Norwood Podiatry Associates
24 Walpole Street
First Floor
Norwood, Massachusetts 02062
Phone 781-762-4205
Fax 781-255-7905

To Our New Patient:

Welcome to Norwood Podiatry Associates!

Our policy requires that you complete and sign the New Patient Forms included with this letter. These include our Patient Registration, Comprehensive Health Review (include all current medications and dosages), and Consent to Treat.

If these forms are not completed when you arrive for your appointment we reserve the right to reschedule. Cancellations for appointments must be received at least 24 hours prior to the scheduled appointment. Because new patient appointments are in high demand, failure to appear at your first appointment without notification will result in a $60 missed appointment fee.

To maximize your time with us, we ask that you bring the following to your first visit: medical insurance card(s), referral (if required by your insurance company), and prior medical records (you may request that your last physical and medication list be faxed to us at 781-255-7905).

We are located at 24 Walpole Street in Norwood.

If you are being seen for evaluation of fungal nails or other nail problems, please do not trim or cut your toenails prior to your visit. Also, please remove any toenail polish before your visit.

We look forward to your appointment with us!

Sincerely,

Norwood Podiatry

Patient Registration

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Nickname (Name I preferred to be called)	Birth Date (mm/dd/yyyy)	Sex ❑ M ❑ F	Spouse's Name	
Street Address			Home Phone # ( )	
City	State	Zip Code	E-Mail	Mobile Phone # ( )
Primary Language	Ethnicity			
Race	Occupation			
Employer	Employer Address		Employer/Work Phone # ( )	
Pharmacy Name	Pharmacy Address		Pharmacy Phone Number	
Primary Care Physician (PCP) Name	PCP Phone Number		Date PCP Last Seen	
Heart Doctor Name	Heart Doctor Phone Number			
Diabetes Doctor Name	Diabetes Doctor Phone Number			
Vascular Doctor Name	Vascular Doctor Phone Number			

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST)

Primary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Policy Type HMO PPO POS		
Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $
Secondary Insurance	Subscriber Name	Birth Date (mm/dd/yyyy)	Policy Type HMO PPO POS		
Insurance ID #	Group #	Policy #	Effective Date	Expiration Date	Co-Payment $

IN CASE OF EMERGENCY

Name of Nearest Friend or Relative	Relationship to Patient	Home Phone # ( )	Work or Mobile Phone # ( )

REFERRAL

How did you learn about us? (Please check all that apply) ❑ Dr. _____ ❑ Hospital/ER ❑ Lecture ❑ Insurance Plan

❑ Phonebook ❑ Internet ❑ Website ❑ Friend/Family: _____ ❑ Other: _____

The above information is true to the best of my knowledge. I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Norwood Podiatry Associates and Cape Ann Foot & Ankle all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature below on all insurance submissions. Norwood Podiatry Associates and Cape Ann Foot & Ankle may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Comprehensive Health Review

Patient Name: _____ Date of Birth: _____ Today's Date: _____

HISTORY OF PRESENT ILLNESS / WHAT BRINGS YOU IN?

What is your specific foot/ankle problem? _____

_____

_____

When did the problem begin? _____

The problem is: ❑ Improving ❑ Worsening ❑ Unchanged

What aggravates the problem? _____

Is the problem painful? ❑ Yes ❑ No If so, rate your current pain: (none) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Describe the pain: ❑ Sharp ❑ Dull ❑ Aching ❑ Throbbing ❑ Cramping ❑ Itching ❑ Popping

❑ Burning ❑ Tingling ❑ Clicking ❑ Shooting ❑ Stabbing ❑ Other: _____

Describe previous treatments: _____

Is this from an injury? ❑ Yes ❑ No If so, is it work-related? ❑ Yes ❑ No _____

Which foot/ankle is involved? ❑ Right ❑ Left ❑ Both

First visit to a doctor for this problem? ❑ Yes ❑ No

Have you had a similar problem in the past? ❑ Yes ❑ No

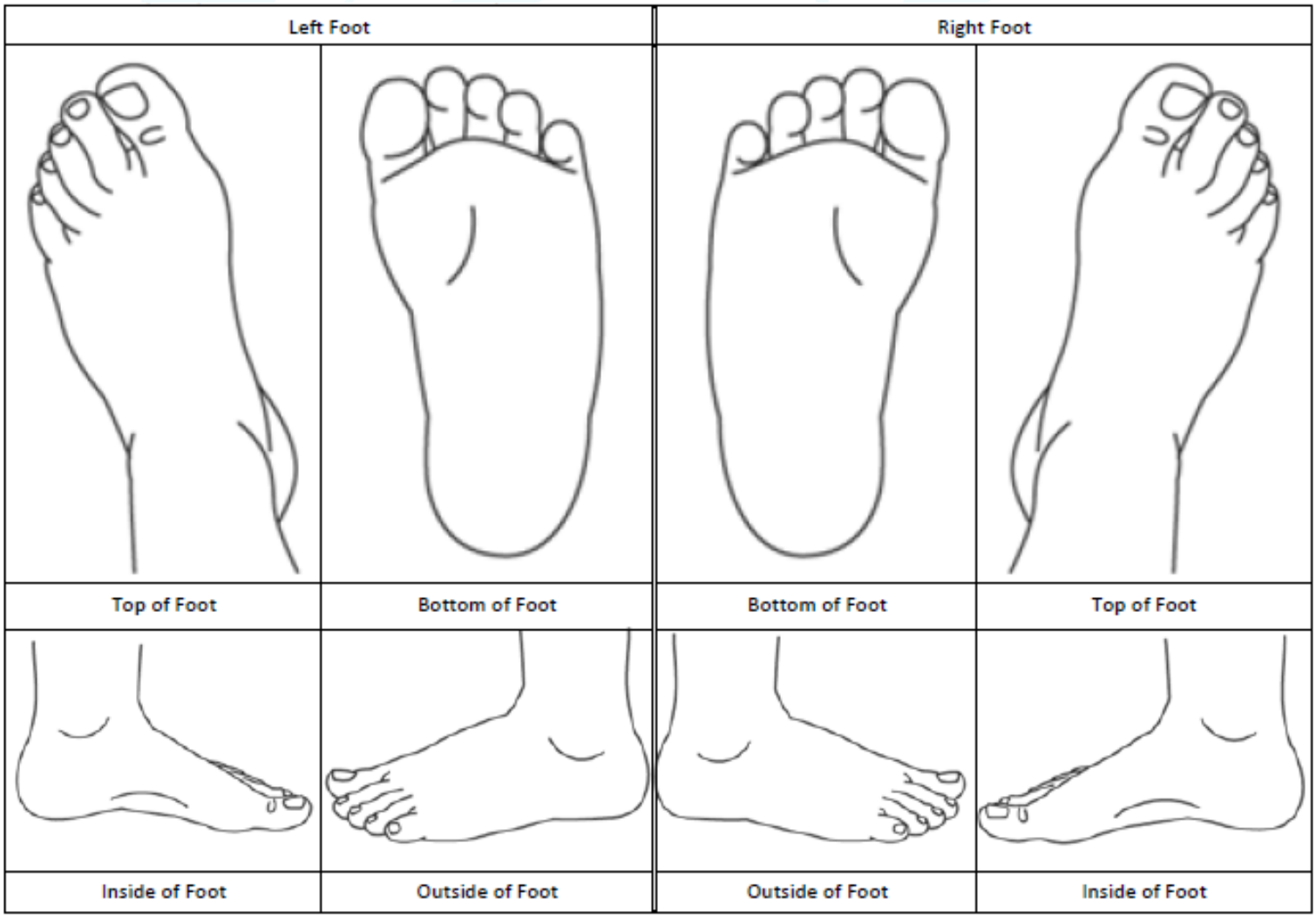
How was the problem onset? ❑ Sudden ❑ Gradual

The problem is worst: ❑ AM ❑ PM ❑ At Rest ❑ With Activity

What improves the problem? _____

Where Does It Hurt?

On the diagram below, please mark the place(s) where you are experiencing pain or problems with your feet:



Comprehensive Health Review

Patient Name: _____ Date of Birth: _____ Today's Date: _____

PAST MEDICAL HISTORY

- ❑ Diabetes Type 1 2 Duration ____ years Last Blood Sugar _____ HbA1c ____
- ❑ Acid Reflux
- ❑ Anemia
- ❑ Anesthesia Complications
- ❑ Arthritis (❑ Osteo / ❑ Rheum)
- ❑ Asthma
- ❑ Back Problems/Sciatica
- ❑ Blood Clot/DVT
- ❑ Cancer: _____
- ❑ Cellulitis/Skin Infection (❑ MRSA?)
- ❑ Circulation Problem
- ❑ Dementia/Alzheimer's
- ❑ Excessive/Easy Bleeding
- ❑ Fibromyalgia
- ❑ Foot/Leg Ulcer
- ❑ Gout
- ❑ Healing Problems/Keloids
- ❑ Heart Disease/Heart Attack
- ❑ High Blood Pressure (❑ Low BP?)
- ❑ High Cholesterol
- ❑ Hormone Therapy
- ❑ Immune Disorder/HIV
- ❑ Kidney Disease (❑ Dialysis)
- ❑ Liver Disease (❑ Hepatitis)
- ❑ Leg Cramps/Leg Pain at Rest
- ❑ Lung Condition: _____
- ❑ Mitral Valve Prolapse/Murmur
- ❑ Multiple Sclerosis
- ❑ Nervous Disorder/Depression
- ❑ Neuropathy
- ❑ Osteomyelitis/Bone Infection
- ❑ Parkinson's Disease
- ❑ Previous Addiction to: _____
- ❑ Pulmonary Embolism
- ❑ Rashes/Skin Condition
- ❑ Raynauds Disease/Phenomena
- ❑ Seizure Disorder/Epilepsy
- ❑ Sickle Cell Disease/Trait
- ❑ Sleep Apnea
- ❑ Stomach Ulcers
- ❑ Stroke ❑ Rt ❑ Lt (year _____)
- ❑ Thyroid Condition (❑ Hi ❑ Lo)
- ❑ Varicose Veins
- ❑ Women – Are You Pregnant or Breast Feeding?
- ❑ Other problems not listed: _____

PAST SURGERIES

- ❑ Foot/Ankle Surgery: _____
- ❑ Joint Replacement: _____
- ❑ Open Heart/Bypass Surgery: _____
- ❑ Hysterectomy ❑ Tubal ligation ❑ C-Section
- ❑ Stent Placement: Heart Leg
- ❑ Cosmetic Surgery: _____
- ❑ Appendix ❑ Gallbladder ❑ Tonsils/Add
- ❑ Leg Bypass ❑ Open Fracture Repair
- ❑ Carotid Surgery ❑ Vein Surgery
- ❑ Hernia repair ❑ Thyroid ❑ Back surgery

FAMILY HISTORY (circle relative)

Mother **F**ather **S**ister **B**rother **G**rand**P**arent

❑ Cancer	M F S B GP
❑ Diabetes	M F S B GP
❑ Gout	M F S B GP
❑ Heart Disease	M F S B GP
❑ High Blood Pressure	M F S B GP
❑ Severe Arthritis	M F S B GP
❑ Anesthesia Complications	M F S B GP
❑ Foot Problems	M F S B GP
❑ Other: _____	M F S B GP

Peripheral Vascular Health Screening

1. Do you experience aching, cramping, or pain in your arms, legs, thighs, or buttocks when you walk or exercise? Yes No

2. If you answered "yes" to question number 1, does the pain go away with rest? Yes No

3. Do you have numbness and tingling in your arm(s) or leg(s) or feet? Yes No

4. Are you fingers or toes pale, discolored, or bluish? Yes No

5. Are your hands or feet cold to the touch? Yes No

6. Do you have open sores or ulcers on your leg(s) or feet that won't heal? Yes No

7. Do you exercise on a regular basis? Yes No

8. Do you have a family history of diabetes or cardiovascular problems (immediate family: Parent, Sister, Brother)? Yes No

9. Have you had any previous surgeries and/or angioplasty on the arteries? Yes No

Comprehensive Health Review

Patient Name: _____ Date of Birth: _____ Today's Date: _____

MEDICATIONS (include RX meds, OTC meds, and vitamins)

Medication	*Dosage*	*Medication*	*Dosage*

ALLERGIES

- ❑ **None**
- ❑ Adhesives/Tape
- ❑ Aspirin
- ❑ Codeine
- ❑ Cortisone
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Penicillin
- ❑ Seafood/Shellfish
- ❑ Sulfa Drugs
- ❑ _____

SOCIAL HISTORY

Occupation: _____

❑ I Drink Alcoholic Beverages How much/often? _____

❑ I Use or Have Used Tobacco Products Type: _____

Packs/Day _____ Years _____ When Stopped? _____

❑ I Use or Have Used Drugs that are Illegal _____

I Live With: ❑ No One ❑ Spouse ❑ Children ❑ Parents ❑ Other

I Stand _____ % of My Day

I Exercise Each Week: ❑ 0 days ❑ 1-2 days ❑ 3+ days

List Sports/Activities: _____

❑ My foot/ankle problem limits my activities

I am: ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Widowed

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ❑ Recent Weight Changes
- ❑ Fever/Chills
- ❑ Nausea or Vomiting
- ❑ Fatigue

EYES
- ❑ Eye Disease/Injury
- ❑ Wear Glasses/Contacts
- ❑ Blurred or Double vision
- ❑ Glaucoma

EARS/NOSE/MOUTH/THROAT
- ❑ Hearing Loss
- ❑ Nose Bleeds
- ❑ Sore Throat/Voice Change
- ❑ Sinus Problems
- ❑ Difficulty Swallowing

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Arrhythmia/Irregular Heart Beat
- ❑ Leg Pain when Walking
- ❑ Swelling of Hands/Feet

MUSCULOSKELETAL
- ❑ Muscle Pain or Cramps
- ❑ Joint Pain
- ❑ Stiffness/Swelling Joints
- ❑ Low Back Pain
- ❑ Trouble Walking

GASTROINTESTINAL
- ❑ Indigestion/Heartburn
- ❑ Diarrhea
- ❑ Blood in Stools
- ❑ Stomach Pains

RESPIRATORY
- ❑ Shortness of Breath
- ❑ Chronic/Frequent Cough
- ❑ Wheezing

GENITOURINARY
- ❑ Frequent Urination
- ❑ Painful Urination
- ❑ Kidney Stones
- ❑ Blood in Urine

INTEGUMENTARY
- ❑ Rash or Itching
- ❑ Dry Skin
- ❑ Change in Hair/Nails

HEMATOLOGICAL
- ❑ Bruise Easily
- ❑ Slow to Heal

ENDOCRINE
- ❑ Hormonal Problem
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Too Hot/Too Cold

NEUROLOGICAL
- ❑ Migraines
- ❑ Frequent Headaches
- ❑ Numbness/Tingling
- ❑ Dizzy Spells
- ❑ Paralysis/Tremors

PSYCHIATRIC
- ❑ Anxiety
- ❑ Depression
- ❑ Nervousness
- ❑ Insomnia
- ❑ Confusion/Memory Loss

STATS

Age _____ Height _____ Weight _____ Shoe Size _____

I understand that completing this paperwork is a chore. The information I have provided is true to the best of my knowledge. I recognize that the information I have provided will help me receive better care. I thank you for taking such an interest in my health.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Fee Policy

I acknowledge that I was provided a copy of the Financial Policy and that I have read (or that I have had the opportunity to read if I do choose), understand and will comply with the policies as stated. You are ultimately responsible for payment of charges for services you receive from Norwood Podiatry Associates and Cape Ann Foot and Ankle.
You must inform the office of any changes in your insurance. Medicare will not pay for cutting of nails, corns or calluses. You are responsible for these charges at the time of service. If you have Diabetes, Peripheral Vascular Disease, or Neuropathy Medicare will pay for these services, however, only if certification of your diagnosis is obtained by your Primary Care Provider. Patient with Diabetes must see the doctor managing their diabetes at least every 6 months, for your visits to be covered, you must provide the date that you saw your doctor. HMO plans require referrals. It is your responsibility to obtain referrals prior to your appointment. If you arrive to a scheduled appointment without a referral, we will need to reschedule your appointment. Copayments are due at the time of service. If we must bill you for your copay, a $10 fee will be added to the charge for each bill sent. There is a $35 fee for returned checks, this is not covered by your insurance.

Initials: _____

Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read if I so choose) and understand the Notice.

Initials: _____

Privacy Policy Authorization

Due to implementation of HIPAA (the Patient Privacy Act), I hereby authorize Norwood Podiatry Associates and Cape Ann Foot & Ankle to leave messages at my home or mobile phone numbers which I have provided and leave messages with family members or answering machines regarding the following: 1. Confirm or change appointment, 2. Results of testing ordered by the physician, 3. Any pertinent information that may be relative to my care.

Initials: _____

Consent to View External Prescription History

I authorize Norwood Podiatry Associates and Cape Ann Foot & Ankle to view my external prescription history via electronic prescribing services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my provider and staff at Norwood Podiatry Associates and Cape Ann Foot & Ankle and it may include prescriptions back in time for several years.

Initials: _____

Consent to Treatment

I hereby voluntarily consent to outpatient care by Norwood Podiatry Associates and Cape Ann Foot & Ankle, encompassing routine care, diagnostic procedures, examination and medical treatment including but not limited to minor surgical procedures, routine lab work, x-rays, ultrasound, photographs, three dimensional digital scans, and administration of medication and injections prescribed by the podiatrist. I agree to ask questions to clarify treatment should I not understand the treatment plan.

Initials: _____

Insurance Assignment Release

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Norwood Podiatry Associates and Cape Ann Foot & Ankle and their podiatrists all insurance benefits, if any, otherwise payable to me for service(s) rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree that should my account become delinquent and is referred to an attorney or collection agency for collection, I will be charges an additional 33 1/3% of any unpaid balance at the time of referral for all costs of collections and attorneys fees. I authorize the use of my signature below on all insurance submissions.
Norwood Podiatry Associates and Cape Ann Foot & Ankle may use my health care information and may disclose such information to the disclosed insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Initials: _____

HIPAA Release

I authorize Norwood Podiatry Associates and Cape Ann Foot & Ankle to communicate with the following family member, relative, or friend as identified below:

Name: _____ Relation: _____ Phone: _____

I request the following restrictions to the use and disclosure of health information:

_____

X _____

PATIENT/GUARDIAN SIGNATURE DATE