Needham Podiatry
145 Rosemary St, Suite B
Needham, MA 02494

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Podiatric Physician and Surgeon
Board Certified, American Board of Podiatric Surgery
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(781)444-1129
f (781)444-3666

Patient Name:_____ Today's Date: _____/_____/_____

SS#: _____-_____-_____ D.O.B: _____/_____/_____
Gender: □ Male □ Female Status: □Married □ Single □ Divorced □ Widowed

Address: _____ City:_____ State:_____ Zip:_____

Home:(_____) _____ - _____Cell:(_____) _____ - _____ Consent to: call □ text □

Email:_____@_____ . _____ Preferred method of contact: home □ cell □ email □

Primary Ins:_____ Secondary Ins:_____

Subscriber Name: _____ Date of Birth _____/_____/_____

Language: □ English □ German □ Spanish □ Other **Ethnicity:** □ Hispanic/Latino □ Non-Hispanic
Race: □ White □ Asian □ Black/African American □ American Indian/Alaskan Native
□ Native Hawaiian □ Pacific Islander □ More than one race □ Other

Primary Care Physician: _____ Phone:(_____)_____ - _____

Describe your foot problem/injury_____

How long have you had this problem? _____ yrs / mo. Injury date, if applicable: ____/____/_____

Medications currently taking: _____

Pharmacy: _____ **Address:**_____ **Lab:**_____

Allergies: _____ **Past Surgical History**: _____

Are you Diabetic? □ Yes □ No **How many years?** _____ **Do you take Insulin?** □ Yes □ No

Please indicate if you have the following:

□ AIDS/HIV
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Back Problems
□ Bleeding Disorders
□ Cancer
□ Ear Problems
□ Eye problems
□ Gout
□ Heart Disease/Hypertension
□ Hepatitis
□ Kidney Problems
□ Leg Ulcers
□ Liver Disease
□ Psychiatric Disorder
□ Respiratory Disease
□ Shortness of Breath
□ Stomach Ulcers
□ Stroke
□ Varicose Veins
□ Other:_____

Height:_____ **Weight:**_____

Do you Smoke?
□ Current Smoker □ Ex-Smoker □ Never Smoked

Do you drink Alcohol in excess?
□ Yes □ No

Do you use illegal drugs?
□ Yes □ No

Patient Name:_____ Date:_____/____/_____

Financial Disclaimer

 I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to **Needham Podiatry, PC** all benefits, if any, otherwise payable to me for services rendered.

 I understand that I am financially responsible for all charges whether or not covered or paid by my insurance.
 I hereby authorize Needham Podiatry, PC to release all information necessary to secure payments of benefits.
 I authorize the use of this signature on all insurance submissions.
 I understand that I will be responsible for any balance not paid by my insurance if I fail to provide current and accurate insurance and/or referral information on or before my visits to ensure my claims may be filed with in the 90 day filing limit imposed by my insurance.
 I am aware that my co-pay is due at time of visit and any coinsurance or deductible balance is my responsibility as part of my contract with my insurance carrier.
 HIPAA Privacy Notice received.

Signature:_____ Date: _____/_____/_____

Treatment Consent
I hereby consent and give permission for the doctors at Needham Podiatry, PC to administer and perform such treatment or procedure as the doctor deems necessary for treatment.

Signature:_____ Date: _____/_____/_____

Treatment Consent for Minors:
If the above named patient is under the legal age, please print and sign name of parent or legal representative who is authorizing treatment of minor child.

Name (please print): _____

Signature:_____ Date: _____/_____/_____