



Advanced Podiatry of Norwood

Shenouda Corp

Michael Mitry, DPM & Christopher Karter, DPM

95 Chapel Street, Suite 3C

Norwood, MA 02062-32155

Phone: 781-762-5155 Fax: 781-444-5044

PATIENT REGISTRATION

Today's Date: ____/____/____

Name: _____ D.O.B: ____/____/____ SS#: _____-____-_____

Gender: Male Female Status: Married Single Divorced Widowed

Address: _____ City: _____ State: _____ Zip: _____

Phone - Home: (____) _____ - _____ Cell: (____) _____ - _____ Consent to call: Yes No

Email: _____ @ _____ . _____ Method of contact: home cell email

Primary Ins: _____ Secondary Ins: _____

Subscriber Name: _____ Date of Birth ____/____/____

Primary Care Physician: _____ Phone: (____) _____ - _____

Pharmacy: _____ Address: _____ City: _____

MEDICAL HISTORY:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Blindness <input type="checkbox"/> Reduced Vision | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Gout | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ulcers leg/foot |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Kidney <input type="checkbox"/> Failure <input type="checkbox"/> Stones | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Liver Disease | Are you taking? <input type="checkbox"/> Aspirin <input type="checkbox"/> Blood Thinners |

CURRENT MEDICATIONS: _____

ALLERGIES: _____

SURGICAL HISTORY: _____

SOCIAL HISTORY: 1. Do you Smoke? Current Previous Never
2. Do you drink Alcohol in excess? Yes No 3. Do you use illegal drugs? Yes No

DIABETES: Type1 Type2 How many years? _____ Do you take Insulin? Yes No

Diabetes treating physician name: _____ Date last seen: ____/____/____

Diabetes Medication: _____ Last A1C: _____%

Weight: _____ lbs Height: _____' _____"

CHIEF COMPLAINT:

Describe your problem or injury: _____

Location: Right foot Left foot Right toe/s 1 2 3 4 5 Left toe/s 1 2 3 4 5

How long? _____ yrs / mo. Injury date, if applicable: ____/____/____

Name: _____

Date: ____/____/____

Financial & HIPAA Disclaimer

1. I, the undersigned, certify that I (or my dependent) have insurance coverage and that my insurance card is a form of payment and must be valid at time of my visit. I agree it is my responsibility to know my insurance coverage. I am choosing to be treated by a provider of this practice despite my coverage requirements. I agree to assign all benefits, if any, directly to ***Shenouda Corporation**, otherwise payable to me, for reimbursement of services rendered.
2. I understand that I am financially responsible for all charges whether or not covered or paid by my insurance.
3. I hereby authorize ***Shenouda Corporation** to release all information necessary to secure payments of benefits and/or medical records for treatment and coordination of care with other providers.
4. I authorize the use of this signature on all insurance claim submissions.
5. I understand that I will be responsible for any balance not paid by my insurance if I fail to provide my current insurance and if I fail to obtain a referral authorization on or before my visits to ensure my claims may be filed within the filing limit imposed by my insurance.
6. I am aware that my copay is due at time of visit and any coinsurance or deductible balance will be billed to me once my claim is processed by my insurance. I understand if I choose to have elective surgery and I have a large un-met deductible, I will be required to pay a downpayment of \$1,000 to book surgery. I agree to pay a \$500 surgery cancellation fee unless I am not medically cleared.
7. I understand it is my responsibility per contract with my insurance carrier to pay my specialist copay, coinsurance, and/or deductible. If my insurance processes my claims with a copay higher than what I paid at time of my appointment I will receive a bill for the difference payable upon receipt of bill. I understand a \$5.00 late fee will be added every month if not paid after receiving first bill. A 48 hour notice is required for appointment cancellation or a NO-SHOW (missed) appointment fee of \$50 will be charged to my account.

Per the Health Insurance Portability and Accountability Act of 1996 all of your information is kept private using a secure network and password system. Your information will only be used for treatment and/or to receive payment of claims.

Consent to Treatment

I hereby consent and give permission for the doctors at Advanced Podiatry of Norwood to administer and perform such treatment or procedure as the doctor deems medically necessary for treatment.

Consent to Release of Medical Records

I hereby give consent to release my medical records to other providers for coordination of my treatment and for the payment of my claims by my insurance carrier.

I give (relative/friend/case worker/attorney) _____ permission to have access to my
 Medical Financial records.

I, the undersigned patient, agree to the above terms of Shenouda Corp by my signature.

Signature: _____ Date: ____/____/____

Consent to Treatment for Minors or Disabled Patients:

If the above-named patient is under the legal age, please print and sign name of parent or legal representative who is authorizing treatment of minor child. Child under age 18 cannot be treated without parent or legal guardian present.

Name (please print): _____

Signature: _____ Date: ____/____/____

***Shenouda Corporation Facilities**

Advanced Podiatry of Needham
Advanced Podiatry of Norwood
Hanover Podiatry