Dr. William A DiGiacomo, MD., F.A.C.P
Dr. W. Scott DiGiacomo, MD., F.A.C.G

PATIENT REGISTRATION

Welcome to our Office, Please Print and Answer all Questions

Patient Information (Please Complete Using Your Name as Listed on Insurance Card:

First Name: ______________________ Middle Initial: ______ Last Name: ______________________

Address: ______________________________________ City: ______________________

State: ____________ Zip: ____________ Home Phone: ______________ Cell: ______________

Email Address: ____

Occupation/Employer: ______________________________ Work Phone: ______________________

Date of Birth: __________________________ SS#: __________________________ Sex: M / F

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widow

Pharmacy Name: ____ **(REQUIRED)**

Address: ____ Phone: ______________________

Referring Physician Information: (INCLUDE FIRST AND LAST NAME)

Referring Physician: ____

City: ______________________ Zip Code: ______________ Phone #______________________

Primary Care: ____

City: ______________________ Zip Code: ______________ Phone #______________________

Emergency Contact Information:

Name: __________________________ Relationship: ____________ Phone # ____________________

Billing and Insurance:

Primary Health Insurance

Insurance Company Name: __________________________________ Phone # ____________________

Policy Holder's Information:

Name: ______________________ Relationship to Patient: __________ Phone # ____________________

Address: ____

Date of Birth: ______________________________________ SS # __________________________

Patient Release - Must be signed by patient if over 18 or legal guardian of patient is under 18

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

Signature of Patient or Legal Representative: __________________________ **Date:** ____________

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PATIENT MEDICAL HISTORY

Please Print and Answer all Questions

Patient Information (Please Complete Using Your Name as Listed on Insurance Card:

First Name: ______________________ Middle Initial: _____ Last Name: ______________________

Date of Birth: ______________________________

FAMILY HISTORY: Please provide a brief list of your family diagnoses or surgeries:

Surgical History:
Please list any hospitalizations, surgeries, fractures, or major illnesses you have had:

Type of Surgery	Year or Date	Doctor	Location

Medical History:
Please provide a brief list of your past diagnoses or surgeries:

Medication:
List any medications you are currently taking (please include over the counter medications)
PLEASE PRINT LEGIBLY - NO CURSIVE PLEASE

Medication	Dosage	Frequency

Drug Allergies:
Please provide a list of all known drug allergies

Signature: ______________________________ **Date:** ____________________

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PATIENT ACKNOWLEDGMENT OF
DR. WILLIAM A DIGIACOMO & DR. SCOTT DIGIACOMO OFFICE POLICIES

*** PLEASE READ THE FOLLOWING CAREFULLY BEFORE INITIALING***

Insurance Information - Co-Payment and Responsibility

Payment if required for all services at the time they are rendered. I understand that regardless of insurance enrollment, I am ultimately responsible for all costs of treatment rendered and it is my responsibility to understand my healthcare coverage including co-payments, deductibles, and co-insurance. Checks returned for insufficient funds will be charged an additional $50 fee.

Patient/Guardian Initials: __________

Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit.

Patient/Guardian Initials: __________

Insurance Cards

New Patients of those with a change in their information must provide a valid insurance card or temporary print out at the time of the visit. If I am unable to present one, I may pay in full at the time of service and submit a claim to my insurance carrier at my convenience. I understand by signing below that I am responsible for notifying the office of any changes to my insurance / contact information.

Patient/Guardian Initials: __________

HIPAA POLICY

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibit our Doctors and staff from discussing appointments, medication, test results or treatment plan with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. **If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below.** Only these individuals will be provided with information. Should you wish to update the names below, please ask the receptionist for a HIPPA form.

Name of Individual: ______________________________ Relationship to Patient: ______________

Name of Individual: ______________________________ Relationship to Patient: ______________

I acknowledge the practice's adherence of the Notice of Privacy related to the Health Insurance Portability and Accountability Act of 1996 and may request a personal copy at any time.

Signature: ______________________________ **Date:** ______________________