Boston Common Podiatry Inc
Jordana L. Szpiro D.P.M.

264 Beacon Street, 2nd Floor
Boston, MA 02116
Tel: (617)262-2266
Fax: (617)262-2261

Comprehensive Foot Care and Surgery

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.) <u>it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referrals or authorizations PRIOR to treatment.</u> 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 Inc
Jordana L. Szpiro D.P.M.

264 Beacon Street, 2nd Floor
Boston, MA 02116
Tel: (617)262-2266
Fax: (617)262-2261

Comprehensive Foot Care and Surgery

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 Inc
Jordana L. Szpiro D.P.M.

264 Beacon Street, 2nd Floor
Boston, MA 02116
Tel: (617)262-2266
Fax: (617)262-2261

Comprehensive Foot Care and Surgery

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**

Current Medication

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	**___ Arthritis**	___ Bleeding Disorder
__ Stroke	___ Bunions	___ Neurological Disorder
__ Hammertoes	___ Flatfeet	___ Circulation problems in legs or feet

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:_____