WELCOME

RODNEY R. GALLO, JR., D.P.M.
Acton Foot and Ankle Associates
179 GREAT ROAD, SUITE 101
ACTON, MA. 01720

Name: ____ DATE OF BIRTH: _________________
Last First Middle initial

Address: ____
Street City/Town State Zip Code

Home Phone ( )_________________ Marital Status S_M_W_D_ S.S.#: _______________________

Employer: ___________________________________ Business Phone ( )______________Ext.______

Spouse's Name: ____
Parent or Guardian if a minor

Nearest Relative Not Living With You: ______________________________Phone # ( )____________

Whom May We Thank For Referring You?: ____

Name Of Physician If Under Medical Care: ____

Have You Ever Had Previous Treatment By A Podiatrist: Yes _________ No ___________

My Chief Foot Complaint Is: ____

HEALTH HISTORY

1. Are You In Good Health?
2. Have You Been Treated by A Physician During The Past 5 Years?
3. Are You Sensitive To Or Allergic To Anesthetics ____ Penicillin ____ Aspirin ____ Codeine ____
Or Any Other Medication?
4. Are You Taking Any Medication Now? If So List:
5. Have You Ever Had Excessive Bleeding Requiring Special Treatment?
6. Have You Ever Had Any Of The Following:

_____ Stroke
_____ Rheumatic Fever
_____ Hepatitis
_____ Diabetes
_____ Arthritis
______ Low Back Pain
_____ Heart Trouble
_____ Asthma
_____ Jaundice
_____ Epilepsy
_____ Gout
_____ Knee Pain
_____ High Blood Pressure
_____ Tuberculosis
_____ Kidney Disease
_____ Nervous Disorder
_____ Stomach Ulcers
_____ Foot or Leg Injuries

7. Who Is Financially Responsible For This Account? ____________________________________
8. Address If Different From Patient ____

Phone Number ( )____________________ SS#: _________________________________

9. Is Treatment Being Covered By Insurance? ________ YES _________ NO

Name of Carrier: ______________________ Subscriber: ___________________________

Policy #__________________________ Group #__________________________________

Secondary Insurance:_______________________Subscriber:__________________________

Policy #___________________________ Group #_________________________________

MEDICAL RELEASE AND PERMISSION POLICY

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND REQUEST PAYMENT OF BENEFITS DIRECTLY TO THE PHYSICIAN.

I HEREBY GIVE RODNEY R. GALLO, JR., D.P.M. PERMISSION TO TREAT MY FEET.

____

Patient Signature

PAYMENT POLICY

I __________________________ UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING A WRITTEN REFERRAL FOR THIS VISIT (IF REQUIRED BY MY INSURANCE PROVIDER) AND WITHOUT ONE, THE TOTAL PAYMENT FOR SERVICES RENDERED TODAY BY ACTON FAMILY PODIATRY IS MY RESPONSIBILITY AND NOT THAT OF THE INSURANCE COMPANY. ALL PAYMENTS (INCLUDING INSURANCE PAYMENTS) WILL BE MAILED DIRECTLY TO OUR OFFICE.

____ _______________

Patient Signature **Date**