phone Ocopay Amount Soc. Sec. or ID# Ocopay Amount Phone Ocopay Amount Soc. Sec. or ID# Ocopay Amount Phone Ocopay Amount Primary Instruction Primary Instruction Primary Instruction Primary Instruction Phone Ocopay Amount Phone Ocopay Amount Primary Instruction Primar	Address	City		State	Zip		
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Name	Spouse's Name	meml	pers seen				
Street Address City State Zip	RESPONSIBLE PARTY: (if differ	ent from above)					
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HEALTH HISTORY							
_	ever had:						
Yes N	o Angina or chest pain	Yes 	No 	Irregular heart beat			
	Asthma or wheezing			Known occupational exposure to Loud noises or chemical compounds			
	Bleeding tendency (including family history)			(e.g. Benzene)			
	Cancer (including family history)			Lung disease, TB			
	Diabetes: NIDDM			Metal implants, clips, rods, etc.			
	IDDM Emphysema			Migraines			
	Epilepsy or convulsions			Pacemaker			
	Heart Disease			Stroke			
	Hepatitis Type:			** Mental illness, drug addiction, HIV or AIDS, please discuss with the			
	High blood pressure			Physician.			
	Trigit blood pressure			Other illness			
Explanation of the above "Yes" answers:							
List any p	ast surgeries you have had:						
List any n	nedications you are currently taking:						
List any allergies:							
Do you drink alcoholic beverages? How much?							
Do you or have you ever smoked?							
	many years? Have you quit?						
Who is yo	ou primary care physician?			Last date seen?			
Female –	Are you are pregnant?	Н	ow mar	ny months?			
reason, I	e insurance payment of medical benefits to DONA will be responsible for payment of services render checks may apply. Co-pays must be made on the contract of t	ed. I understar	-				
I affirm that this information is true and accurate.							
Patient or authorized person's signature: Date:							