GREATER BOSTON FOOT CARE

Greater Boston Foot Care, PLLC
45 Resnik Road, Suite 107
Plymouth, MA 02360
Phone: 508-747-3567 | Fax:508-830-1224
www.greaterbostonfootcare.com

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. There are limitations upon to whom and under what circumstances your medical information can be disclosed. **We do not share your private medical information with anyone including your spouse, parent, or employer unless you request it or unless required by law.**

The law allows us to share your medical information with your insurance company to verify eligibility and that payment is appropriated for the visit. They may also review your record to ensure that we meet quality standards. We share information with other providers who are 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, including x-rays or MRIs. These other providers are also required to protect the confidentiality of your health information under HIPAA.

We may consult you by mail or leave a general message by phone, but we will not give your test results or other private information to a family member without your permission.

We are not affiliated with any drug companies or other marketing services and will not release your health information to anyone for the purpose of marketing services to you. We may, however, give you a reminder by phone of an upcoming appointment. We may disclose information to the FDA in the event of an adverse drug reaction, as required by law, to the Department of Public Health in the event of certain communicable diseases.

You may review your medical records or obtain a copy of them upon request. There is a charge for copying depending on the number of pages involved. HIPAA also allows you to make additions or corrections to your medical records. If you have questions about our policy of protecting your private medical record, you may discuss them with our office manager.

Cancellation Policy

I understand the office requires 24 hours' notice for appointment cancellations. If 24 hours' notice is not provided, I understand I may be charged a No-Show/Cancellation Fee.

Permission to Treat

I hereby give permission to Greater Boston Foot Care PLLC to examine and/or administer treatment as necessary in the diagnosis & treatment of my foot and ankle problem(s), **including but not limited to in person visits as well as telehealth visits**. I certify that I and/or my dependents have insurance coverage or will pay privately & assign directly to Greater Boston Foot Care PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by my insurance.

☐ I Accept ☐ I decline Notice of Privacy Practices

☐ I Accept ☐ I decline Cancellation Policy

☐ I Accept ☐ I decline Permission to Treat

☐ I give ☐ I decline Consent to Request Medication History from Pharmacy

Signature: ______________________________ Date: ____________________

Relationship to patient: ______________________