Podiatric Registration and History

Date ______ E-Mail ________________

Name ________________ Social Sec # ______________

What is the reason for coming today ____________________________

In case of emergency contact

Name ______________ Relationship ______ Phone ______________

Personal History

(Please Circle)

Single Married Widowed Separate Divorced

Male Female

Race: American Indian – Alaskan Asian Black Caucasian Other Pacific Islander

Ethnicity: Hispanic Non-Hispanic Decline

Language: ____________

Occupation: ____________ Full Time Part Time Retired At home

Do You Smoke: Yes Never Former

If yes or former, How much per pack: ______

Do you drink alcohol: Yes No

If yes, how frequently: ________

Is there any personal or family history of diabetes? Yes No

Circulation disorders Yes No

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Please circle if you have had any of the following:

Aids/HIV	Epilepsy	Rash
Allergies to Anesthetics	Fainting	Respiratory Disease
Anemia	Foot or Leg Cramps	Rheumatic Fever
Angina	Gout	Shortness of Breath
Arthritis	Headaches	Sinus Problems
Artificial Heart Valves	Heart Disease	Special Diet
Asthma	Hemophilia	Stroke
Back Problems	Hepatitis or Jaundice	Swelling in Ankles,, Feet
Bleeding Disorders	High Blood Pressure	Swollen Neck Glands
Cancer	Kidney Problems	Tired Feet
Chemical Dependency	Liver Disease	Turberculosis
Chest Pain	Low Blood Pressure	Ulcers
Circulatory Problems	Phlebitis	Varicose Veins
Diabetes	Psychiatric Care	

Surgeries you have had ______________________________

Hospitalizations other than for the surgeries listed: ______________________________

____

Have you been under any other Doctors care in the past 2 years? Please Explain:

____

Medications (Please list Prescription, Over-the-Counter and Vitamins)

Allergies (please circle)

Adhesive tape	Demerol	Novocain
Anticoagulant Therapy	Iodine	Penicillin
Aspirin	Latex	Seafood
Codeine	Local Anesthetics	Sulfa

IF NO KNOWN ALLERGIES PLEASE INITIAL HERE ______________

Name of pharmacy you use (include address) ______________________________

PERSONAL INFORMATION

Patient: ______________________

Address: ______________________

____

____

Sex: ________ Age: ________ DOB: ________

Soc.Sec.#: ______________________

Occupation: ______________________

Employed by: ______________________

Home phone: ______________________

Business phone: ______________________

Other phone: ______________________

Marital status: ______________________

Spouse/kin: ______________________

Phone: ______________________

Occupation: ______________________

Employed by: ______________________

Referring M.D.: ______________________

Address: ______________________

(street) (city) (state) (zip)

BILLING INFORMATION

MEDICAL INSURANCE	SUBSCRIBER / DOB	RELATIONSHIP	CERTIFICATE #
BC/BS Plan ________	/		
Medicare			
Medex			
Welfare (Medicaid)			
Other: ________	/		
	Suffix: ________	Group #: ________	

Address: ______________________

(street) (city) (state) (zip)

RESPONSIBLE PARTY for MINOR CHILD

Parent's Name: ______________________

Address: ______________________

____

____

Phone: ______________________

WORKMAN'S COMPENSATION

Party to be billed: ______________________

Address: ______________________

____

____

Claim/File #: ________ Date of Accident: ________

EXTENDED AUTHORIZATION

I hereby authorize Michael Biancamano, DPM to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Michael Biancamano, 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 payment if I have not fulfilled their requirements.

Signature: ______________________ Date: ________

CONSENT FOR TREATMENT

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Michael Biancamano, DPM and/or his designees.

Signature: ______________________ Date: ________

Wachusett Medical Billing, LLC, PO Box 127, Sterling, MA 01564 978-422-3020