

PATIENT INFORMATION

Patient name _____ Today's date _____
Social security # _____ - _____ - _____ Date of birth _____ Age _____
Home address _____ City _____ State _____ Zip _____
School address _____ City _____ State _____ Zip _____
Home phone (_____) _____ - _____ Work phone (_____) _____ - _____ Male _____ Female _____
Cell phone/pager (_____) _____ - _____ Email address _____
Employer _____ Occupation _____
Employer's address _____ City _____ State _____ Zip _____
Primary care physician (First and Last name) _____
Whom may we thank for referring you to our office _____
Pharmacy _____ Address _____ Phone (_____) _____ - _____

INSURANCE INFORMATION

Primary insurance _____ Policy # _____
Name of policy holder _____ Relationship to patient _____
Policy holder's date of birth _____ Holder's address _____
Policy holder's employer _____

Secondary insurance _____ Policy # _____
Name of policy holder _____ Relationship to patient _____
Policy holder's date of birth _____ Holder's address _____
Policy holder's employer _____

Is this a Worker's Compensation injury? Yes _____ No _____ Date of the injury: _____
Did the injury occur at work? Yes _____ No _____ Place of injury _____
Contact person _____ Claim # _____
Name and address to be billed _____

Describe your foot problem _____

Was this problem previously treated? YES / NO If yes, by whom? _____

I authorize the release of any medical or other information to any healthcare professional, or if necessary to process my medical billing claims. I also authorize payment of medical benefits to the above named physicians for services rendered to me by them.

Signature of Patient

Date

Signature of Guardian

Date

FOOT & ANKLE Institute
OF NEW ENGLAND

Robert E. Gallucci, DPM, FACFAS
Stephen J. Rogers, DPM, FACFAS
Douglas A. Reid, DPM, FACFAS
Jonathan Sabourin, DPM

Health History: Do you have, or have you ever had any of the following health problems?

	YES	NO		YES	NO
Bleeding tendency.....	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/blood clots	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/gout.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble/ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems/murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Previous heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/tumor.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>

List any other current medical conditions you may have _____

Please list all current medications/vitamins and supplements that you are taking and their frequency.

Please list all medication allergies and your reaction. (example-penicillin/hives and itching)

Please list all hospitalizations and surgeries. _____

Please list any family history of chronic diseases/problems. (example-diabetes/father, ankle arthritis/uncle)

Social History:

Do you smoke? Yes No If yes, how many packs of cigarettes per day? _____ # of years? _____

Do you drink alcoholic beverages? No Rarely Social Daily Heavy

Do you exercise regularly? Yes No If yes, what activities do you enjoy? _____

Single _____ Married _____ Widow _____ Number of children _____ Height _____ Weight _____ Shoe Size _____

Review of Systems: Do you have or have you had . . .

	YES	NO		YES	NO
Weight change in the last year	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Serious problems with eyes/ears	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands/unusual lumps.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Racing heart/skipping beats	<input type="checkbox"/>	<input type="checkbox"/>	Frequent constipation/diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/tightness	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst.....	<input type="checkbox"/>	<input type="checkbox"/>
Ankle/leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol problems	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>
Frequent cough/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Back pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses/contacts.....	<input type="checkbox"/>	<input type="checkbox"/>	Fractured/broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV (AIDS) concerns	<input type="checkbox"/>	<input type="checkbox"/>

Please give this completed form to the receptionist. The doctor will be with you shortly. Thank You!
www.FootAnkle.info

**FOOT & ANKLE INSTITUTE OF NEW ENGLAND
KENT COUNTY SURGICAL CENTER
MEDICAL PRIVACY POLICY**

1. All patient information is confidential.
2. Every attempt will be made to respect confidentiality when communicating with patients.
3. Patients will be informed of this policy upon entering the practice yearly thereafter.
4. It is our policy to release patient information to other providers only with written patient consent.
5. Only patients themselves may call for test results unless they have authorized us to give information to family members.
6. Employees will review this policy initially and yearly thereafter.

TO PATIENTS:

At times the office may need to contact you regarding:

Test Results
Insurance Claims
To Confirm an Appointment

If we call and you are not available:

May we leave a message on an answering machine at home? Yes No

May we leave a message on an answering machine at work? Yes No

May we leave a message with a family member: Yes No

May we leave a message with a co-worker? Yes No

If yes, name of person _____

Please indicate the best telephone number for us to reach you _____

Patient Signature _____ Date _____

Please Print Name _____

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OUR POLICY REGARDING YOUR HEALTH INSURANCE

So that we may preserve the best possible relationship with our patients, we hope that the following explanation of our position on Health Insurance carriers will be helpful:

1. The proper relationship between patients, doctor, and insurance carrier is often misunderstood. We render to you our very best care, and charge you a fee for that service. Just as the insurance companies do not allow us to set their premium rates, we cannot allow them to set our fees or determine which procedures are best for you. These fees are mutually agreed upon between you and us, and the insurance carrier does not enter into this relationship.
2. Insurance policies vary in the amount that will be paid towards any charges. *Please be aware of your copayment responsibilities*, and that there may be balances due after your insurance has made its payment, which will be your responsibility. We will bill you for these balances, and expect prompt payment.
3. Our services are rendered to you, not the insurance company. You have final responsibility to see that all services are paid.
4. Our office will be happy to file your primary insurance claims for you. Please make sure that we have all of the proper information to do so. If a special form is required, please complete and sign it before providing it to us.
5. If you have more than one insurance, please be aware that we do not file to most secondary carriers. *We will file to your secondary insurance if we are in their network.* If you receive a bill from us for any balance, and you have a secondary carrier, this means that we do not file to that insurance company as a secondary payer, and it is your responsibility to do so.
6. It is your responsibility to call your insurance company with any questions you have regarding your coverage. If your plan requires you to obtain *referrals to specialists*, please comply with this requirement and see that we have all of the necessary documentation prior to your visit.

I understand and agree to the above statements. I also authorize payment of medical benefits to the above named physicians for services provided to me, or any member of my family, covered under my insurance plan.

I authorize the release of any medical or other information necessary to process my medical claims.

Signature _____

Date _____