PATIENT INFORMATION

MR #

(PLEASE PRINT)

NAME _____ DATE _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____ SOCIAL SEC. NO. _____

DATE OF BIRTH _____ AGE _____ SEX M F MARITAL STATUS S M W D SEP.

REFERRED BY _____

PATIENT'S EMPLOYER _____ POSITION _____

BUSINESS ADDRESS _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ SPOUSE'S WORK PHONE _____

PERSON RESPONSIBLE FOR BILL

(IF OTHER THAN ABOVE)

NAME _____ RELATIONSHIP _____

ADDRESS (IF OTHER THAN ABOVE) _____ HOME PHONE _____

EMPLOYER _____ POSITION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

INSURANCE, MEDICARE, WORKER'S COMPENSATION or WELFARE INFORMATION

COMPANY OR PROGRAM _____ INSURED SS# _____ GROUP NUMBER _____ POLICY NUMBER _____

1 _____

2 _____

MEDICAL DOCTOR

MEDICAL DOCTOR _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE ( ) _____

AUTHORIZATIONS

BENEFITS TO PHYSICIAN:

☐ Yes ☐ No I hereby authorize payments directly to the physician of the surgical and/or medical benefits.

☐ Yes ☐ No I also understand I am responsible for any portion of my bill not covered by my insurance company.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Date _____ Signed _____

(Insured Person)

JOEL CHARITON, D.P.M.
DIPLOMATE AMERICAN BOARD OF PODIATRIC ORTHOPEDICS
989 NORTH MAIN STREET
RANDOLPH, MASSACHUSETTS 02368
Telephone (781) 986-3668
Fax (781) 986-7004

MEDICAL HISTORY — INITIAL VISIT

Patient:_____ DATE:_____

Describe your foot problems and/or symptoms:

1.) _____

How long have you had this problem? _____Days Weeks Months

2.) _____

How long have you had this problem? _____Days Weeks Months

3.) _____

How long have you had this problem? _____Days Weeks Months

Describe any past problems with your feet or ankles:_____

_____

_____

_____

List any past surgical procedures on your feet or ankles and approximate dates:

1.) _____ Date:_____

2.) _____ Date:_____

3.) _____ Date:_____

Shoe size:_____Special shoes?_____Current weight:_____Height_____

Do you use? (Y or N) Walker:_____Crutches:_____Cane:_____Wheel Chair:_____

Are you allergic or sensitive to:

Antibiotics: (Penicillin, Sulfa drugs etc.) If yes please list _____

_____

Anti-inflammatory medicines: (Naprosyn, Vioxx, Voltaren, etc.) _____

_____

Over the counter pain relievers: (Motrin, Aleve, Tylenol, Advil, etc.) _____

_____

Other medicine allergies: _____

Any problems with local anesthetics (Novacaine, Lidocaine, etc.)? Y N

Patient: _____ Date: _____

Do you have or have you had any of the following conditions? Y or N

_____High Blood Pressure	_____Arthritis	_____Leg cramps
_____Heart Disease	_____Gout	_____Varicose veins
_____Poor Circulation	_____Visual problems	_____Blood clots
_____Stomach ulcers	_____Anemia	_____Stroke
_____Kidney Disease	_____Skin Problems	_____Cancer
_____Toenail problems	_____Asthma	_____Seizures
_____Joint Replacement	_____Night Sweats	_____Cold Feet
_____Ankle/Foot Swelling	_____Foot Tingling	_____Lung Disease

Do you have Diabetes? Y N If yes, do you take insulin? Y N

When diagnosed_____ Treating physician: _____

Date of last treatment: _____

List any serious illness (last 10 years) _____

_____

_____

_____

List any major surgeries (last 10 years) _____

_____

_____

_____

Are you presently under a physician's care Y N If so, please list the condition being treated and the physician

Condition: _____ Physician:_____

Condition: _____ Physician:_____

Condition: _____ Physician:_____

Condition: _____ Physician:_____

Patient: _____ Date: _____

What medications do you take regularly? _____

_____

_____

Social History: Marital Status S M W D

Employment status FT PT Unemployed Retired

Do you smoke Y N If so, number of packs per day _____

Have you previously smoked Y N When did you quit _____

How many packs? _____ Do you smoke cigars, pipes or use smokeless tobacco products? Y N

Do you exercise Y N If so, describe activities and frequencies _____

_____

Family History:

Mother Living_____Deceased_____Cause of death_____
Father Living_____Deceased_____Cause of death_____
Brother(s) Number_____How many living_____Causes of deaths_____

_____

Sister(s) Number_____How many living_____Causes of deaths_____

_____

_____

Any family history of the following diseases? If so, which family member?

Heart Disease	M F B S	Arthritis	M F B S
Cancer	M F B S	Bleeding disorder	M F B S
Diabetes	M F B S	Stroke	M F B S
Neurologic Disorder	M F B S	Circulation problems	M F B S
High Blood Pressure	M F B S	Vascular disorders	M F B S

Review of Systems:

Please check any of the following that currently apply to you:

Constitutional:

( )	Fever	( )	Head injury	( )	Dizziness
( )	Chills	( )	Weight loss, cause unknown	( )	Appetite loss

HEENT:

( )	Glasses	( )	Glaucoma	( )	Cataracts
( )	Double vision	( )	Blurred vision	( )	Balance loss
( )	Ringing in ears	( )	Poor hearing	( )	Nose bleeds
( )	Mouth sores	( )	Dry mouth	( )	Sore throat

Cardiovascular:

( )	Shortness of breath	( )	High blood pressure	( )	Leg pain
( )	Chest pain	( )	Varicose veins	( )	Palpitations
( )	Irregular heartbeat	( )	Peripheral vascular disease	( )	Cold feet

Respiratory:

( )	Blood in sputum	( )	Prolonged cough	( )	Anorexia
( )	SOB on exertion	( )	SOB lying down	( )	Night sweats

Gastrointestinal:

( )	Nausea	( )	Vomiting	( )	Heart burn
( )	Hepatitis	( )	Gall bladder disease	( )	Ulcer(s)
( )	Blood in stool	( )	Stomach pain	( )	Hernia

Integumentary:

( )	Skin ulcers	( )	Unexplained bruising	( )	Rash
( )	Skin discoloration	( )	Toenail problems	( )	Open sores

Neurological:

( )	Loss of sensation	( )	Burning sensation	( )	Tingling
( )	Numbness	( )	Seizures	( )	Tremors

Initial history reviewed by: Date:_____

_____ _____ _____

JOEL CHARITON, D.P.M.
DIPLOMATE, AMERICAN BOARD OF PODIATRIC ORTHOPEDICS
[illegible] NORTH MAIN STREET
RANDOLPH, MASSACHUSETTS [illegible]
Telephone (781) [illegible]
Fax (781) [illegible]

To Our Patients:

MEDICARE: We accept assignment where applicable for all covered services. You will be responsible for 20% co-payment unless your secondary insurance covers this fee.

HMO'S: Including senior citizen HMO plans - (example: Secure Horizons, Pilgrim 65)
Including HMO plans for patients under 65 years of age Harvard Pilgrim, Tuft's, HMO Blue, Cigna HMO and any other HMO's requiring a referral prior to a visit.

OFFICE POLICY:

You will need to have a referral from your primary care doctor in our office prior to being seen. It is your responsibility to call your primary care doctor and make sure the referral is in this office prior to being seen.
This is not our rule but the insurance companies' rules that we must adhere to.
If the referral is not in the computer system prior to visit or in the office at the time of visit, the patient will be required to reschedule the appointment or pay in full at time of the visit.
Thank you in advance for your cooperation in the matter.

CO-PAYMENT: Patient will be required to pay, to cover administrative costs, if an additional bill is needed for your co-payment amount.

ORTHOTICS/THERAPEUTIC DEVICES: For any orthotics, either semi-custom made or custom made, or other items purchased in this office, payment will be expected at the time of the visit. You will be responsible for payment. **Remember, having insurance does not free you from the responsibility of payment.**

I understand, and agree to pay, in addition to costs provided by statue, such additional sums which are reasonable for collection costs. By regulation, we must ask you to sign this disclosure before this office may treat you or continue to treat you.

_____ _____
Signature Date

JOEL CHARITON DPM

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Joel Charitan, DPM to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by the office of Joel Charitan, DPM describes such uses and disclosures more completely. We are required by law to maintain the privacy of your protected health information and to provide you with a Notice of Privacy Practices (See Attached Form).

****** PLEASE ACKNOWLEDGE THAT YOU HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES ******

Signature of Patient or Legal Guardian _____ *Date of Birth* _____

Print Patient's Name _____ *Print Patient's Name or Legal Guardian, if Applicable* _____

PHI - Protected Health Information
TPO - Treatment Payment or Other Health Care Operations

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of Joel Charitan, DPM reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Donna Chan, 999 North Main Street Randolph, MA 02368 or by calling (781) 986-3448.

With this consent the office of Joel Charitan, DPM may call my home or other alternative location and leave a message on voice mail or in a person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder calls/cards, patient statements, insurance items, prescriptions, laboratory test result, among others. The staff of the office of Joel Charitan, DPM may conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly and any calls pertaining to my clinical care.

I have the right to request that the office of Joel Charitan, DPM restrict how it uses or discloses my PHI to carry out TPO. This practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow the office of Joel Charitan, DPM to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of Joel Charitan, DPM may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____ *Date* _____

Print Patient's Name _____ *Date of Birth* _____

Print Patient's Name or Legal Guardian, if Applicable _____

Effective Date Of Notice April 14, 2003