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: _____

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