NEW ENGLAND
FAMILY FOOT CARE
Dr. Melissa L. Ricci & Dr. Jeffrey P. Pantano

100 Highland Street, Suite 122
Milton, MA 02186

Tel: 617.698.4830
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Date of Appointment: _____

Patient Name: _____***If patient is a minor, please see last page and complete.**

Primary Care Physician: _____ **/ Date of Last PCP Visit:** _____

Sex: ☐ M ☐ F **Date of Birth:**_____**Marital Status:** ☐ S ☐ M ☐ W ☐ D

SSN (Optional): _____ **Height:** _____ft. _____ in. **Weight**_____lbs

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell:** _____ **Email:** _____

Confidential information to be sent via: ☐ Cell ☐ Home ☐ Email ☐ Letter/Mail

Emergency Contact: _____**Relationship to Patient**: _____

Emergency Contact Phone #: _____

Pharmacy Name & Address:_____

☐ Retired ☐ Employed / Employer: _____**Occupation:** _____

How did you hear about us? ☐ Friend/Family ☐ Internet/Google ☐ Insurance Company ☐ Facebook

☐ Advertisement ☐ Doctor Referral/Who? _____ **☐ Other**_____

General Health (check all that apply):

☐ Diabetes/A1c_____	☐ High Blood Pressure	☐ High Cholesterol	☐ Heart Murmur	☐ Pacemaker
☐ Peripheral Neuropathy	☐ Stroke/Year_____	☐ Anemia	☐ Poor Blood Flow/PVD	☐ Blood Clot
☐ Liver Disorder	☐ Stomach Ulcers	☐ Kidney Disorder	☐ Gastric Reflux/GERD	☐ Gout
☐ Osteoarthritis/Location_____		☐ Anxiety	☐ Depression	☐ COPD
☐ Rheumatoid Arthritis/Location _____		☐ HIV	☐ Genetic Disorder_____	
☐ Cancer/Type_____		☐ Heart Attack/Year _____		

☐ Prosthetic/Joint Replacement (provide location) _____

Family History (please indicate the following: M-Mother, F-Father, G-Grandparent, S-Sibling):

☐ Diabetes____ ☐ Hypertension____ ☐ High Cholesterol ____ ☐ Heart Murmur ____
☐ Pacemaker____ ☐ Poor Blood Flow/PVD____ ☐ Blood Clot (DVT/PE)_____ ☐ Liver Disorder____
☐ Anemia____ ☐ Peripheral Neuropathy____ ☐ Gout____ ☐ Stomach Ulcers____
☐ Stroke____ ☐ Kidney Disorder____ ☐ Heart Disease____ ☐ Osteoarthritis____
☐ Rheumatoid Arthritis____ ☐ Cancer/Type_____ ☐ Genetic Disorder ____

Medications: _____

_____

Allergies: _____

Previous Surgeries & Date: _____

_____

Smoker: ☐ Y ☐ N **If yes, number of years:** _____ **Packs per day:** _____ **Drug use**: ☐ Y ☐ N

Reason For Visit: _____

Injury? ☐ Y ☐ N **Date of Injury:** _____

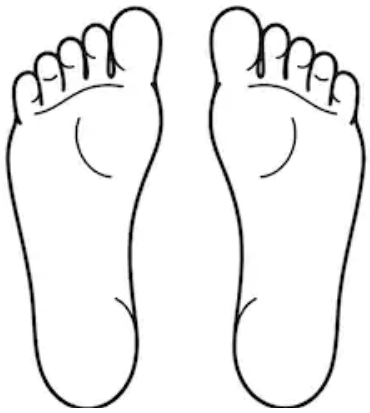
Duration of symptoms: _____

Pain level (circle one): 0 (no pain) 1 2 3 4 5 6 7 8 9 10

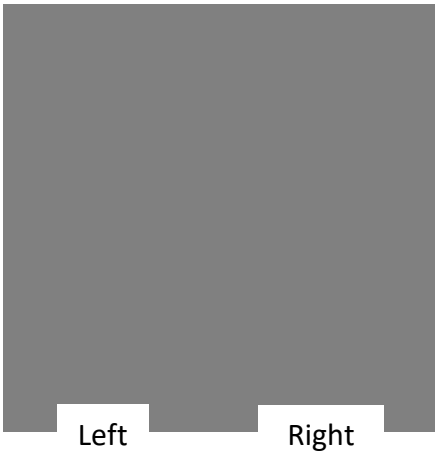
Previous treatment: ☐ Y ☐ N **If yes, please list any previous treatments:** _____

_____

Location of Problem <u>(please mark all areas that apply):</u>



Right Left



Insurance Information:

Insurance Company (Primary) _____

Subscriber's Name _____ **Policy #** _____

Insurance Company (Secondary) _____

Subscriber's Name _____ **Policy #** _____

Authorization:

Advanced Beneficiary Notice:

☐ Y ☐ N I hereby authorize payments directly to the physician of surgical and/or medical benefits.

☐ Y ☐ N I also understand I am responsible for any portion of my bill not covered by my insurance.

Release of Information:

☐ Y ☐ N I hereby authorize release of information for insurance claim purposes.

Print Name _____ **Signature** _____

Date _____

If accompanying a minor:

Guardian Name:_____ Relationship to pt:_____

Guardian cell phone number:_____ Guardian DOB:_____

Guardian Home Address: _____