JAMES FIERRO, D.O., P.A.
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Foulk Road Medical Center
1805 Foulk Road | Wilmington, DE 19810
P: (302) 529-2255 F: (302) 529-2257

Name: ______________________________ Date of Birth: ____ / ____ / ____

Address: ______________________________ City/State ________________ Zip __________

SSN: __________________ Phone (Home): __________________ (Cell): __________________

Race: ______________ Ethnicity: __________________ Preferred Language ________________

Marital Status: ________

Allergies

☐ No Known Allergies
☐ Yes. If so, please list all Drug, Food, and Environmental Allergies.

____

____

Medications

Please list all current Over the Counter and Prescribed Medications with their corresponding dosages (if known)

Personal Medical History

☐ No Known Problems
☐ Yes. If so, please list all Current and Past Medical problems.

____

____

Procedure and Surgeries

☐ None
☐ Yes (If so, please list all Procedures/Surgeries. Ex: Tonsillectomy, 2005)

____

____

Family History

Name ____________________________________

☐ Unknown ☐ Adopted

Type	Mother	Father	Sister	Brother	Grandmother Maternal	Grandmother Paternal	Grandfather Maternal	Grandfather Paternal
Deceased								
Alzheimer's								
Arthritis								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Kidney Disease								
Mental Illness								
Osteoporosis								
Seizures								
Thyroid Disease								
OTHER:								

Social History

Alcohol Use: ☐ Current ☐ Past ☐ Never

Please circle if applicable: Beer | Wine | Liquor

Tobacco Use: ☐ Current ☐ Past ☐ Never

Please circle if applicable: Cigarettes | Cigars | Oral | Pipe | Snuff

Substance Abuse: ☐ Current ☐ Past ☐ Never

Please specify the type: ______________________________

Preferred Pharmacy

Name: ____________________________ Location: ____________________________

Name ____________________________________

Exercise and Physical Activity:

Times per week: _______ Please specify the type: ________________________________

Patient Questionnaire

Do you have a Living Will or an Advanced Directive: ________________________________

Name of Insured Person if Other than Yourself: _______________ His/her Date of Birth: ___________

Do you want to be tested for HIV/AIDS: _______ Date/year of your last Pneumonia Vaccine: _________

Emergency Contact Information

Name of Emergency Contact(s): ______________________________________

Relationship to you: __________________ Emergency Contact Number(s): ____________________

Assignment of Benefits: I hereby assign all medical and surgical benefits to which I am entitled to including Medicare, Medicaid, Private Insurance, Medigap, and any other health plans to James Fierro, D.O., P.A.. I authorize than any holder of medical information about me, to release to my insurance company and to my supplemental insurer and information needed to determine these benefits payable for medical and related services provided by James Fierro, D.O., P.A.

Signature ______________________________________ Date ______________________________

Patient Privacy Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (Hippa), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as the quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry our treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Relation to Patient: ______________________________

Date: ____________________

Contact Form

In order to provide safe and efficient care we need to be able to contact you; please provide the following. This information is private and will not be shared with anyone outside of this office.

Supply what you have, if you do not have a Cell phone number, Email address, or Work phone number just leave them blank.

Your Name:____

Home Telephone Number:____

Cell phone Number:____

Email Address:____

Work Telephone Number:____

Name and Telephone Number of whom we can call if we cannot get ahold of you or if something happens to you and we have to call someone else on your behalf:

____

____

____

Your Signature Date