Tri-Town Podiatry
Irina B. Vasserman, D.P.M.
Podiatric Medicine and Surgery
Comprehensive Family Foot Health

1.

PATIENT INTAKE/HISTORY

Patient Name___________________________________ DOB_________________ Date_________________

Address____ Male______ Female______

City____________________________ State________ Zip_____________ SSN_________________________

Home #_______________________ Cell #________________________ Work # _________________________

E-mail_____________________________________Spouse/Guardian Name_____________________________

EMERGENCY CONTACT

Contact Name___________________________________ Relationship_________________________________

Address____ Contact #_________________________

INSURANCE

Please supply the receptionist with all insurance cards so that we may copy it. We are not able to treat you or bill your insurance without this information.

PRIMARY INSURANCE

Insurance Plan_____________________________ Insurance Member #_________________________

Policy Holder_______________________________ Relationship_______________________________

SECONDARY INSURANCE

Insurance Plan_____________________________ Insurance Member #_________________________

Policy Holder_______________________________ Relationship_______________________________

PRIMARY CARE PHYSICIAN

Name_____________________________________

Address___________________________________

____

Phone #___________________________________

Specialty__________________________________

Date of Last Visit___________________________

REFERRED BY

____

PHARMACY

Name____________________________________

Address__________________________________

____

Phone #__________________________________

22 Mill Street, Suite 307
Arlington, MA 02476-4744
Telephone (617) 870-3530
Fax (781) 641-1020

510 Chapman Street, Suite 1A
Canton, MA 02021-2096
Telephone (617) 870-3530
Fax (781) 575-1455

111 Everett Avenue, Suite 1A
Chelsea, MA 02150-2370
Telephone (617) 870-3530
Fax (617) 466-1869

CHIEF COMPLAINT
Please tell us the reason for your visit today as a new patient.____

____

VITAL SIGNS
Blood Pressure______/______ PaO2______/______Weight_________ Height_________ Shoe Size_________

SURGICAL HISTORY
Please list your past surgical episodes.____

____

MEDICATIONS
Please list all of your current medications or bring a list with you.______________________________________

____

ALLERGIES
Please list all of your allergies.____

____

CURRENT MEDICAL TREATMENT
Please list any medical problems you are currently being treated for. ______________________________________

____

PERSONAL HEALTH HISTORY
Please answer yes/no to the following for any health issues:

Aids/Autoimmune	Y	N	Gout	Y	N	Pinched Nerves	Y	N
Alcoholism	Y	N	Healing	Y	N	Polio	Y	N
Anemia	Y	N	Heart Disease	Y	N	Psoriasis	Y	N
			Heart Valve Implant	Y	N	Reflux	Y	N
Appendicitis	Y	N	High Blood Pressure	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	High Cholesterol	Y	N	Skin	Y	N
Artificial Joints	Y	N	Hormone	Y	N	STD	Y	N
Asthma	Y	N	Intestine	Y	N	Stomach Ulcer	Y	N
Bladder	Y	N	Kidney Disease	Y	N	Stroke	Y	N
Bleeding Disorders	Y	N	Liver Disease	Y	N	Thyroid Problem	Y	N
Breathing Disorders	Y	N	Lung	Y	N	Tonsillitis	Y	N
Cancer	Y	N	Multiple Sclerosis	Y	N	Tuberculosis	Y	N
Cataracts	Y	N	Neurologic Disorder	Y	N	Tumors/Fibroid	Y	N
Chemical Dependency	Y	N	Osteoporosis	Y	N	Ulcers	Y	N
Diabetes	Y	N	Pacemaker	Y	N	Weight Loss	Y	N
Frequent Infections	Y	N	Parkinson's	Y	N	Other:_____________________		

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SOCIAL HISTORY

Please check off the following that apply:

Single______ Married______ Widowed______ Divorced______ # of Children______

Smoking Status: Current______ Previous______ # of Years______ Never______

Alcohol Use: Mild______ Moderate______ Severe______ Never______

Soda/Coffee Use: Mild______ Moderate______ Severe______ Never______

IMMEDIATE FAMILY HISTORY

Please answer yes/no to the following for any health issues:

Aids/Autoimmune	Y	N	Gout	Y	N	Pinched Nerves	Y	N
Alcoholism	Y	N	Healing	Y	N	Polio	Y	N
Anemia	Y	N	Heart Disease	Y	N	Psoriasis	Y	N
			Heart Valve Implant	Y	N	Reflux	Y	N
Appendicitis	Y	N	High Blood Pressure	Y	N	Rheumatic Fever	Y	N
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Chemical Dependency	Y	N	Osteoporosis	Y	N	Ulcers	Y	N
Diabetes	Y	N	Pacemaker	Y	N	Weight Loss	Y	N
Frequent Infections	Y	N	Parkinson's	Y	N	Other:____________________		

HOW DID YOU HEAR ABOUT THE PRACTICE?

☐ Internet/Google ☐ Friend/Family ☐ Facebook ☐ Insurance Company

☐ Doctor Referral (who?)__________________________ ☐ Other________________________________

X ____

PATIENT/GUARDIAN SIGNATURE **DATE**

____

PRINT PATIENT NAME

Tri-Town Podiatry
Irina B. Vasserman, D.P.M.

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PATIENT FINANCIAL AGREEMENT AND PRIVACY POLICIES

Thank you for choosing Tri-Town Podiatry. We have adopted the following financial policy. If you have any questions about this policy, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your insurance policy is a contract between you and your insurance company; Tri-Town Podiatry is not involved. We file all claims with insurance carriers and within standard HIPAA guidelines, however this is not a guarantee of payment. It is your responsibility to pay your bills if your insurance company fails to do so. Podiatry claims are based on the type and complexity of the care the patient receives. The amount of the claim that falls to the responsibility of the guarantor (the patient or the person financially responsible for the bill) may include but is not limited to: non-covered services, insurance deductibles, insurance copays, and/or a coinsurance amount. Every carrier and every insurance package is different. Please contact your carrier if you have ANY questions regarding what is or what is not covered, and what portion of the bill you will be responsible for. For certain types of coverage, if there is a balance due after your insurance company has processed your claim, we will mail a statement that shows the balance due from you.

Insurance companies (both primary and secondary) do not pay for routine foot care (ie: reduction of corns and calluses and the trimming of non-disease nails) without a proper medical diagnosis.

ALL REFERRALS (when required by your insurance contract) must be in place prior to your appointment. A patient who does not have their required referral but who wishes to be seen outside of their plan may pay in full for their visit at the time of service. The office may ask you to reschedule your appointment and coordinate a referral for your next visit if you do not have a valid referral for your current appointment and you are also unable to pay for the visit. By signing below, you are agreeing to pay in full for any services NOT authorized by the insurance company.

For all services rendered to minor patients, we will look to the adult accompanying the patient (the parent or guardian with custody) for payment. Account balances are to be paid within 30 days of the statement date. If you are unable to pay in full by that date, please contact our Billing Department at (803) 606-9621 to make payment arrangements.

PATIENT PRIVACY POLICY

Tri-Town Podiatry complies with all standard HIPAA rules and regulations. The HIPAA "Notice of Privacy Practices" is available upon request at the time of service or can be mailed to you upon request. If you require a private registration area when checking in, please alert an agent at the front desk.

ATTESTATION AND ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize payments directly to the physician for medical and/or surgical benefits as well as authorize release of information for insurance claim purposes. The information for release may include information that may be considered a communicable or venereal disease including: hepatitis, syphilis, gonorrhea, HIV, and AIDs. I also consent to foot/ankle x-ray images, which will become part of my permanent records and/or sent to other physicians and insurance companies as may be needed for my care.

I have read and understand the financial and privacy policies of the practice and agree to be bound by the terms. I also understand that such terms may be amended at any time by the practice. In addition, I have received or know how to obtain and view the HIPAA "Notice of Privacy Practices" policy for Tri-Town Podiatry.

X ____

PATIENT/GUARDIAN SIGNATURE **DATE**

____

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