



Steven I. Berman, DPM
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East Boston, MA 02128
617-567-6666
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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?

| | | | |
|--|--|--|---|
| <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Toenail Problems <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Ankle/Foot Swelling | <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Visual Problems <input type="checkbox"/> Anemia <input type="checkbox"/> Skin Problems <input type="checkbox"/> Asthma <input type="checkbox"/> Night Sweats <input type="checkbox"/> Foot Tingling | <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Blood Clots <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Seizures <input type="checkbox"/> Cold Feet <input type="checkbox"/> Lung Disease | Do you have Diabetes? ___ Y ___ N If yes, do you take insulin? ___ Y ___ N |
|--|--|--|---|

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.

| | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Hypertension _____ | Mother: Deceased Y___ / N___ |
| <input type="checkbox"/> Circulatory Disease _____ | <input type="checkbox"/> Skin Disease _____ | Father: Deceased Y___ / N___ |
| <input type="checkbox"/> Neurological Problems _____ | <input type="checkbox"/> Diabetes _____ | How many |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | Brothers _____ / Sisters _____ |

Additional space, if necessary _____

ALLERGIES

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

| | | | |
|--------------------------------------|---|--|----------------------------------|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Over the counter pain relievers: | <input type="checkbox"/> Anti-inflammatory Pain Medication | <input type="checkbox"/> Tape |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Motrin | <input type="checkbox"/> Naprosyn | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Aleve | <input type="checkbox"/> Vioxx | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Voltaren | <input type="checkbox"/> Other |
| <input type="checkbox"/> Silver | <input type="checkbox"/> 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)

ASSIGNMENT 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 it 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 \$30 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 either 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)