Mark Gasparini, D.P.M.
Podiatric Medicine and Surgery
Patient Registration
119 New York Ave
Massapeqa, NY 11758

Name:________________________ SS#_____-____-______ Date of Birth:___/___/____

Age:______ Email:________________________

Street Address:_________________________________ City:______________Zip:_________

Primary #(_____)_______-________ Work: (_____)_____________Cell:(_____)_____-_____

Primary Care Doctor:

Doctors Name:___________________________ Phone: (_____)_______-_________

Address:________________________________ City:____________________Zip:__________

Date Last Seen:_____/______/______

How Did you hear about the office?
____

Emergency Contact:

Name:___________________________ Phone: (____)______-_______

Relationship:______________

Insurance:

Medicare# (if applicable)_________________________

Primary Insurance Name:________________________

ID#________________________________

Secondary Insurance Name:________________________

ID#________________________________

MARK GASPARINI, D.P.M.,A.A.C.F.A.S.
119 New York Ave
Massapequa NY 11758
(516) 804-9038

Patient Registration Signature Form

Patient Name (Print) _________________________________

Date of Birth _______/________/__________

Date:_________________________________

Signatures:

1) **Authorization to Release Information**

Signature:_________________________________

2) **Authorization to Pay Benefits to Physician**

Signature:__________________________________

3) **Notice of Privacy Practices Patient Acknowledgement**

Signature:__________________________________

4) **Permission to Treat a Minor (UNDER AGE of 18)**

Signature:___________________________________

Name and Relationship to patient (if signed by a personal representative of patient):

____

Medical History
Mark Gasparini, D.P.M.,A.A.C.F.A.S.
Podiatric Medicine and Surgery

Name:_________________________ Height:_________ Weight:_________Shoe Size:______

Chief Complaint:____Duration:________

Present Medications____

____Allergies___________

Personal Medical History:

Do you, have you had, or are you taking any medications for the following conditions (check all that apply):

☐ Chest Pain	☐ Asthma	☐ Shingles	☐ Seizures
☐ Hypertension	☐ Dizzy Spells	☐ Kidney Disease	☐ Stroke
☐ Stroke	☐ Cancer	☐ Shortness of Breath	☐ Thyroid Disorders
☐ Headaches	☐ Diabetes	☐ Ulcers	☐ Other__________
☐ Glaucoma	☐ Arthritis	☐ Skin Disorders	
☐ Allergies	☐ Difficulty Hearing	☐ Hepatitis	
☐ Depression	☐ Pneumonia	☐ Cataracts	
☐ Gout	☐ Memory Loss	☐ High Cholesterol	

List any previous surgeries (last 3 years):____

Family History:	Father	Mother	Siblings	Children	Grandparents
High Blood Pressure	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Heart Attack/Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐

Do you Smoke? ☐YES ☐NO ☐ Sometimes ☐Cigarettes ☐Cigars ☐Pipes
No. of Years_______ How much??______________

Do you regularly drink alcohol?? ☐ YES ☐ NO ☐ Socially
How many ounces/beers/Glasses of Wine per day??____________________

FEMALES ONLY:

Are you pregnant, planning a pregnancy or nursing a child? ☐ YES ☐ NO

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Dr.Gasparini.com

Office Policy effective October 15, 2009

Non-Payment of co pays **at time of scheduled visit** will
Will incure a **$10.00** fee in addition to co pay amount.

24 Hour Advanced notice is needed for cancelled
Appointment otherwise a **$45.00 fee will be charged.**

We require **72 hours advanced notice** for **any referrals** needed.
It is **YOUR RESPONSBILITY** to know if you need referrals
From your insurance carrier. You will be responsible for
Payment at time of your visit if you do not have a referral.

Bounced Checks will be charged a **$45.00** fee along with the
Bank fee.

Patient Name: ____

Signature: ____

Date: ____/_____/201__

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Podiatric Medicine and Surgery

** This is a confidential record of your medical history; all information will be kept in the office and/or in a secured location. No information will be given out without your express written permission. I agree that all the information is TRUE. It is my responsibility to pay the doctor for his services. Payment is due when services are rendered. I understand Dr Gasparini's office will file insurance claims for services rendered as a courtesy, and according to our agreement with them. I agree to make full and complete payments within 30 days of denial claim by my insurance plan. If the account is not pain in full, I agree to pay a monthly account maintenance fee of $15.00 per month until it is paid in full. I agree to pay all actual collection fees along with the entire balance due after services are rendered.**

You are **ENTIRLY responsible for your insurance policy. If your policy requires a referral prior to your appointment, it is **YOUR** responsibility to obtain the referral from the appropriate physician.**

X____ Date_____/_____/201__