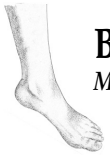


Boston Foot and Ankle

Medicine & Reconstructive Foot Surgery

Patient Master Record

Today's Date_____

PATIENT'S NAME: _____

First Name -----Initial --------Last Name

Date of Birth:_____ Age:_____ What Name Do You Like To Be Called: _____

Mailing Address:_____City:_____State: ____ Zip:_____

*E-mail :_____ Home Telephone: _____

Work Telephone: _____ Cell Phone: _____

Social Security #: _____ Sex: ___M ___F Weight: _____ Height: ____' _____"

Primary Language _____

Race: ❑ White ❑ Black/African American ❑ Asian ❑ Other _____; Ethnicity: Hispanic/Latino? ❑Yes ❑ No

EMERGENCY CONTACT: _____ Relationship: _____

Contact's Home Telephone: _____ (and/or) Work Telephone: _____

PATIENT'S EMPLOYER: _____ Position: _____

Employer's Phone: _____ Employer Address: _____

PRIMARY CARE PHYSICIAN:_____

Primary Physician Address:_____ Telephone_____

YOUR PHARMACY:_____ City & St:_____ Tel:_____

PRIMARY HEALTH INSURANCE CO.: _____

Primary Policy No. _____

Name of Subscriber: _____ Subscriber's Date of Birth:_____

Do You Have Other Health Insurance Coverage? Yes _____ No _____ Secondary Policy No. _____

Secondary Health Insurance Company: _____

REFERRED BY :_____

REASON FOR 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: _____

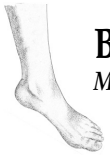
Name of Adjuster:_____ Telephone:_____

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, payment for any services rendered will become the responsibility of the patient/guardian.
2) I hereby authorize Boston Foot and Ankle to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to Kenneth M. Leavitt 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. I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment as may be deemed necessary by Dr. Leavitt.
3) I allow the Office to communicate with me by email, including informational updates about foot problems that I may find helpful and changes in the office or practice. ***If you wish to opt out of receiving any emails from our office, please check this box:*** ☐

✘_____ _____

Signature (Parent, if patient is a minor) *Date*



Boston Foot and Ankle
Medicine & Reconstructive Foot Surgery

PATIENT MEDICAL HISTORY

TODAY'S DATE_____

PATIENT'S NAME: _____
First Name -----Initial --------Last Name

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

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations/Arrhythmia
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Stroke / TIA
- ☐ Other:_____

LIVER
- ☐ Hepatitis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other:_____

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Back / Neck Pain
- ☐ Osteoporosis
- ☐ Other:_____

INFECTIOUS DISEASE
- ☐ HIV
- ☐ Hepatitis
- ☐ Chronic Skin Infections
- ☐ Other:_____

LUNG
- ☐ Shortness of Breath
- ☐ Lung Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Other:_____

KIDNEY
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Recurrent Infections
- ☐ Other:_____

NERVOUS SYSTEM
- ☐ Seizure Disorder
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Other:_____

ENDOCRINE
- ☐ Diabetes (insulin dependent)
- ☐ Diabetes (non-insulin dependent)
- ☐ Thyroid Disease
- ☐ Other:_____

GASTROINTESTINAL
- ☐ Reflux / Heartburn
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Bleeding Ulcers
- ☐ Other:_____

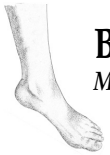
GENITO-URINARY
- ☐ Recurrent Urinary Tract Infections
- ☐ Prostate Enlargement
- ☐ Prostate Cancer
- ☐ Other:_____

HEMATOLOGIC
- ☐ Bleeding Disorders
- ☐ Clotting Disorder
- ☐ History of DVT/Blood Clot
- ☐ 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	HOSPITAL/CITY/STATE	YEAR	SURGEON
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____



Boston Foot and Ankle
Medicine & Reconstructive Foot Surgery

PATIENT MEDICAL HISTORY

TODAY'S DATE_____

PATIENT'S NAME: _____

First Name -----Initial --------Last Name

ALLERGIES: Do you have any Drug Allergies? ___Yes ___No Please list **ALL allergies** and your reactions

Drug or Food Allergies	**What Kind of Reaction?**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Are you allergic to adhesive tape? ___yes ___No

Are you allergic to latex? ___Yes ___No

MEDICATIONS: Do you currently take any medications? ___Yes ___No Please list **ALL current medications**

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

TOBACCO HISTORY

- ☐ I do not use tobacco products
- ☐ I smoke ____cigarettes per day.
- ☐ I smoke cigars
- ☐ I chew tobacco
- ☐ I quit smoking in _____(year)

ALCOHOL HISTORY

- ☐ I never drink alcohol
- ☐ I quit drinking in _____ (year).
- ☐ I drink most days, _____drink(s) per day
- ☐ I infrequently drink alcohol
- ☐ I drink ____alcoholic beverages per week
- ☐ I have a history of alcohol abuse

✘_____ _____

Signature (Parent, if patient is a minor) *Date*

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Patient Privacy Act (HIPPA), requires that our office obtains authorization to leave messages at your home with family members or on voice mail, email, etc. **I hereby give my consent for Dr. Kenneth M. Leavitt and staff to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) as follows:**

1. Boston Foot and Ankle's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. The doctors and staff reserve the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by writing to the Boston Foot and Ankle office at New England Baptist Hospital, 125 Parker Hill Ave. Suite 390, Boston, MA 02120.
2. **PHONE CALLS:** The doctors and staff may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
3. **MAIL:** The doctors and staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential.
4. **E-MAIL:** The doctors and staff may call my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
5. I have the right to request that the doctors and staff restrict how they use or disclose my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
6. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the doctors and staff may decline to provide treatment for me.

❑ I AUTHORIZE ❑ I DO NOT AUTHORIZE

✘_____ _____

Signature of Patient or Legal Guardian *Date*

_____ _____

Print Patients Name *If applicable Print Name of Legal Guardian*