DR. SALVATORE L. DELELLIS
DR. CHRISTOPHER P. ROEVER
1264 SOUTH PINELLAS AVENUE, TARPON SPRINGS, FL 34689
PHONE: (727)-937-6398 FAX: (727)-937-6568

Patient Information

Date: _____ Male: _____ Female: _____

Patient: _____
Last Name First Name Middle Initial

S.S #: _____ D.O.B: _____ Age: _____ Ht: _____ Wt: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Shoe Size: _____

E-Mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Secondary Address: _____

City: _____ State: _____ Zip Code: _____

Employed By: _____ Job Description: _____
Do you mostly: ☐Sit ☐ Stand

Work Address: _____

Emergency Contact: _____ Spouse's Name: _____

Address: _____

Phone #: _____ Relationship: _____

Primary Language: _____ Referred By: _____

Insurance Information: Medicare #: _____

Insurance/Secondary: _____ Policy #: _____

Address: _____ Group #: _____

Phone #: _____ Insured's Name: _____

What is your foot, ankle, lower leg problem? _____

_____

When did this problem start?

_____

Was it: ☐ Gradual ☐ Sudden Was there any trauma or injury? ☐ Yes ☐ No

Has is become: ☐ Worse ☐ Better ☐ Unchanged What time of day does it hurt the worst? _____

Type of Pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Burning ☐ Tingling ☐ Numbness ☐ Constant
☐ Intermittent ☐ Hurts when walking ☐ Hurts at rest ☐ Aggravated by shoe wear
☐ Aggravated by athletic activity ☐ Other: _____

Has your foot been treated before? ☐ Yes ☐ No When? _____ Where? _____

Please tell us what your goals and expectations are relating to your problem:

Relating to your specific complaint(s), what would you like to accomplish **during your first visit** and in future that you may not be able to currently do: _____
_____

DIABETIC'S ONLY:
Diabetic Doctor & Date Last Seen: _____
Eye Doctor & Date Last Seen: _____
Date of Last Flu Shot: _____
Kidney problems: _____

Former Podiatrist: _____
Name Address Date Last Seen

Primary Care Physician: _____
Name Address Date Last Seen

Other Physicians: _____
Name Address

Pharmacy: _____
Name Phone Number

Allergies:
☐ No Known Allergies ☐Novocain ☐Iodine ☐Penicillin ☐Aspirin ☐Sulfa ☐Cortisone ☐Codeine
☐Adhesive Tape ☐Other: _____
What type of adverse or allergic reaction did you have? _____
Were you ever hospitalized for an allergic reaction? _____

Medications: Please give **exact dosage**. Include all over the counter medications/vitamins.

Prescription	Prescriptions	Vitamins/Herbs/Diet Pills
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past History: (Please check yes or no for the following)

☐ Elevated Cholesterol ☐Triglycerides

☐ Diabetes- ☐ Insulin Dependant ☐ Non-Insulin Dependant- Month & Year Diagnosed: _____

☐Yes ☐No Peripheral Neuropathy

☐Yes ☐No Stroke Month: _____ Year: _____

☐Yes ☐No Prolonged Bleeding

☐Yes ☐No Circulation Problems: LEGS- ☐Upper ☐Lower FEET- ☐Left ☐Right ☐Both

☐Yes ☐No Phlebitis- ☐ Right ☐Left ☐Both

☐Yes ☐No Night Cramps- ☐ Legs ☐ Feet ☐ Left ☐Right ☐ Both

☐Yes ☐No Raynaud's Disease

☐Yes ☐No Anemia Sickle Cell Anemia ☐Yes ☐No

☐Yes ☐No Arthritis ☐ Osteoarthritis ☐ Rheumatoid ☐ Gouty

☐Yes ☐No Osteoporosis

☐Yes ☐No Gout- Location: _____ Last Episode: _____

☐Yes ☐No Fibromyalgia ☐ Lupus Erythematosis ☐ Ankylosing Spondylitis

☐Yes ☐No Neck Pain Back Pain ☐Yes ☐No

☐Yes ☐No High Blood Pressure How Many Years? _____

☐Yes ☐No Heart Problems- ☐Tachycardia ☐Atrial Fibrillation ☐Heart Attack ☐Other: _____

☐Yes ☐No Coronary Artery Disease

☐Yes ☐No Asthma- ☐COPD ☐Emphysema ☐Lung Infections

☐Yes ☐No Glaucoma

☐Yes ☐No Cataracts

☐Yes ☐No Thyroid Problems- ☐ Hypothyroidism ☐ Hyperthyroidism

☐Yes ☐No Cancer- Location: _____ Type: _____

☐Yes ☐No Kidney Problems- _____

☐Yes ☐No Gallbladder Disease

☐Yes ☐No Colitis

☐Yes ☐No Depression

☐Yes ☐No Bipolar

☐Yes ☐No Rheumatic Fever

☐Yes ☐No Sexually Transmitted Disease

☐Yes ☐No Dizziness- ☐Vertigo ☐Unstable Gait ☐Frequent Falls

☐Yes ☐No Other: _____

PAST SURGURIES:

_____

_____

_____

FAMILY HISTORY: Please check any/all boxes that apply and fill in the information below:

Relative:	**Status:**		**Cause of Death:**
Father	☐**Alive** _____ Age	☐**Deceased** _____ Age	_____
Mother	☐**Alive** _____ Age	☐**Deceased** _____ Age	_____
Brother	☐**Alive** _____ Age	☐**Deceased** _____ Age	_____
Sister	☐**Alive** _____ Age	☐**Deceased** _____ Age	_____

Other:

_____	☐**Alive** _____ Age	☐**Deceased** _____ Age	_____
_____	☐**Alive** _____ Age	☐**Deceased** _____ Age	_____
_____	☐**Alive** _____ Age	☐**Deceased** _____ Age	_____

Please list any other known medical diagnosis/ medical issues that have been in your family history and their relation to you.

_____ _____

_____ _____

PERSONAL HABITS:

Have you ever smoked tobacco? ☐Yes ☐No
Do you use chewing tobacco? Yes No

Do you currently smoke? ☐Yes ☐ No
☐Cigarettes ☐Cigars ☐Pipe
Amount per day: _____

I quit using tobacco use completely. ☐Yes ☐No
How many years did you smoke prior to quitting? _____
How many packs a day did you smoke? _____

Do you drink alcohol? ☐Yes ☐No
Alcohol consumption per day: ☐One ☐Two ☐ More

EXERCISE: ☐Walking ☐Jogging ☐Gym ☐Biking ☐Other: _____

How often? ☐Once a Week ☐ Two-Three times a Week ☐ Daily

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/ diagnostic treatment and/or minor surgical treatment by **Sal L. DeLellis, DPM PA** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/ current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ **Date:** _____

AUTHORIZATION AND ASSIGNMENT

I request the payment of Authorized Medicare/ Insurance benefits to be made to either me or on my behalf of any services furnished by **Sal L. DeLellis, DPM PA**. I authorize any holder of medical information about me to release to CMS/ Insurance Carriers and its agents any information needed to determine these benefits or benefit related services. I hereby authorize **Sal L. DeLellis, DPM PA** to furnish information to Medicare/ Insurance Carriers concerning my medical condition, illness and treatment to determine for related services. I hereby authorize (assign) medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services. I certify that the information given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status of change in the above information.

Signature: _____ **Date:** _____

DESIGNATED RELATIVE

I authorize discussion of my General Medical Condition and Diagnosis (including treatment, payment, and health care operations) with: ☐ Spouse ☐ Children ☐ Other: _____

Please list the family members or significant other, if any, whom we may inform about your medical condition, in case of an emergency.

Name: _____ **Phone:** _____
Name: _____ **Phone:** _____

Signature: _____ **Date:** _____

PRIVACY NOTICE

I have received a copy of **Sal L. DeLellis, DPM PA** office privacy notice per HIPPA guidelines.

Signature: _____ **Date:** _____

Patient Name (Print): _____ **S.S #:** _____
Witness: _____ **Relationship:** _____

Notice of Privacy Practices for Protected Health Information (HIPPA)

"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information". Please Review It Carefully!

We Safeguard Information About Your Health And person:

We collect information from you and store it in a medical record as well as in a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance, and other non-office personnel have no access to the chart area. Service technicians may have access to the computers, but only for service of computer operations.

Typical Uses And Disclosures Of medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for health care operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other health care providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospital and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (death, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-Approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Workers compensation
- Disaster relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

<u>Patient Privacy Rights:</u>

You Have The Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days. You may also get an electronic copy if we have one available.

- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed at our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years, starting April 14th, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict the consent.
- Restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for the healthcare item or service.
- Request confidential communications. All communications in our office are confidential. You may specifically- request that all communications be confidential with a written request directed to our office.
- Not to have your protected health information sold for marketing purposes.
- Opt out of receiving fund-raising communications.
- Be notified following a breach of your unsecured protected health information.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We may contact you for Appointment Reminders, and we may provide you with information about health-related or product benefits and services. Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities Under HIPPA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our Privacy Policy or its execution either verbally or in writing to our <u>PRIVACY OFFICER</u> at: Sal L. DeLellis DPM PA

Dr. Salvatore L. DeLellis
1264 South Pinellas Avenue, Tarpon Springs, FL 34689
Phone: (727)-937-6398 Fax: (727)-937-6568

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

Effective Date of Notice: **July 2011**
Amended Dates: **Jan 2015**