CAMBRIDGE FOOT & ANKLE

Welcome to Our Office

Exceptional credentials. Complete Capabilities. State-of-the-art care.

Patient Information

Date | Last Name | First Name | MI | ☐ Male ☐ Female

Home Phone | Cell Phone | E-mail Address

Street | City | State | Zip Code

Social Security # | Driver's License # | Age | Date of Birth / / | Marital Status | # of Children | Children's Ages

Employer | Phone Number | Ext.

Street | City | State | Zip Code

Occupation | May we call you at work? ☐ Yes ☐ No | Work Hours

Emergency Contact | Relationship | Phone Number

Spouse/Domestic Partner Information (If appropriate)

Last Name | First Name | MI | ☐ Male ☐ Female | Age | Date of Birth / /

Home Phone | Cell Phone | Social Security # | Driver's License #

Street | City | State | Zip Code

Employer | Phone Number | Ext.

Street | City | State | Zip Code

Financially Responsible Party (If different from patient)

Last Name | First Name | MI | ☐ Male ☐ Female | Age | Date of Birth / /

Home Phone | Social Security # | Driver's License # | Marital Status | # of Children | Children's Ages

Street | City | State | Zip Code

Employer | Phone Number | Ext.

Street | City | State | Zip Code

Occupation | May we call you at work? ☐ Yes ☐ No | Work Hours

Insurance Information (Please bring insurance card to each appointment)

Primary Insurance | Phone Number | Group #

Street | City | State | Zip Code

Insured's Name | Insured's ID # | Copay $ (required at each visit)

Primary Insurance | Phone Number | Group #

Street | City | State | Zip Code

Insured's Name | Insured's ID # | Copay $ (required at each visit)

Who may we thank for referring you? First & Last Name | Phone Number

Please read and sign below: I directly assign all medical and surgical benefits to the doctor. I understand that I am financially responsible for all charges whether paid by my insurance provider or not. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that fees for service and insurance copays are payable at the time of service, unless other arrangements are made in advance. It is my responsibility to pay any deductible amount or co-insurance.

It is the policy of this office to bill your insurance for reimbursement. However, we shall allow no more than sixty (60) days for payment. After sixty (60) days you will be billed for any outstanding balance on your account. All outstanding balances are due thirty (30) days from the statement date.

I HEREBY GIVE AUTHORIZATION FOR TREATMENT. Signature | Date

Patient Foot/Ankle History

Describe your foot/ankle problem:

When did the problem begin? (date) | Describe any accident/event | Is this problem work related? ☐ Yes ☐ No

Please bring all imaging films to your first appointment.

		Date taken?
☐ Yes	☐ No Previous X-rays?	
☐ Yes	☐ No Previous MRI?	
☐ Yes	☐ No Previous CT?	
☐ Yes	☐ No Previous Labs?	

☐ Yes ☐ No Previous Surgery? Surgery type

Previous Physician | Phone Number

Do you have, or have you been treated for:

- ☐ Anemia
- ☐ Ankle injury
- ☐ Arch pain
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Blood disease
- ☐ Broken foot bone(s)
- ☐ Bunions
- ☐ Callouses
- ☐ Childhood foot problems
- ☐ Corns
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Flat feet
- ☐ Glaucoma
- ☐ Hammertoes
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heel pain
- ☐ Hepatitis
- ☐ High arch feet
- ☐ High blood pressure
- ☐ HIV
- ☐ Ingrown nails
- ☐ Intoeing
- ☐ Kidney trouble
- ☐ Knee pain
- ☐ Liver disease
- ☐ Lower back pain
- ☐ Motion sickness
- ☐ Neurological disorder
- ☐ Neuroma
- ☐ Phlebitis
- ☐ Psychiatric / Psychological care
- ☐ Rash
- ☐ Reflux / Heartburn
- ☐ Rheumatism
- ☐ Sleep apnea*
- ☐ Stroke
- ☐ Ulcers

If "yes" to any above, please explain:

Patient Medical History Overview

Height | Weight | Shoe Size | How much are your feet at work? ☐ 20% ☐ 40% ☐ 60% ☐ 80% ☐ 100%

List all allergies:

List all medications you are currently taking:

Are you taking any nutritional or dietary supplements? (e.g. Ginkgo biloba, Ginsing, Echinacea) ☐ Yes ☐ No List

Do you smoke? ☐ Yes ☐ No Pack/Day Years | Did you ever smoke? ☐ Yes ☐ No Pack/Day Years | When did you quit?

Do you use "recreational drugs"? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit | Do you drink alcoholic beverages? ☐ None ☐ Rarely ☐ Moderately ☐ Daily ☐ Quit

List

List any sports/activities you participate in:

- ☐ Yes ☐ No Do you use a CPAP machine? *
- ☐ Yes ☐ No Are you slow to heal after cuts?
- ☐ Yes ☐ No Any abnormal bruising or bleeding?
- ☐ Yes ☐ No Any pain in calves or buttocks when walking?
- ☐ Yes ☐ No Is the pain relieved by rest?
- ☐ Yes ☐ No Do your feet hurt at night?
- ☐ Yes ☐ No Have you had a serious Illness?
- ☐ Yes ☐ No Have you been hospitalized or under lengthy medical care?
- ☐ Yes ☐ No Do you have any implants?
- ☐ Yes ☐ No Cardiac (e.g. valve, pacemaker, graft, etc.)
- ☐ Yes ☐ No Cosmetic (e.g. breast, facial, etc.)
- ☐ Yes ☐ No Orthopedic (e.g. knee, hip, etc.)

If "yes" to any, please explain:

Patient Physicians

Did your Family Physician or other Specialist refer you? ☐ Yes ☐ No | Family Physician name: | Specialist Name: | Speicalty

Family Physician Name: | Date last seen | Phone Number | City | State | Zip

Specialist Name: | Date last seen | Phone Number | City | State | Zip

Did you come here for a: ☐ Consultation ☐ Surgical Evaluation ☐ Second Opinion on Surgery ☐ Independently for an Opinion

Family History

Has any blood relative had any of the following? (If "Yes" please indicate who)

- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Birth Abnormalities
- ☐ Yes ☐ No Cancer or Tumor
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Foot Problems
- ☐ Yes ☐ No Heart Trouble
- ☐ Yes ☐ No High Blood Pressure
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Tuberculosis

CAMBRIDGE
FOOT & ANKLE

Podiatric Medicine
Traumatic & Reconstructive Surgery of the Foot and Ankle

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PRIVACY POLICY CONSENT

PATIENT CHART #_____

DEAR PATIENT,

It is very important that we maintain privacy regarding your personal and medical information. WE DO NOT GIVE OUT ANY INFORMATION TO ANYONE OTHER THAN THOSE DESIGNATED BY YOU (OR IN THE CASE OF A MINOR, THE PARENT OR GUARDIAN).

During your treatment, we may have to release certain information to our business associates; such as hospitals, surgery centers, laboratories, DME suppliers, physical therapists, pharmacies, your primary care physician, medical specialists and/or your family, caretaker, significant other or employer via the telephone, mail or fax machine. We may have to telephone you and will need your permission to leave a message or test results on your answering machine. If you object to any of the above, please indicate below what your objections are:

I object to: _____

I do not object to any of the above policy: _____

Signature: _____

Patient/Parent/Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES: (Initials please)

I AGREE THAT I WAS PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICE_____

I AGREE THAT I REFUSED A COPY OF THE NOTICE OF PRIVACY PRACTICE_____