NEW ENGLAND FOOT & ANKLE, P.C.

WELCOME TO OUR OFFICE

Mr, Mrs, Ms, Dr:_____ Date of Birth:_____

What Name Do You Like To Be Called: _____

Address:_____City:_____State: _____ Zip:_____

E-mail:_____ Would youl like access to patient portal: ___Yes ___No

Home Telephone: _____ Cell Phone: _____

Confirm appointment by: Home Telephone ___ Cell ___ Text ___

Age: _____ Sex: ___M ___F Weight: _____ Height: _____ Shoe Size: _____

Single: _____ Married: _____ Widowed: _____ Separated: _____ Divorced: _____

Employed By: _____ Occupation: _____ Bus. Phone: _____

Employer Address: _____

Medical Insurance Co.: _____ Policy No. _____

Name of Subscriber: _____ Date of Birth:_____

Do You Have Other Health Insurance Coverage? Yes _____ No _____

Medical Insurance Company: _____ Policy No. _____

OFFICE POLICY REGARDING INSURANCE

To preserve the best possible relationship with you, our patient, and to preavent any misunderstanding, we hope the following explanation of our office policy regarding insurance and payment for services is helpful.

1) Professional services are rendered and billed directly to your insurance carrier; however you, the patient/guardian, are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you (the patient or subscriber) and your insurance carrier. If for any reason the insurance carrier denies charges, payment for any services rendered will become the responsibility of the patient/guardian.

2) We expect and appreciate payment for office visits at the time of service. We will accept cash, check, MasterCard, Visa or debit card.

3) For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) **it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment**. If the insurance carrier denies any charges due to lack of referral authorization, you (the patient or guardian) are responsible for all charges incurred.

* * *

4) **If any type of supplies are dispensed during the course of treatment, (e.g. arch supports, accommodative pads, creams, surgical shoes, etc) are non-refundable and payment is due at the time of service. We cannot bill you or the insurance company for these supplies.**

5) I have read, understand and agree to the above office policies and understand that I am financially responsible for any balance due on my account.

6) I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

✗_____ _____

Print (Parent, if patient is a minor) *Date*

✗_____

Signature

(OVER PLEASE) 80628

Medical Information

Have you ever had, or been treated for, any of the following?

MAJOR DISEASE
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Angina
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Arrhythmia
- ❑ Heart Murmur
- ❑ Mitral Valve Prolapse
- ❑ Stroke
- ❑ High Cholesterol

HEENT
- ❑ Headaches
- ❑ Glaucoma
- ❑ Hearing Problems

RESPIRATORY
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Emphysema

ARTHRITIS
- ❑ Osteoarthritis
- ❑ Rheumatoid
- ❑ Gout

VASCULAR
- ❑ Anemia
- ❑ Prolonged Bleeding
- ❑ Pacemaker
- ❑ Poor Circulation
- ❑ Leg Pain When Walking
- ❑ Varicose Veins
- ❑ Blood Clots

PSYCHOLOGICAL
- ❑ Anxiety
- ❑ Depression
- ❑ Psychiatric Care
- ❑ Drug Dependence
- ❑ Alcohol Dependence

GASTROINTESTINAL
- ❑ Ulcers
- ❑ Acid Reflux (GERD)
- ❑ Stomach Problems
- ❑ Hiatal Hernia
- ❑ GI or Rectal Bleeding
- ❑ Bowel Disorders

MISCELLANEOUS
- ❑ Epilepsy/Seizures
- ❑ Thyroid Disease
- ❑ Muscle Disease/Polio
- ❑ Kidney Problems
- ❑ Bladder Problems
- ❑ Prostate Problems
- ❑ HIV
- ❑ Hepatitis/Liver Disease
- ❑ Cancer (type:_____)
- ❑ Memory Problems

FAMILY HISTORY
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Cancer
- ❑ Keloid Scars
- ❑ RSD
- ❑ Sickle Cell Disease
- ❑ Rheumatoid Arthritis
- ❑ Psoriatic Arthritis
- ❑ Gout
- ❑ Raynaud's Disease
- ❑ Blood Clot (DVT/PE)
- ❑ Circulation Problems (amputations/vein issues)

OTHER MEDICAL PROBLEMS:

_____

_____

_____

Primary Doctor: _____ Last visit: _____

Address: _____

Previous Podiatrist: _____ Last visit: _____

Pharmacy Name: _____ Address: _____ Telephone: _____

What is your foot/ankle problem? _____

How long has it been present? _____ weeks _____ months _____ years

What surgeries or operations have you had? _____

_____

What prescription medications are you now taking? _____

_____

Are you allergic to any of the following?

❑ Latex ❑ Novocaine ❑ Iodine ❑ Penicillin ❑ Codeine ❑ Aspirin ❑ Adhesive Tape ❑ Tetanus

Do you have any other allergies/ sensitivities? ❑ Yes ❑ No If yes, what? _____

Do you smoke? ❑ Yes ❑ No If yes, how many packs per day?_____

Do you drink alcohol? ❑ Yes ❑ No If yes..... ❑ Socially ❑ Daily

(WOMEN) Are you pregnant? ❑ Yes ❑ No

I hereby give my permission to the Doctors at New England Foot and Ankle to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition, and authorize, to the extent necessary, disclosure of medical information to assist in processing my insurance claim and to communicate with the treating physicians. Furthermore, I assign all payment of medical benefits provided by my insurance company policy for medical/surgical care to New England Foot & Ankle, P.C.

Signature:_____ Date:_____

(Patient or the person authorized to consent for the patient)

Relationship to patient _____

HOW DID YOU LEARN ABOUT US?

Please check all statements that apply:

☐ 1. My friend _____ told me about your office.

☐ 2. Doctor _____ referred me.

☐ 3. _____ Hospital referred me

☐ 4. I saw Dr. _____ at a lecture / foot screening.

☐ 5. Other _____

MESSAGES LEFT AT YOUR HOME/ANSWERING MACHINE

Due to the recent implementation of the Patient Privacy Act (HIPAA), it is necessary to obtain authorization for our office to leave messages at your home, mobile or answering machines regarding the following:

- Confirm or Change Appointment
- Results of testing ordered by the physician
- And/or any pertinent information that may be relative to your care
- Share information with: PCP _____

  Family Member _____

  Other _____

☐ I AUTHORIZE

☐ I DO NOT AUTHORIZE

✘ _____ _____

Signature (Parent, if patient is a minor) *Date*