Dr. James Fierro, D.O., P.A.
1805 Foulk Road, Suite F
Wilmington, DE 19810 Ph: (302) 529-2255 Fax: (302) 529-2257

Name: _____ Date 0f Birth: ___/___/_____

Address: _____ City/State _____ Zip: _____

SSN: _____ Phone (Home): _____ (Cell): _____

Race: _____ Ethnicity: _____Preferred Language: _____

Marital Status: _____

Allergies:

____ No Known Medication Allergies

____ Yes. List below as well as the type of reaction. Please include environmental allergies as well.

Medications:

Please include all medications, including Over the Counter medications

Preventive Screenings: Please list dates of your last.

Colonoscopy: _____ Yearly Skin Exam: _____

Mammogram (if applicable): _____ Pap Smear (if applicable) _____

Bone Density: _____ Flu Shot: _____

Eye Exam: _____ Tetanus Shot: _____

Dental Exam: _____ Pneumonia Shot: _____

Past Medical History

Have you ever been diagnosed with any if the following conditions:

____Hypertension
____High Cholesterol
____Diabetes
____Asthma
____COPD
____Kidney Disease
____Cancer
____Heart Disease
____Headaches
____Depression
____Anxiety
____Bipolar Disorder
____Thyroid Disease
____Heart Attack
____Stroke
____Osteoporosis
____Sleep Apnea
____Anemia
____Acid Reflux
____Hepatitis
____Liver Disease
____Autoimmune Disorders
____Other*(please list below)
_____
_____
_____

Family History

____ Unknown
____ Adopted

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

Procedures and Surgeries

____ None

____ Yes. Please list below with dates

_____

_____

Specialists:

Please list any specialists that you see (for example: cardiologist, endocrinologist)

_____

_____

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:

Local Pharmacy: _____ Location: _____

Mail Order Pharmacy (if applicable): _____

Exercise and Physical Activity:

Times per week: _____ Please specify the type: _____

Other

Do you have a living will or Advanced Directive? _____

Insurance Information

Medicare ID# _____

Do you have insurance Primary to Medicare? Yes No If yes, please list. _____

Medicare Supplement _____ ID # _____

Medicare Advantage Plan _____ ID #_____

Medicaid ID #

Primary Insurance _____ ID_____ Gp _____

Policy Holder Name _____Relationship (Circle) Self Spouse Parent Other

SSN _____ Policy Holder's DOB _____

Employer _____

Secondary Insurance _____ ID_____ Gp _____

Policy Holder Name _____Relationship (Circle) Self Spouse Parent Other

SSN _____ Policy Holder's DOB _____

Employer _____

Name of insurance holder if other than yourself: _____

His/Her date of birth: _____ Relationship to Insurer (Ex: Spouse) _____

Emergency Contact Information

Name of Emergency Contact(s) :_____

Relationship to you: _____ Phone number: _____

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 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 protested 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 to 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 of 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 at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

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.

Your Name: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Work Phone: _____

Please provide name and telephone number of whom we can call if we cannot get a hold of you or if something happens to you and we have to call someone else on your behalf.

Name: _____

Phone Number: _____

Relationship to you: _____

Your Signature: _____ Date: _____