Advanced Podiatry of Needham
Michael Mitry, DPM & Christopher Karter, DPM
Podiatric Physician & Surgeon
1410 Highland Avenue, Suite 204
Needham, MA 02492-2617
Phone: 781-444-4044 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:

☐ AIDS/HIV
☐ Anemia
☐ Angina
☐ Arthritis
☐ Asthma
☐ Back Problems
☐Bleeding Disorders
☐ Neuropathy

Are you taking?

☐ Blindness/Reduced Vision
☐ Cancer
☐ Gout
☐ Hearing Loss
☐ Hepatitis
☐ Hypertension
☐ Kidney ☐Failure ☐ Stones
☐ Liver Disease

☐ Aspirin ☐ Blood Thinners
☐ Psychiatric Disorder
☐ Respiratory Disease
☐ Shortness of Breath
☐ Stomach Ulcer
☐ Stroke
☐ Ulcers leg/foot
☐ Varicose Veins
☐ Other:_____

CURRENT MEDICATIONS:_____

_____

ALLERGIES:_____

SURGICAL HISTORY:_____

SOCIAL HISTORY: Do you Smoke? ☐ Current ☐ Previous ☐ Never
Do you drink Alcohol in excess? ☐ Yes ☐ No
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:_____%

VITAL SIGNS: Height:_____' _____" Weight:_____ lbs

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: _____/_____/_____

Patient 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 90-day 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 if $1,000 to book surgery. I agree to pay a $500 surgery cancelation fee unless I am not medically cleared.
7. I understand it is my responsibility per contract with my insurance carrier to pay my specialist co pay, coinsurance, and/ordeductible. 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 cancelation or a NO-SHOW (missed) appointment fee of $50 will be charged to my account.

Per the Health Insurance Portability and Accountability Act of 1969 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 Needham 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

Revised 03/15/2022