PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

DR.ROBERT KELEMEN
THE FOOT SPECIALIST

26 ASYLUM STREET
MILFORD, MA 01757
508-473-5959

20 HOPE AVE. #102
WALTHAM, MA 02453
781-899-9622

PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: __/__/__

PATIENT NAME: _____ _____ __ **DATE OF BIRTH:** __/__/__ **SEX:** M F
LAST FIRST MI

HOME ADDRESS: _____ **CITY/STATE:** _____ **ZIP:** _____

HOME PHONE #: (___)___-____ **WORK PHONE#:** (___) ___-____ **CELL#:** (___) ___-_____

E-MAIL: _____

PRIMARY LANGUAGE: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE #:** (___) ___-____

PRIMARY CARE DOCTOR: _____ **PHONE:** _____
PHARMACY: _____ **LOCATION:** _____ **PHONE #:** (___) ___-____
WHO REFERRED YOU TO US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ **DATE OF BIRTH** _____

ID # _____ **GROUP #** _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ **CITY/STATE:** _____ **ZIP:** _____ **PHONE #:** (___) ___-____

INSURED NAME: _____ **DATE OF BIRTH** _____

ID # _____ **GROUP #** _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS): PLEASE PROVIDE A COPY OF YOUR MED LIST IF YOU HAVE ONE

NAME **DOSE** **HOW OFTEN DO YOU TAKE?**

_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

USE OF ALCOHOL: ☐ NEVER ☐ NO LONGER USE ☐ HISTORY OF ALCOHOL ABUSE
☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

USE OF TOBACCO: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ ☐ SMOKE ___ PACKS/DAY FOR ___ YEARS

USE OF RECREATIONAL DRUGS: ☐ NEVER ☐ QUIT – HOW LONG AGO? _____ TYPE _____
☐ RARE ☐ OCCASIONAL ☐ MODERATE ☐ DAILY

OCCUPATION: _____

EXERCISE: ☐ NEVER ☐ RARE ☐ OCCASIONAL ☐ WEEKLY ☐ SEVERAL TIMES A WEEK ☐ DAILY

TYPES OF EXERCISE: _____

FAMILY HISTORY

☐ DIABETES: TYPE 1 OR TYPE 2 (CIRCLE ONE) ☐ CANCER ☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ THYROID DISEASE ☐ RHEUMATOID ARTHRITIS
☐ OTHER _____

YOUR MEDICAL HISTORY

ALLERGIES: ☐ MEDICATIONS _____
☐ ANESTHESIA _____ ☐ FOODS _____
☐ TAPE ☐ LATEX ☐ SHELLFISH ☐ IODINE ☐ OTHER
☐ NONE KNOWN

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N

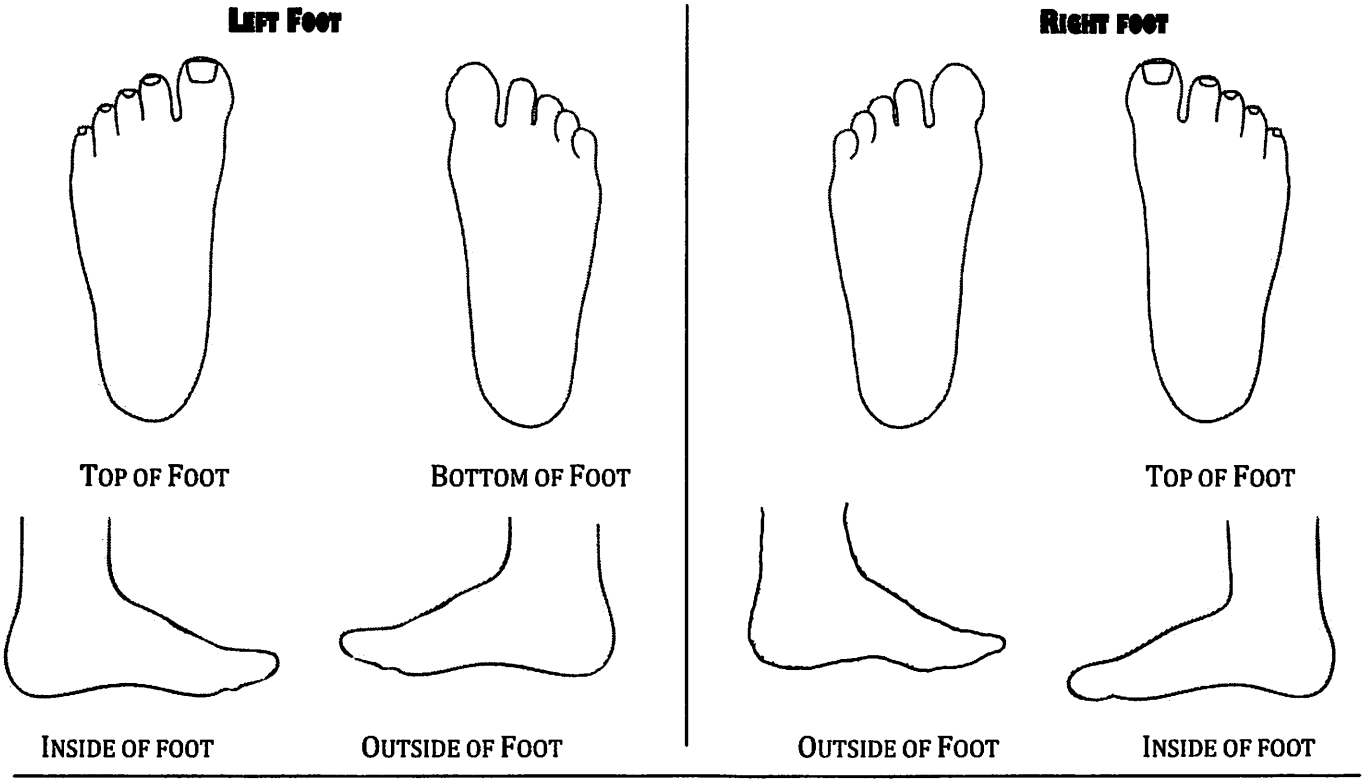
PATIENT NAME: _____

DATE OF BIRTH: ____/____/_____

BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES: TYPE 1	Y	N	DIABETES: TYPE 2	Y	N			

CURRENT PROBLEM

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ **DAYS / WEEKS / MONTHS / YEARS (CIRCLE ONE)**

DID YOUR PAIN OR PROBLEM: ☐ **BEGIN ALL OF A SUDDEN** ☐ **GRADUALLY DEVELOP OVER TIME**

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ **NO PAIN** ☐ **SHARP** ☐ **DULL** ☐ **ACHING** ☐ **BURNING**
☐ **RADIATING** ☐ **ITCHING** ☐ **STABBING** ☐ **OTHER** _____

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) **0 1 2 3 4 5 6 7 8 9 10 (WORSE)**

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ **STAYED THE SAME** ☐ **BECOME WORSE** ☐ **IMPROVED**

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ **WALKING** ☐ **STANDING** ☐ **RESTING**

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? _____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? _____

PATIENT NAME: _____
DATE OF BIRTH: ____/____/_____

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.
I HEREBY GIVE PERMISSION TO DR. ROBERT KELEMEN TO EXAMINE, TO PHOTOGRAPH, TO ADMINISTER TREATMENT AND TO PERFORM SUCH MINOR OPERATIVE PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY FOOT/ANKLE PROBLEM. I ACKNOWLEDGE THAT I HAVE READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTOOD THE NOTICE OF PRIVACY ACT (HIPAA). I UNDERSTAND THAT A PAPER COPY WILL BE PROVIDED TO ME IF I REQUEST ONE. I AUTHORIZE DR. ROBERT KELEMEN TO RELEASE ANY INFORMATION REGARDING MY MEDICAL HISTORY AND TREATMENT TO ANY THIRD PARTY PAYER, OR THEIR CONTRACTED AGENTS, TO VALIDATE OR DETERMINE BENEFITS PAYABLE FOR SERVICES RENDERED TO MYSELF OR ANY DEPENDENTS.

FINANCIAL POLICY/ ASSIGNMENT OF BENEFITS & PAYMENTS

IT IS ALWAYS GOOD POLICY TO UNDERSTAND AND AGREE WITH THE FINANCIAL POLICY OF AN OFFICE. WE APPRECIATE YOU AS OUR PATIENT AND STRIVE TO PROVIDE YOU WITH THE BEST POSSIBLE CARE POSSIBLE. MISUNDERSTANDINGS REGARDING INSURANCE COVERAGE AND FINANCIAL POLICY MAKE IT UNCOMFORTABLE FOR EVERYONE. IF YOU EVER HAVE ANY QUESTIONS OR WISH TO DISCUSS YOUR ACCOUNT WITH US, PLEASE DO NOT HESITATE. YOUR SIGNATURE BELOW INDICATES THAT YOUR UNDERSTANDING AND AGREEMENT TO THE FOLLOWING POLICIES:

I AUTHORIZE PAYMENT FOR SERVICES RENDERED TO ME OR MY DEPENDENTS TO BE PAID DIRECTLY TO THE OFFICE OF THE FOOT SPECIALIST, DR. ROBERT KELEMEN.

PRE-AUTHORIZATION BY YOUR INSURANCE COMPANY: IF MY INSURANCE PLAN REQUIRES A PRE-AUTHORIZATION (REFERRAL) FROM MY PRIMARY CARE PHYSICIAN, I, AS THE INSURED PARTY, AM RESPONSIBLE FOR OBTAINING THE REFERRAL PRIOR TO MY APPOINTMENT. IF THIS HAS NOT BEEN DONE, I WILL BE ASKED TO PAY FOR MY VISIT OR WILL BE ASKED TO RESCHEDULE MY APPOINTMENT UNTIL THIS REQUIRED INFORMATION IS OBTAINED. OF COURSE, I HAVE THE RIGHT TO PAY FOR MEDICAL SERVICES THAT ARE NOT DETERMINED TO BE COVERABLE BY MY INSURANCE COMPANY.

_____	_____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN	SIGNATURE OF DOCTOR
_____	_____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT	DATE

_____