GREATER BOSTON FOOT CARE

Greater Boston Foot Care, PLLC
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NEW PATIENT FORM

Patient Information

Name (First, Middle, Last) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Date of Birth	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address (*Including Apt, Unit or Suite Number*)			Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Engaged	
City, State, ZIP				
Preferred Phone Number ☐ Cell ☐ Home ☐ Work		Alternative Phone Number ☐ Cell ☐ Home ☐ Work		
How would you like to be reminded about appointments? (chose up to 3) ☐ Phone call ☐ Text ☐ Email		Okay to leave message at primary phone number? ☐ Yes ☐ No		
Email Address (Required for online portal access)				
Employer				

Emergency Contact Information

Name (First, Middle, Last)	Phone Number	Relationship to Patient

Guarantor/ Responsible Party Information (person responsible for payment) (Skip if Self)

Name (First, Middle, Last)	Date of Birth
Email Address	Phone Number

Preferred Pharmacy

Pharmacy Name	
Pharmacy Location (Address)	City, State

Medical Insurance (Primary)

Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent

PRIMARY Insurance Company Name		Policy Number/ Member ID
Name of Insured (if other than self)	Insured Date of Birth	Insured Social Security Number
Name of Insured Employer	Insured Work Phone Number	

Medical Insurance (Secondary)

Patient is: ☐ Subscriber ☐ Spouse ☐ Dependent

SECONDARY Insurance Company Name		Policy Number/ Member ID
Name of Insured (if other than self)	Insured Date of Birth	Insured Social Security Number
Name of Insured Employer	Insured Work Phone Number	

Primary Care Doctor (PCP) ☐ I do not have a PCP

Name of Provider

Date Last Seen	☐ MD ☐ DO ☐ Other (Specify) _____

Other Doctors and Specialties

Demographics ☐ Decline

Preferred Language

☐ English ☐ Other: _____

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black/ African American ☐ European ☐ Native Hawaiian/ Pacific Islander ☐ Hispanic/ Latino

☐ Other: _____

How did you hear about our office?

☐ Relative ☐ Friend ☐ Google ☐ Bing ☐ Facebook ☐ Yelp ☐ Insurance Company ☐ Mail ☐ Physician Referral

☐ Other (Specify): _____

Lower Extremity Medical History

What is(are) the chief compliant(s) that bring you to the office for medical treatment?

_____

_____

_____

_____

_____

Symptoms of Current Problem?

Which side?

☐ Right ☐ Left

Type of Pain

☐ Dull ☐ Achy ☐ Throbbing ☐ Burning ☐ Sharp ☐ Shooting

Severity of pain?

☐ Mild

☐ Moderate

☐ Severe

Area of pain?

☐ Bottom of Heel ☐ Back of Heel ☐ Arch ☐ Ball of Foot ☐ Big Toe ☐ Top of Foot ☐ Ankle ☐ No pain

☐ Other (specify): _____

Onset?

☐ Slow ☐ Sudden ☐ Traumatic

Has pain changed?

☐ Better ☐ Worse ☐ Same

How long has it been a problem?

☐ Days ☐ Weeks ☐ Months ☐ Years

What aggravates the pain?

☐ Standing ☐ Sitting ☐ Walking ☐ Running ☐ Certain Shoes ☐ Other (specify): _____

What treatment modalities have you tried for the discomfort/pain?

☐ Changing shoes ☐ Anti-inflammatory medications ☐ Decreasing activities ☐ Icing ☐ Heating ☐ Stretching ☐ Injections ☐ Antibiotics

☐ Pre-fabricated Arch Supports ☐ Custom Orthotics ☐ Padding ☐ Massage ☐ Acupuncture ☐ Soaking ☐ Surgery

☐ Other: _____

Other comments:

Past Medical History, Social History and Family History

General

Weight: _____

Height: _____

Shoe Size: _____

Allergies

☐ No known allergies

☐ Adhesive/ Tape
☐ Aspirin
☐ Codeine
☐ Iodine
☐ Local Anesthetics
☐ Penicillin
☐ Seafood
☐ Sulfa
☐ Other (Specify below):

_____

Medications

☐ None

List all medications and doses you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

General Medical History

Personal

☐ Anemia
☐ Anticoagulant history
☐ Arthritis
Type:_____
☐ Asthma
☐ Atrial fibrillation
☐ Back problem(s)
☐ Benign prostatic hyperplasia
☐ Blood clot(s)
☐ CHF
☐ COPD
☐ Cancer
☐ Dementia
☐ Depression
☐ Diabetes Mellitus Type 1
☐ Diabetes Mellitus Type 2
☐ Dialysis
☐ Epilepsy
☐ Fibromyalgia
☐ Gout
☐ HIV
☐ Heart attack
☐ Heart disease
☐ Hemophilia
☐ Hepatitis
☐ High cholesterol
☐ Hypertension
☐ Kidney disease
☐ Liver disease
☐ Neuropathy
☐ Peripheral vascular disease
☐ Psoriasis
☐ Stroke
☐ Thyroid disease
☐ Ulcer (GI)
☐ Ulcer of skin

Surgeries, Injuries, and other Illnesses

List surgeries, serious injuries, and other illnesses not on the previous list:

Family History

Social History

Your Occupation

Do you currently smoke?

☐ Yes ☐ No Please specify amount if yes:_____

Years smoked:_____

Are you a past smoker?

☐ Yes ☐ No Please specify amount if yes:_____

Years smoked:_____

Do you drink alcohol?

☐ Yes ☐ No Please specify amount if yes:_____

Recreational drug use?

☐ Yes ☐ No Please specify if yes:_____

Pregnant or possibly pregnant?

☐ Yes ☐ No

How often do you exercise?

Review of Symptoms

Constitutional

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight Loss/ Gain
- ☐ Fatigue/ lethargy
- ☐ Weakness

Gastrointestinal

- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Heartburn

Neurological

- ☐ Tremors
- ☐ Burning
- ☐ Strokes
- ☐ Unsteady gait
- ☐ Numbness/tingling

Head

- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches

Musculoskeletal

- ☐ Back problems
- ☐ Joint pain
- ☐ Lower back pain
- ☐ Joint stiffness
- ☐ Muscle cramps
- ☐ Other: _____

Endocrine

- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Other: _____

Ears, Nose/ Throat

- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Ringing
- ☐ Sore Throat

Hematologic

- ☐ Anemia
- ☐ Easy bruisablity
- ☐ Bleeding easily
- ☐ Blood Clots

Respiratory

- ☐ Cough
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other: _____

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss

Eye(s)

- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other: _____

Cardiovascular

- ☐ Chest pain
- ☐ High Blood Pressure
- ☐ Heart Murmur(s)
- ☐ Varicose Veins
- ☐ Other: _____

Skin

- ☐ Itching
- ☐ Keloid scarring
- ☐ Rash
- ☐ Eczema
- ☐ Suspicious lesions

Notice of Privacy Practices

This note describes how medical information about you can be used and how you can get access to this information. Please read carefully.

Your medical record is protected under HIPAA federal law, which imposes limitations on who and under what circumstances your medical information can be disclosed. We don't share your private medical information with anyone, including your spouse, parents, or employer, unless you request it or unless required by law.

The law permits us to share your medical information with your insurance company to verify eligibility and ensure that payment is appropriate for the visit. They may also review your record to ensure that we meet quality standards. Additionally, we share information with other providers treating you or who referred you to us for consultation or treatment. We also provide information about your care and diagnosis when we request tests at the hospital or labs, such as x-rays or MRIs. These other providers are also obligated to protect the confidentiality of your health information under HIPAA.

We may contact you by mail or leave a general message on your phone, and we can also send you information about your care and diagnosis via our HIPAA-compliant text messaging system. However, we will not disclose your test results or other private information to a family member without your explicit consent.

We are not affiliated with any drug companies or other marketing services and will not release your health information for marketing purposes. In the event of an adverse drug reaction, as required by law, we may disclose information to the FDA. Additionally, we may disclose information to the Department of Public Health in the case of certain communicable diseases.

You have the right to review your medical records or obtain a copy of them upon request. There may be a fee associated with this service. HIPAA also allows you to make additions or corrections to your medical records. If you have any questions or concerns about our policy of protecting your private medical record, please don't hesitate to contact our office manager.

Permission to Treat

I hereby grant permission to the providers and/or medical assistants affiliated with Greater Boston Foot Care, PLLC, to examine and/or administer treatment as necessary in the diagnosis and treatment of my foot and ankle concerns. This authorization includes in-person visits and telehealth consultations. I acknowledge that no guarantees have been made to me as to the outcome of any care or treatment provided. I also understand that I have the right to discuss the risks, benefits, and alternatives of any proposed treatment with my healthcare provider. I certify that I and/or my dependents have insurance coverage or will pay privately, and I assign all insurance benefits, if any, payable to Greater Boston Foot Care, PLLC, to the services rendered. I acknowledge that I am financially responsible for all charges, regardless of whether they are covered by insurance. Failure to pay may result in the suspension of my ability to schedule a follow-up appointment until a resolution is reached in accordance with our financial policy. Should you have any further inquiries, please request a copy of our financial policy. Occasionally, we capture images of your feet and/or ankles for the purpose of charting. These images will not be shared with any third party without your explicit written consent.

Disclaimer Regarding the Use of Artificial Intelligence in Medical Charting

At Greater Boston Foot Care PLLC, we may use artificial intelligence (AI) technology to assist in preparing and documenting medical charts, streamlining administrative tasks so providers can focus on your care. If you choose to opt out, all documentation will be completed manually, without affecting the quality of care you receive. Rest assured, your privacy and the security of your health information are our highest priorities, and our AI tools comply with all relevant privacy laws, including HIPAA. If you have any questions or concerns, please speak with your provider or contact our office. Thank you for trusting us with your care.

By signing below, I acknowledge my understanding, acceptance and responsibility of all the policies and/or notices contained on this page.

Patient Name: _____

Signature (Self or Guardian): _____ Date: _____

Financial Policy

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. It is the patient's responsibility to inform our office of any changes to their insurance coverage. If for any reason the insurance carrier denies charges, payments for any services rendered will become the responsibility of the patient/guardian.

COPAYMENT: It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the doctor.

DEDUCTIBLE AND CO-INSURANCE: I understand and agree that as the patient, I am responsible for any deductible and co-insurance amounts required by my health insurance plan. I acknowledge that the healthcare provider does not have access to or control over the specifics of my insurance deductible and cannot provide the exact amount owed. It is my responsibility to verify and understand the terms of my insurance policy, including my deductible and co-insurance requirements, prior to receiving services. I agree to fulfill any financial obligations related to my deductible as determined by my insurance provider.

REFERRAL: It is the patient's (or guardian's) responsibility to confirm that all necessary referrals are received by our office prior to the appointment. If your insurance plan requires a referral from your primary care doctor, it is your responsibility to contact your PCP office for the referral. It is also your responsibility to confirm that this has been received by our office prior to your appointment. Without a referral, we will need to reschedule your appointment. We do provide the option of paying a $200 deposit to keep your appointment. The $200 deposit will be refunded upon receipt of the referral within 2 business days. If the referral is not received within 2 business days, the $200 deposit is non-refundable and will be applied towards your bill. Please note, patient is responsible for any additional costs incurred from treatment and services rendered.

SELF-PAY: Self-pay is available to patients that do not have insurance coverage. It is also available to patients who require services that are not covered by insurance. A down-payment will be required before seeing the doctor. At a minimum, an evaluation and management fee will be charged. Additional procedures/services may be recommended by the doctor. You will be informed of these charges before proceeding with treatment. Full payment is due at time of service.

PRODUCTS: Unfortunately, insurance does not cover products purchased in the office. Full payment is due at time of service. On rare occasion, custom orthotics are covered by insurance however prior authorization is required.

NO-SHOW POLICY: Failure to attend an appointment without prior contact with the office will result in a $50.00 fee for established patients and $100.00 fee for new patients. Extenuating circumstances may be considered on a case-by-case basis for patients who demonstrate a genuine inability to attend their missed appointment.

LATE CANCELLATION POLICY: It is imperative that patients notify the office for rescheduling or cancelling scheduled appointments via phone, text message, or email **at least 24 hours prior to their scheduled appointment**. If unable to speak to someone on the phone, please leave a voicemail. Failure to provide at least 24 hour notice, **will** result in **a** $50.00 **fee** for established patients and a $100.00 **fee** for new patients. Extenuating circumstances may be considered on a case-by-case basis for patients who demonstrate a genuine inability to notify our office within 24 hours.

LATE ARRIVAL POLICY: To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is important for each patient to be on time. If you arrive more than 10 minutes late for your appointment, you may need to be rescheduled.

By signing below, I acknowledge my understanding, acceptance and responsibility of all the policies and/or notices contained on this page.

Patient Name: _____

Signature (Self or Guardian): _____ Date: _____