***DRS. KIERSTEIN & DIFRANCESCA, D.P.M., P.C.***
*PODIATRIC MEDICINE AND SURGERY*

196 Parkway South
Suite 302
Waterford CT, 06385
Tel. (860) 447-1488
Fax (860) 447-1489

5 Case Street
Norwich CT, 06360
Tel. (860) 889-0022
Fax (860) 887-8763

Dear Patient;

Welcome to the podiatric medical and surgical practice of Dr. Joseph W. DiFrancesca and Dr. Jeffrey M. Kierstein. Your appointment with us has been scheduled on _____ in the **Norwich** / **Waterford** office. On this date please arrive ten minutes before your appointment with the following pieces of information:

1. **A completed and signed copy of your health and information sheets that have been mailed to you.**
2. **An insurance card. We will need to take a copy of your card, which allows us to bill the insurance company on your behalf.**
3. **A referral (if required by your insurance carrier) must be obtained prior to the visit for services to be covered.**
4. **Payment (cash, personal check, Visa, or Mastercard) of any copay associated with your health insurance plan. The copay information is usually listed on your insurance card.**

***Please do not send any of the information into the office ahead of time, as we would not want this personal health information lost in the mail.***

These should be available on the day of your visit. Missing information could result in a delay with your appointment. If you have any questions please do not hesitate to contact the office. The office also asks that if you need to change or cancel your appointment, please contact the office prior to 9:00 AM on the day of the appointment. Failure to do so will result in a $75.00 no show charge applied to your account for any missed new patient appointments.

Thank you for choosing our office to provide effective, professional management of all your foot health needs.

Sincerely,

The offices of Drs. Kierstein and DiFrancesca, DPM

- ***Please print clearly and use <u>black</u> ink when completing paperwork. Thank you.***
- ***Please arrive with all paperwork completed; failure to do so may require the appointment be rescheduled. Thank-you.***

Joseph W. DiFrancesca, DPM, PC
BD4021173

Jeffrey M. Kierstein, DPM, PC
BK6724074

# PATIENT INFORMATION

(PLEASE PRINT)

Name: Sex: **M/ F**

SSN# Date of Birth: Age: Marital Status: **S M W D Sep** .

Email Address: .

Address: City: Zip:

Home Phone: Business Phone: Cell Phone : .

Personal Physician: Date Last Seen: Referred By:

Patient's Employer: Position: **Full Time/Part Time**

Business Address:

Spouse's Name: Spouse's Employer: Spouse's work phone:

Pharmacy: Phone Number# .

## PERSON RESPONSIBLE FOR BILL

**(IF OTHER THAN ABOVE)**

Name: Relationship:

Address (If other than above) Home Phone: Date Of Birth:

Employer: Position: SSN:

Business Address: Business Phone:

## INSURANCE, MEDICARE, WORKER'S COMPENSATION OR WELFARE INFORMATION

Company or Program Insured SSN Group Number Policy Number

1.

2.

## NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

**(If not already listed)**

Name: Relationship:

Address (if other than above): Home Phone:

Employer: Position: Business Phone:

## NOTICE OF PRIVACY PRACTICES

A copy of our **"Notice of Privacy Practices"** is on display in the waiting room. If you would like a copy please ask the front desk, they will provide you with a copy at any time.

I acknowledge that I was given the opportunity to receive a copy of the **"Notice of Privacy Practices"** upon request.

_____

Signature Date

_____

Authorized Representative if applicable (please print)

Joseph W. DiFrancesca, DPM, PC Jeffrey M. Kierstein, DPM, PC

# HEALTH HISTORY

*Welcome to our practice, as a new patient; please fill out the information below to the best of you ability.*

Patient name: _____ Date of Birth: _____

Chief Complaint: _____

Nature: _____ Location: _____
(example: sharp, throbbing, shooting, etc.) (Where is the pain/problem specifically?)

Duration: _____ Onset: _____
(How Long? When did it start?) (example: sudden, slow, etc.)

Course: _____ Aggravations: _____
(Is it getting worse, better, or staying the same?) (What makes it worse? ex. shoegear)

Timing: _____ Treatment: _____
(Does the pain/problem occur at a specific time?) (Ex. primary dr., clinic, over the counter meds)

**Past Medical History** Have you ever had the following: (circle "no" or "yes", leave blank if uncertain)

AIDS or HIV……..….no yes
Anemia……..……..no yes
Arthritis……...no yes
Artificial heart valve....no yes
Artificial joints…..…...no yes
Location? _____
Asthma…….no yes
Back trouble…….no yes
Bleeding tendency …...no yes
Cancer……..no yes
Circulation problems…no yes

Diabetes…….…...no yes
Type 1 or type II
How long? _____
Frequent infections…..no yes
GI disease…….no yes
Gout……..…no yes
Healing problems……..no yes
Heart disease…….no yes
Hepatitis……no yes
High blood pressure…..no yes
Kidney disease……..no yes
Liver disease…….no yes

Lung disease……..no yes
Mitral Valve Prolapsed…..no yes
Neurological disorder……no yes
Pneumonia……..……..no yes
Rheumatic fever…..……...no yes
Stomach ulcers……..….no yes
Stroke……...….no yes
Thyroid disease……...…no yes
Tuberculosis……..no yes
Venereal disease...…….no yes
Any other disease……..no yes
If so, What?_____

| **Previous Hospitalizations/Surgeries/serious Illnesses** | When | Hospital, City, ST |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Medication** (include non prescription) _____
_____

**Patient social history:**

| | |
|---|---|
| Marital status | Single_____ Married _____ Separated _____ Divorced _____Widow ____ |
| Use of alcohol | Never _____ Rarely _____ Moderate _____ Daily _____ |
| Use of tobacco | Never _____ Previously, but quit_____ Current pack/day _____ |
| Use of drugs | Never _____ Type/frequency _____ |
| Employment | Sit_____ Stand_____ Stand & walk _____Retired _____ |
| Activity on feet | Rarely _____ Moderate _____ Daily _____ Types_____ |

**Family Medical History:**

| | Age | Diseases (diabetes, heart, vascular, neurological, etc.) | If deceased, cause of death |
|---|---|---|---|
| Mother | _____ | _____ | _____ |
| Father | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**Bunion(s)** ….no yes **Hammertoes**….no yes **Flat feet** ……no yes

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# REVIEW OF SYSTEMS

Please answer to the best of your ability.

## Constitutional Symptoms

Good general health lately……no yes
Recent weight change……no yes
Chills……..…..no yes
Fever……..no yes
Night sweats..……no yes
Fatigue……...no yes

## Cardiovascular

Heart trouble……no yes
Chest pain……..……...no yes
Shortness of breath with exertion…….no yes
Swelling of feet ankles, hands……..no yes

## Respiratory

Frequent cough……..….no yes
Shortness of breath…….....…no yes

## Integumentary (Skin)

Rash or itching……..…no yes
Change in hair or nails……no yes
Varicose veins……no yes

## GI

Abdominal pain ……..…..no yes
Heart burn ……no yes
Vomiting ……..no yes
Yellowing of the skin ……..no yes
Bowel habit change ……..…no yes

## GU

Kidney dialysis ……no yes
Increased urinary frequency ……..….no yes
Currently pregnant ……...no yes

## Eyes

Loss of vision ……no yes
Blurred vision ……no yes
Photosensitivity ……..no yes

## Psychiatric

Memory loss ……..…no yes
Panic attack ……. no yes
Any other psychiatric disorder ……..…no yes

_____
Signature of patient or guardian Date

Doctor's Review:

_____
Signature of Doctor

## Neurological

Lightheaded or dizzy……..no yes
Numbness or tingling……..no yes
Paralysis……..no yes

## Endocrine

Glandular or hormone problem…….…..no yes
Excessive thirst or urination……no yes

## Hematologic/lymphatic

Slow to heal after cuts……no yes
Bleeding or bruising tendency……...….no yes
Anemia……no yes
Phlebitis…….…..no yes
Past Transfusion……..no yes
Enlarge glands……no yes

## Musculoskeletal

Joint pain……...…..no yes
Joint stiffness or swelling……...….no yes
Weakness of muscles or joints……..….no yes
Back pain……...…no yes
Cold extremities…….……..….no yes

## Ear, Nose, Mouth, Throat

Difficulty swallowing …….……..no yes
Difficulty hearing ……...…..no yes

## Immunologic

Arthritic flare up ……no yes
Hepatitis B carrier ……..no yes
HIV carrier ……..no yes
Seasonal allergies ……..……no yes

## Allergies

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotic……no yes
Novocain or other anesthetic…….…..no yes
Aspirin or other pain remedy…...……no yes
Codeine or other narcotic……..no yes
Betadine/iodine or other antiseptic…..…no yes
Other drugs or medication:
_____
_____

Other food or environmental allergies:
_____
_____

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## *Release of Information to Insurance Company*

☐ Yes ☐ No I hereby authorize release of information for insurance claim purposes. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS

.

## *Release of Information to patient's Physician and Family Members*

I authorize Dr. Kierstein, Dr. DiFrancesca and employees to release medical information (i.e. test results, appointments and information about medications I have been prescribed) to:

***Please check all that apply for times when the staff is contacting you by phone:***

_____ Patient only
_____ Patient and spouse
_____ Anyone answering the phone

***I give permission for information to be left on my answering machine. Please check all that apply.***

_____ Appointments at our office
_____ Appointments with other Doctors or at the hospital
_____ Test Results
_____ Information regarding prescriptions I am taking or changes in prescriptions.

***I give permission for the following information to be sent to my Primary Care Physician:***

_____ Office Notes
_____ Proposed treatments to obtain a referral if a referral is needed.

***I give permission for the following information to be sent to my email account:***

_____ Appointment reminders
_____ Update of information requests

Signed _____ Date _____

***DRS. KIERSTEIN & DIFRANCESCA, D.P.M., P.C.***

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# Patient Financial Policy

As you know, health care today is in a state of constant change. We will do our best to help you though any insurance problems you may have. To avoid this, we require every patient to present his or her most recent insurance card so we can have accurate insurance information on file. ***If we do not have this information full payment will be required at the time of service.***

***In addition we are asking every patient, or guardian in case of a minor, to sign the following statements, which acknowledges your financial responsibility for services rendered.***

**Financial Responsibility of Patients**

1. **I understand I am responsible for all services rendered.**

   **_____Initial**

2. **I understand this office will bill my insurance company; I am responsible for my yearly deductible, co-pays, and non-covered services. If payment is not made at the date of service I understand that a ten ($10.00) dollar service fee may be incurred.**

   **_____Initial**

3. **If this office does not participate with your insurance company, you will be responsible for all charges incurred at the time of the visit. As a courtesy to you, for expensive treatments a payment plan may be put into place.**

   **_____Initial**

4. **I understand that if I am covered under a gatekeeper or capitated plan (Oxford Health and Bluecare); I need to obtain a referral from my primary care physical first. This office needs to receive the referral from my doctor before my scheduled visit. It is my responsibility to make sure this referral is current and complete; i.e. necessary testing and services need to be authorized. If the appropriate referral has not been received in the office by the time of my appointment; (1) I may cancel my appointment without penalty, or (2) I may choose to proceed with my scheduled appointment and I will be financially responsible for services rendered. Cancelled appointments will be rescheduled after the necessary paperwork is received and when we have an opening in our schedule.**

   **_____Initial**

5. **I understand that there will be a $50.00 charge applied to my account for established patients if I neglect to cancel an appointment by 9 AM on the day of the appointment or if I neglect to show for an appointment.**

   **_____ Initial**

6. **<u>The Medical Assistance Program (Medicaid, Medicaid Low Income Adult, Community Health Network, etc.) will not cover all podiatry services provided to any member</u>. By signing my name below, I am agreeing to pay for any and all non-covered podiatry services received at this office for any dates of service based on this Medical Assistance Program policy. This means that I am responsible for the unpaid (uncovered by insurance) portion of the services received at this office, even though I am or may be an eligible member of a Medical Assistance Program. By signing my name below, I am agreeing to receive and pay for any non-covered podiatrist service pursuant to section 17b-262-531(a) of the Regulations of Connecticut State Agencies should it be determined that I am or may be an eligible member of a Medical Assistance Program.**

   **_____ Initial**

**Benefits to Physicians:**

☐ **Yes** ☐ **No I hereby authorize payment directly to the physician of the surgical and/or medical benefits.**

☐ **Yes** ☐ **No I also understand that I am responsible for any portion of my bill not covered by my insurance company.**

**I understand all of the above and hereby state the information is correct to the best of my knowledge.**

Date: _____ 20_____ Signed: _____