LIEKE LEE, D.P.M.
DREW H. TAFT, D.P.M.
JOHN M. HURCHIK, D.P.M.
DAVID DECOSMO, CO

AFFILIATES IN FOOT CARE, P.C.
www.footdoctorsmass.com

100 UNICORN PARK DR, SUITE 3
WOBURN, MA 01801
(781) 979-0919
Fax: (781) 979-0334

Welcome to Affiliates In Foot Care, P.C.

Thank you for selecting us to help you with your Podiatric medical needs. We look forward to meeting you. Enclosed you will find an appointment card with your appointment date and time. If you are not certain about our location, please see the enclosed directions sheet.

Your insurance may require that you have an insurance referral from your Primary Care Physician. If you do need one, please call the office of your Primary Care Physician with the name of the physician you are seeing at our office and your appointment date.

Please bring the following information with you for your appointment. This information will help us to evaluate your condition and effectively form a treatment plan.

1. A list of each medication that you take (prescription and non-prescription, including vitamins, supplements and herbal products), the dosage and how often you take each one.

2. The first and last name, address, phone number and specialty of your Primary Care Physician.

3. Your insurance cards. We will need to make copies.

4. X Ray, CT scan or MRI films that you may have had taken that pertain to your present foot problem. Our doctors will need to read the actual films. If your exam was done through Winchester Hospital and Associates, we can access them via the internet.

5. The completed patient information sheet that we have enclosed in this mailing. **Please verify completed information.**

We would appreciate it if you would arrive at our office at least 15 minutes before your scheduled appointment. We will then be able to complete your registration in our system and hopefully allow your appointment to begin at your scheduled time. If you have any questions, please feel free to call our office prior to your appointment.

Please be advised that if you do not call to cancel your appointment, there will be a $30 charge for the missed appointment.

Affiliates in Foot Care, P.C

Please print the following information. Answer all questions completely. **Please sign Page Two of form**.

PATIENT INFORMATION

Last Name_____ First Name: _____ Date of Birth: ___/___/___
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____Email Address: _____
Sex: _____ Relationship to Insurance Subscriber: Self_____ Spouse _____Child_____Other_____

SUBSCRIBERS INFORMATION

Last Name:_____ First Name:_____

Address:_____City:_____State:_____ZIP:_____

Date of Birth: _____/_____/_____

MEDICAL INSURANCE INFORMATION (Please bring your insurance card. We will need to make a copy.)

Primary Medical Doctor (PMD): _____

PMD Mailing Address: _____Phone # (___) _____- _____

Pharmacy Used:_____Phone# (___) _____-_____

What foot problem brings you to this office?_____

***Medical Conditions*:** (Check all that apply)

__Insulin Dependent Diabetes	__Stroke	__Gout	__Liver Disease
__Non Insulin Dependent Diabetes	__Arthritis	__Lung Disease	__Renal Dialysis
__Poor Circulation	__Heart Disease	__Asthma	__Bleeding Problems
__Rheumatic Fever	__Hypertension	__High Cholesterol	__Neuropathy

__Other (explain) _____

Current Medications: (prescription and non-prescription, attach list if available)

Name	**Dosage**	**Frequency**	**Name**	**Dosage**	**Frequency**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medications you are allergic to or have had bad effects from:_____

Our Mission Statement is to offer quality foot care to our patients in a pleasant and professional environment. Our staff is committed to the needs of our patients working with confident, competent and caring standards of excellence providing understanding and respect of each individuals needs.

Patient Authorization

I hereby give my permission to the doctors of Affiliates in Foot care, P.C. to perform diagnostic, therapeutic and/or operative procedures as may be deemed necessary in the diagnosis and/or treatment of my feet. I also request that payment of authorized Medicare or other insurance benefits be made directly to Affiliates in Foot Care, P.C. for any services furnished to me. I authorize any medical information about me to be released to the Health Care Financing Administration or other insurance regulators or agents and any information needed to determine those benefits or the benefits payable for related services. I give permission to Affiliates In Foot Care to check my prescription eligibility and prescription history.

Patient Signature: _____Date:____/____/_____

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DIRECTIONS TO THE OFFICE

Taking I-93 SOUTH

Going south take exit 36 (Montvale Ave)
Keep left at the ramp
Turn left onto Montvale Ave continue straight
Then turn left onto Unicorn Park Dr. at second set of lights
100 Unicorn Park Dr. is the first building on your left
We are on the first floor in Suite 3

Taking I-93 NORTH

Going north on I-93 take exit 36 (Montvale Ave)
Turn right onto Montvale Ave
Then turn left onto Unicorn Park Dr.
100 Unicorn Park Dr. is first building on your left
We are on the first floor in Suite 3

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