Matthew P. Butler, DPM

www.MassFeet.com

Patient Name: _____
(last) (first) (middle initial)

Address: _____

_____

Home Phone #: _____ Cell Phone #: _____

Date of Birth: _____ Female: ☐ Male: ☐

Social Security #: _____

Employer: _____ Work Phone #: _____

Primary Medical Insurance: _____ ID# _____

Secondary Medical Insurance: _____ ID# _____

Primary Care Physician: _____ **Phone #:** _____

Referral # _____ Start Date: _____ End Date: _____ # of Visits: _____

Copay: $ _____

MEDICAL, FAMILY AND SOCIAL HISTORY

What is your current medical condition?: _____

Do you have allergies to medications?: _____

What surgeries have you had in the past?: _____

Medical conditions that run in your family: _____

Do you smoke? ☐Yes ☐No Do you drink alcohol regularly? ☐Yes ☐No History of drug abuse? ☐Yes ☐No

What is your foot complaint: _____

What Pharmacy do you use? _____ Telephone #: _____

Please provide this office with a list of your current medications

I authorize the release of any medical or other information necessary to process this claim.

Signed _____ Date: _____

I authorize payment of medical benefits to Matthew P. Butler, DPM and accept responsibility for payment of services rendered in the absence of a required referral.

Signed: _____

E-MAIL:

REFERRAL SOURCE - WHO POINTED YOU OUR WAY:

MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Allergies to Anesthetics	☐ Yes	☐ No	Eye Problems	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Allergies to Medicine or Drugs	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Foot or Leg Cramps	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Artificial Heart Valves or Joints	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Swelling in Ankles, Feet	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis or Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Tired Feet	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No	Neuropathy	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
Ear Problems	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Surgeries you have had _____

_____

_____

Hospitalization other than for the surgeries listed _____

_____

_____

Family Physician _____ Last Visit Date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? ☐ Yes ☐ No

If yes, please explain _____

_____

_____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

_____

_____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? ☐ Yes ☐ No

ALLERGIES

☐ Adhesive/Tape
☐ Anticoagulant Therapy
☐ Aspirin
☐ Codeine
☐ Demerol
☐ Iodine
☐ Local Anesthetics
☐ Novocaine
☐ Penicillin
☐ Seafoods
☐ Sulfa

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistant or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Podiatrist • Surgeon

Dr. Matthew P. Butler

DR. MATTHEW P. BUTLER
191 South Main Street, Suite #102
Middleton, MA 01949
Phone: (978) 774-2800
Fax: (978) 304-1013

massfeet.com

AUTHORIZATION FOR DISCLOSURE

Due to the recent changes in the Healthcare Insurance Portability and Accountability Act (HIPPA) which went into effect on April 14, 2003, we are now required to obtain a list of authorized persons other than yourself, who, at your request, may have access to your confidential medical records.

Please list below any person(s) with whom we may communicate on your behalf in regard to diagnosis, treatment and billing information. Please notify us if there is a change to your list at this time.

I, ______________________________ authorize the following list of people to have access to my diagnosis, treatment and billing information.

Name: ______________________________ Relationship: ____________________

Phone: ______________________________ DOB: ______________________

( ) 24 month duration as set by MA Law as the maximum allowed.

( ) Limited access From: ____________________ To: ______________________

I, ______________________________ authorize the following list of people to have access to my diagnosis, treatment and billing information.

Name: ______________________________ Relationship: ____________________

Phone: ______________________________ DOB: ______________________

( ) 24 month duration as set by MA Law as the maximum allowed.

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NO SHOW POLICY

We value all of our patients here at the Podiatry office of Dr. Matthew Butler and we want to do our best to accommodate all. Your standing appointments are what we call "your time" meaning that we will honor "your time" in expectation of rendering you professional and courteous service for your appointment. If you are running late for your appointment, please call the office to let us know in case a schedule adjustment is required. If you are greater than 15 minutes late from your scheduled appointment, we will do our utmost to see you as close to your appointment time as possible, but there may be a wait as we accommodate our other scheduled patients.

We understand that there are times when you must miss an appointment due to unforeseen circumstances. If you are unable to make your scheduled appointment, we ask that you notify us at least 4 hours in advance so that we have the slot available for another patient in need.

Our "No Show/Late Cancellation" policy is as follows:

1. **First No Show/Late Cancellation:** Patient notified of No Show policy by telephone if they do not show or in person upon late arrival.

2. **Second No Show: Charge/Late Cancellation:** The patient will be responsible for a $25.00 fee with their balance paid prior to scheduling any further appointments. A written letter will be sent notifying the patient of the No Show policy, confirming their second no show.

3. **Third No Show/Late Cancellation:** The patient will be charged $50.00, with their balance paid prior to scheduling any further appointments. A written letter will be sent notifying the patient of the No Show policy, confirming this was their third no show. This will also serve as a warning letter, notifying them that the fourth no show may be grounds for dismissal from the practice.

4. **Fourth No Show/Late Cancellation:** After the fourth no show or late cancellation, the patient can be dismissed from the practice.

Initial: _____

Date: _____

Podiatrist • Surgeon

DR. MATTHEW P. BUTLER

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Middleton, MA 01949
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Brigham and Women's Faulkner Hospital
1153 Centre Street, Suite #5C
Boston, MA 02130
Phone: (617) 983-1900
Fax: (617) 302-2468

Advanced Care Plan

Check "Yes" or "No" below.

1. Do you have an Advanced Care Plan?
   - o **Yes**
   - o **No – If No, Skip to Patient Name and Signature**

2. Do you have a surrogate decision maker?
   - o **Yes. Name of individual:**

     _____
   - o **No**

3. Are you currently in Hospice care?
   - o **Yes**
   - o **No**

Patient Name:_____

Signature:_____

Date: _____

Return this form to the front desk when completed

For in-office use:
Yes to either question 1 or 2: 1123F
No answer given:1124F
Yes to question 3: G9692