BOSTON COMMON
Podiatry, Skin & Wellness

264 Beacon St 2nd Floor
Boston MA, 02116
617-262-2266 (P)
617-262-2261 (F)
www.bostoncommonpodiatry.com

Patient's Name: ____________________________ ____________________
{First, Last Name} {Date of Birth}
What would you like to be called: ______________ Martial Status ______________ Age: ______________
Address:______________________________City:______________State: Zip: __________
Email:______________________________Home Telephone: ______________
Work Telephone:______________________________Cell Phone: ______________
Social Security #: ______________ Sex:____M____F MGH ID # ______________
Height:______Weight:______Shoe Size: ______
Emergency Contact: ______________________________ Relationship:______________
Telephone #: ______________________________
Employer:______________________________ Position: ______________
Employer's Phone: ______________________________
Employer's Address: ______________________________
Primary Care Physician: ______________________________
Primary Care Address:______________________________ Telephone: ______________
Primary Health Insurance Co: ______________________________
Primary Policy No.______________________________
Name of Subscriber: ______________________________ Subscriber's D.O.B: ______________
Do you have other health Insurance coverage? Yes____No____
Secondary Health Insurance Company: ______________________________
How did you hear about us? *(Please circle one*) (a) Google (b) Yelp (c) City Search (d) BCP website (e) Ad/ post card (f) Physician referral (g) Family member (h) Friend/ Co-work (i) other: ______________
Reason of Visit: ______________________________
Is this a result of **Work Injury**?____Yes____No or is it a result of an Auto Accident?____Yes____No
Workers Comp or Auto Accident Carrier: ______________________________
Claim Number: ______________________________ Date of Accident: ______________
Name of Adjuster: ______________________________ Telephone: ______________

PATIENT CONSENT FOR EXTENDED AUTHORIZATION AND TREATMENT

1) For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc.) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment. Professional services are rendered and billed directly to your insurance carrier; however you, the patient/guardian, are directly responsible for services rendered by the doctor. A health insurance policy is a contract between you (the patient or subscriber) and your insurance carrier. If for any reason the insurance carrier denies charges, payments for any services rendered will become the responsibility of the patient/guardian.

2) I hereby authorize Jordana L. Szpiro, DPM to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Jordana L. Szpiro, DPM all payments for medical services rendered to myself or my dependents. I am aware that it is my obligation to know my insurance company's policies and that I am responsible for payments if I have not fulfilled their requirements. I hereby request and voluntarily consent to such office care, including routine diagnostic producers and medical treatment as may be deemed necessary by Jordana L. Szpiro, DPM and her designees.

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

X:______________________________ ______________
(Signature) (Date)

BOSTON COMMON
Podiatry, Skin & Wellness

264 Beacon St 2nd Floor
Boston MA, 02116
617-262-2266 (P)
617-262-2261 (F)
www.bostoncommonpodiatry.com

Patient's Name: ______________________________ ______________________
{First, Last Name} {Date of Birth}

Have you ever been diagnosed and/or treated for any of the following conditions? Y/N

Cardiovascular
___High Blood Pressure
___Chest Pain
___Palpitations/ Arrhythmia
___Heart Attack
___Congestive Heart Failure
___Stroke/ TIA
___Other:_____________________

Lung
___Shortness of Breath
___Lung Disease
___Asthma
___Emphysema
___COPD
___Other:_____________________

Gastrointestinal
___Reflux/ Heartburn
___Crohn's Disease
___Ulcerative Colitis
___Irritable Bowel Syndrome
___Bleeding Ulcers
___Other: _____________________

Liver
___Hepatitis
___Hepatitis B
___Hepatitis C
___Other:_____________________

Kidney
___Kidney Disease
___Kidney Failure
___Recurrent Infections
___Other:_____________________

Genito-Urinary
___Recurrent Urinary Tract Inf.
___Prostate Enlargement
___Prostate Cancer
___Other: _____________________

Musculoskeletal
___Fibromyalgia
___Back/ Neck Pain
___Osteoporosis
___Other:_____________________

Nervous System
___Seizure Disorder
___Multiple Sclerosis
___Parkinson's Disease
___Other:_____________________

Endocrine
___Diabetes (insulin dependent)
___Diabetes (non-insulin dependent)
___Thyroid Disease
___Other: _____________________

Hematologic
___Bleeding Disorders
___Clotting Disorders
___History of DVT/Blood Clotting
___Other:_____________________

Infections Disease
___HIV
___Hepatitis
___Chronic Skin Infections
___Other: _____________________

- Cancer: Type:______________________________ Treatment: ______________________________
- Do you have medical conditions that are not listed above?___Yes___No

Please list and explain: ______________________________
Have you ever had a complication with anesthesia?___Yes___No If yes, please describe the complication: ______________________________

Surgical History: Please list ALL SURGERIES that you have had below. Provide as much information as possible. If you require additional room, please write them on the back of this sheet.

Surgery	Year	Surgeon
1. ____________________	____________	____________________
2. ____________________	____________	____________________
3. ____________________	____________	____________________

Signature of Patient/Guardian:______________________________ **Date:** ____________________

Boston Common
Podiatry, Skin & Wellness

264 Beacon St 2nd Floor
Boston MA, 02116
617-262-2266 (P)
617-262-2261 (F)
www.bostoncommonpodiatry.com

Patient's Name: ______________________________ ______________________
{First, Last Name} {Date of Birth}

ALLERGIES Do you have any Drug Allergies?___ Yes___No
Please list **ALL food and drug allergies** and your reactions to those medications below:

Drug or Food	**what kind of Reaction?**
1. ______________________	______________________
2. ______________________	______________________
3. ______________________	______________________

MEDICATIONS: Do you currently take any medications? Yes___No
Please list **ALL Current medications**
1. ______________________ 2. ______________________
3. ______________________ 4. ______________________

Tobacco History
____I do not use tobacco products
____I smoke cigarettes I smoke____cigarettes per day I smoke____packs per day
____I smoke cigars I smoke____cigars per day____I chew tobacco
____I quit smoking in_____(year) I used to smoke____cigarettes per day; or____packs per day.

Alcohol History
____I never drink alcohol____I drink most days,____drink(s) per day
____I infrequently drink alcohol____I quit drinking in____(year)
____I drink____alcohol beverages per week____I have a history of alcohol abuse.

Family History

Mother Living ______	Deceased	Cause of Death ______________________
Father Living ______	Deceased	Cause of Death ______________________
Brother Living ______	Deceased _____	Cause of Death ______________________
Sister Living______	Deceased_____	Cause of Death ______________________

Is there a family (blood relatives) history of:

____Heart Disease	Who ______________________
____Arthritis	Who ______________________
____Bleeding Disorder	Who ______________________
____Stroke	Who ______________________
____Bunions	Who ______________________
____Neurological Disorder	Who ______________________
____Hammertoes	Who ______________________
____Flatfeet	Who ______________________
____Circulation problems in legs or feet	Who ______________________

Do you have any artificial joints?____yes____no If, yes where? ___________________
Do you have a Heart Valve Implant?____yes____no

Signature of Patient/Guardian:_____________________________ Date:_____________________