Central Connecticut Foot Care Center, LLC
807 Broad St. Meriden, CT 06450*203-238-3668*Fax 203-238-3670

WELCOME TO OUR OFFICE

Your appointment is______________at______________with Dr. Boucher.

(You will be receiving an appointment reminder call 1 day prior to your appointment. Please be sure we have the correct telephone number to contact you and or leave a message.)

Our medical staff and office personnel want to take this opportunity to acquaint you with our office policies in order to make your visit with us as pleasant as possible. We are committed to providing you with the finest in personal service and healthcare.

NEW PATIENT VISIT FORM:

Please complete the enclosed new patient visit forms (8 pages) and bring the completed forms with you to your appointment. If it is more convenient you can mail in the completed forms. Please answer all questions.

OFFICE HOURS:

Office hours are by appointment only. Appointments can be scheduled on Monday, Tuesday and Thurs from 9-4 PM and Fri from 9-3:00 PM. We are closed on Wednesdays. We ask all New Patients to arrive at least 15 minutes prior to your scheduled appointment to facilitate the registration process. Our goal is to allow the appropriate amount of time for each patient. However, sometimes a particular case is more complex than anticipated and more time may be required. We ask your patience and understanding that scheduled appointment times are approximate. If you are unable to keep your appointment please call 203-238-3668 at least 24 hours in advance to reschedule. There will be a fee of $50.00 for appointments not cancelled with appropriate notice.

REFERRALS and COPAYMENTS (for HMO and Managed Care Patients):

If your insurance is an HMO or other managed care plan which requires a referral for a specialist visit, it is your responsibility to get the referral from your primary care physician. Please have the referral made out to Dr. Tina Boucher. Co-payments are due at the time of visit. We do not bill for co-payments. For your convenience we accept credit cards, checks and cash.

LATENESS:

We strive to see patients on time. Arriving late for an appointment may require rescheduling. Every effort will be made to accommodate you with a rescheduled appointment.

PRESCRIPTION REFILLS:

Prescriptions are filled at the time of your appointment. If a refill is required at another time please have your pharmacy fax us a written request to 203-238-3670. Please allow 24-48 hours call back time for refills. Prescriptions requested after hours will be reviewed on the next business day and be processed as stated above. If you have not been seen in a year or more, your prescription will not be filled. You will need to make a follow up appointment.

PATIENT REGISTRATION FORM – Please print

Patient Information

Name______________________________
Last First Middle Initial

Address______________________________
Street City State Zip

Phone #______________________________ Phone ______________________________
Home Cell

Date of Birth____________________ Sex________ SS#______________________________

E-Mail Address:______________________________

Employer:______________________________ Occupation:______________________________

How Did You Hear About Our Office?:______________________________

Pharmacy Name:______________________________ Phone Number:______________________________

Insurance Information (please present insurance card at time of visit)

****Insured is the name of the person who carries the insurance, not always the patient****

Primary Insurance Carrier:______________________________

Relationship of patient to insured: self spouse child other

Name of Insured______________________________

Insured DOB________________ ID#______________________________

Group Number______________________________

Secondary Insurance Carrier:______________________________

Relationship of patient to insured: self spouse child other

Name of Insured:______________________________

Insured DOB:________________ ID#______________________________

Group Number:______________________________

Referring Physician______________________________
Name Address Telephone

Primary Care Physician:______________________________
Name Address Telephone

Emergency Contact:____________________ relation____________ Phone#______________________________

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature______________________________ **Date**____________________

Review Of Symptoms (Please check all that apply)

Hearing/Ears/Eyes/Nose/Throat

- □ Loss of balance
- □ Difficulty in hearing
- □ Ringing in ears
- □ Impaired Vision
- □ Dry eyes
- □ Nasal stuffiness
- □ Sinus Congestion
- □ Frequent Sneezing
- □ Allergic rhinitis
- □ Fever blisters
- □ Canker sores
- □ Cavities
- □ Neck pain/stiffness
- □ Swollen lymph nodes
- □ Enlarged thyroid
- □ Hoarseness
- □ Difficulty swallowing
- □ Sore throat/tonsils

Lungs

- □ Cough
- □ Shortness of breath
- □ Phlegm
- □ Wheezing
- □ Snoring at night

Cardiovascular

- □ Chest Pain
- □ Irregular or fast heartbeat
- □ Swelling in feet/Ankles
- □ pain in calves
- □ Cold Feet
- □ Mitral valve prolapse

GI

- □ Nausea
- □ Vomiting
- □ Constipation
- □ Diarrhea
- □ Bloating
- □ Gas
- □ Heart Burn
- □ Hemorrhoids
- □ Dark stools
- □ Blood in stool
- □ Change in color/size of stool

Female Reproductive **Are you **Pregnant**? __Yes __No

- □ Irregular Period
- □ Heavy bleeding
- □ Prolonged period
- □ Severe menstrual pain
- □ Vaginal discharge
- □ Breast pain, mass or discharge
- □ Frequent urination

Male Reproductive

- □ Penile discharge
- □ Testicular/scrotal mass
- □ Testicular cancer
- □ Difficulty urinating
- □ Reduced power of urination
- □ Frequent urination
- □ Erectile dysfunction
- □ Testicle pain

Neuromuscular

- □ Joint pain/stiffness
- □ Muscle aches/cramps
- □ Fractures
- □ Limb length discrepancy
- □ Scoliosis
- □ Loss of height
- □ Osteoporosis
- □ Popping/crunching joints
- □ Hip/knee/low back pain
- □ Numbness feet/legs
- □ Burning in feet/legs

Skin

- □ Allergic reaction
- □ Acne
- □ Rosacea
- □ Dermatitis
- □ Ulcers
- □ Pigmentation changes
- □ Warts
- □ Hair loss
- □ Irregular moles

Is there anything you wish to tell your physician privately? __Yes __No