

**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 -D1- \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

1 \_\_\_\_\_

2 \_\_\_\_\_

**MEDICAL DOCTOR**

MEDICAL DOCTOR \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_

**AUTHORIZATIONS**

**BENEFITS TO PHYSICIAN**

YES  NO -----D2-----

YES  NO -----D3-----

-----D4-----

Date \_\_\_\_\_ Signed \_\_\_\_\_

-----D5-----



**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 for  
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

-----D9-----

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: \_\_\_\_\_

-----D10-----

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 death \_\_\_\_\_

Sister(s) \_\_\_\_\_ Number \_\_\_\_\_ How many living \_\_\_\_\_ Causes of death \_\_\_\_\_

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

Diabetics 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

-----D11-----

**Review of Systems:**

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

-----D12-----

- |                                 |   |  |
|---------------------------------|---|--|
| <input type="checkbox"/> Fever  | <input type="checkbox"/> Head injury                | <input type="checkbox"/> Dizziness     |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight loss, cause unknown | <input type="checkbox"/> Appetite loss |

**HEENT:**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Glasses         | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Cataracts    |
| <input type="checkbox"/> Double vision   | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Balance loss |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing   | <input type="checkbox"/> Nose bleeds  |
| <input type="checkbox"/> Mouth sores     | <input type="checkbox"/> Dry mouth      | <input type="checkbox"/> Sore throat  |

**Cardiovascular:**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Leg pain     |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Varicose veins              | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Cold feet    |

**Respiratory:**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Blood in sputum | <input type="checkbox"/> Prolonged cough | <input type="checkbox"/> Anorexia     |
| <input type="checkbox"/> SOB on exertion | <input type="checkbox"/> SOB lying down  | <input type="checkbox"/> Night sweats |

**Gastrointestinal:**

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Nausea         | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Heart burn |
| <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Ulcers     |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Stomach pain         | <input type="checkbox"/> Hernia     |

**Integumentary:**

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Skin ulcers        | <input type="checkbox"/> Unexplained bruising | <input type="checkbox"/> Rash       |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Toenail problems     | <input type="checkbox"/> Open sores |

**Neurological:**

- |  |  |                                   |
|--|--|-----------------------------------|
| <input type="checkbox"/> Loss of sensation | <input type="checkbox"/> Burning sensation | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Numbness          | <input type="checkbox"/> Seizures          | <input type="checkbox"/> Tremors  |

Initial history reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

-----D13-----



**To Our Patients:**

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

**HMD'S:** Including senior citizen HMD 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 statute, 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

# Please send clear image to recreation

## JOEL CHARITON DPM

### Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Joel Chariton, 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 Chariton, 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 Chariton, 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 Chon, 999 North Main Street Randolph, MA 02348 or by calling (781) 986-3448.

With this consent the office of Joel Chariton, DPM may call my home or other alternative location and leave a message on voice mail or to 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 results, among others. The staff of the office of Joel Chariton, 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 Chariton, 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 Chariton, 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 Chariton, 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