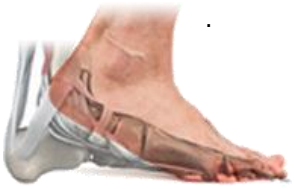

Steven I. Berman, DPM
52 Crest Ave
Winthrop, MA 02152
617-567-6666
Fax: 617-567-6668

NAME: _____
Last **First** **Middle**

ADDRESS: _____
Street apt# City State Zip

HOME PHONE (____)_____ WORK PHONE (____)_____ CELL # (____) _____

AGE:_____ **DATE OF BIRTH:** ___/___/_____ **SOCIAL SECURITY#:** _____ **SEX: M / F**

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ EMPLOYER PHONE _____

MARITAL STATUS (CIRCLE) S M W D EMAIL: _____

RACE: _____ **ETHNICITY**: _____ **LANGUAGE PREFERRED**: _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME NUMBER _____ WORK NUMBER _____

****PRIMARY CARE PHYSICIAN** _____ PHONE# (____) _____

PHYSICIAN'S HOSPITAL AFFILIATION _____ **DATE OF LAST VISIT ____/____/_____

WHO REFERRED YOU TO OUR OFFICE_____

WHAT IS YOUR FOOT PROBLEM _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HAVE YOU BEEN TREATED FOR IT? YES____ NO ____ BY WHOM? _____

_____ _____
PATIENT/GUARDIAN SIGNATURE **DATE**

MEDICAL INFORMATION

Have you ever had any of the following?

□ High Blood Pressure	□ Arthritis	□ Leg Cramps	**Do you have Diabetes?**
□ Heart Disease	□ Gout	□ Varicose Veins	**___Y ___N**
□ Poor Circulation	□ Visual Problems	□ Blood Clots	
□ Stomach Ulcers	□ Anemia	□ Stroke	
□ Kidney Disease	□ Skin Problems	□ Cancer	**If yes, do you take insulin?**
□ Toenail Problems	□ Asthma	□ Seizures	**___Y ___N**
□ Joint Replacement	□ Night Sweats	□ Cold Feet	
□ Ankle/Foot Swelling	□ Foot Tingling	□ Lung Disease	

HEIGHT _____ **WEIGHT** _____ **SHOE SIZE** _____

Previous Hospitalizations / Surgeries / Serious Illness (and When?) _____

_____

_____

What Medications & Vitamins are you taking now and what doses? _____

_____

_____

(Women) Are you Pregnant? Yes____ No ____ Are you taking Birth Control Pills? Yes___ No__

Are you under the care of a physician? Yes ____ No ____

If yes for what reason (s)? _____

SOCIAL HISTORY

Do you live alone? ___ Yes ___ No **For how long?** _____

Do you have any children? ___ Yes ___ No **If yes, how many?** _____

Do you exercise? ___ Yes ___ No **If yes, how often?** _____

Are you on a special diet? ___ Yes ___No **If yes, what kind?** _____

Do you Smoke? ___ Yes ___ No **If yes, how many packs per day? #____for #____years.**

If not, when did you quit? How many packs had you smoked? #_____ per day for # _____ years.

Do you drink alcohol? ___ Yes ___ No **How much _____ Daily ____ Weekly ____ Monthly _____**

Do you have history of substance abuse? ___ Yes ___ No **If yes, what substance (s)?** _____

FAMILY HISTORY

Has anyone in you family ever been diagnosed with the following? Name the relationship next to the condition in the space provided.

☐ **Heart Disease**_____	☐ **Hypertension** _____	**Mother: Deceased Y___ / N___**
☐ **Circulatory Disease** _____	☐ **Skin Disease**_____	**Father: Deceased Y___ / N___**
☐ **Neurological Problems** _____	☐ **Diabetes**_____	**How many**
☐ **Cancer** _____	☐ **Arthritis**_____	**Brothers _____ / Sisters _____**

Additional space, if necessary _____

_____

ALLERGIES

Do you have a history of skin reaction or other adverse reaction to:

☐ **Antibiotics**	☐ **Over the counter pain relievers:**	☐ **Anti-inflammatory**	☐ **Tape**
☐ **Penicillin**		**Pain Medication**	☐ **Tetanus**
☐ **Sulfa Drugs**	☐ **Motrin**	☐ **Naprosyn**	☐ **Latex**
☐ **Codeine**	☐ **Aleve**	☐ **Vioxx**	☐ **Other**
☐ **Silver**	☐ **Tylenol**	☐ **Voltaren**	
	☐ **Advil**		

Other medicine allergies: _____

Any Problems with local Anesthetics (Novocaine, Lidocaine, etc.)? _____

_____

PHARMACY USED: _____ **LOCATION:** _____

PHONE: _____ **FAX:** _____

NOTES: _____

_____

To the best of my knowledge, the above information submitted is correct. I understand that giving incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I, hereby, give my permission to Dr. Berman to diagnose and administer treatment of my foot condition.

Signature: _____ Date: _____ Review by: _____

PAYMENT AGREEMENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by East Boston Foot Center and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs. _____ (Initials)

MEDICARE ASSIGNMENT OF BENEFITS: I authorize and assign payment of medical benefits to Steven I. Berman, D.P.M. for the services provided to me. I authorize Dr. Steven I. Berman to release any medical or other information necessary to process claims submitted on my behalf. _____ (initials)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of East Boston Foot Center. I authorize East Boston Foot Center to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that East Boston Foot Center may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or is designated agent. _____ (Initials)

ASSIGMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE:
I authorize payment to be made directly to East Boston Foot Center for insurance benefits payable to me. I understand that I am financially responsible to East Boston Foot Center, for any covered and non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue amount is referred to a collection agency, I will be responsible for the cost of collection including reasonable attorney fees. _____ (Initials)

PRIVACY POLICY: I acknowledge having received the ”East Boston Foot Center’s Notice of Privacy Policies”. My rights, including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the policy. I understand that I may revoke in writing my consent for release of my information, except to the extent that East Boston Foot Center has already made disclosures with my prior consent. _____ (Initials)

HMO POLICIES: I understand that is my responsibility to obtain referrals from my primary care physician. If I do not supply East Boston Foot Center with a referral for any appointment where one is required, I understand that I will be responsible for payment in full at the time of service. _____ (Initials)

RETURNED CHECKS: I understand that I will be charged $35 for any returned checks from the bank for “non-sufficient funds”. _____ (Initials)

MEDICAL RECORDS REQUEST: I understand there will be at minimum a $25 fee for request of medical records from any party other than my health insurance company and that this fee will be paid prior to the records being released. An additional fee of $10 will be charged for copies of x-rays in ether disc or photo format. You will not be charged for any literature handed out to you by the office or one of the doctors unless told so upfront. If just a small amount of documentation is requested, this can be given to you the patient at the doctor’s discretion without requiring payment. _____ (Initials)