PATIENT INFORMATION

Patient name _____ Today's date _____

Social security # ___-___-___ Date of birth ___/___/___ Age_____

Home address _____ Apt. # _____ 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

Stephen J. Rogers, DPM
Candace Criscione, DPM
Robert E. Gallucci, DPM

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

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

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	☐	☐	Difficulty swallowing	☐	☐
Serious problems with eyes/ears	☐	☐	Stomach/abdominal pains	☐	☐
Swollen glands/unusual lumps	☐	☐	Frequent nausea/vomiting	☐	☐
Racing heart/skipping beats	☐	☐	Frequent constipation/diarrhea	☐	☐
Chest pain/tightness	☐	☐	Frequent urination	☐	☐
Shortness of breath	☐	☐	Excessive thirst	☐	☐
Ankle/leg swelling	☐	☐	Frequent headaches	☐	☐
Fatigue/tiredness	☐	☐	Numbness/tingling	☐	☐
Cholesterol problems	☐	☐	Joint pain/swelling	☐	☐
Frequent cough/wheezing	☐	☐	Back pain	☐	☐
Wear glasses/contacts	☐	☐	Fractured/broken bones	☐	☐
Skin problems	☐	☐	HIV (AIDS) concerns	☐	☐

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

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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OF NEW ENGLAND

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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 _____