Elizabeth A. Franger DPM I Robert R. Franger DPM I Frederick M. Kaestel DPM
626 Main Street Shrewsbury MA, 01545
508-842-7910

Demographics:

Patient Name ________________________________ **Today's Date**_________________________

DOB ____ **Gender** _____________________________

Address_____________________________________

Cell Phone __________________________ **Home Phone** _________________________________

Email address ____

Race ____________________ **Ethnicity** ____________________________________

Spouse / Parent / Emergency Contact ____

Health Care Proxy ____

Pharmacy: ____

Insurance

Primary Insurance Company ___________________________

Policy Number _______________________________________ **Subscriber**__________________________

Secondary Insurance Company _______________________

Policy Number _______________________________________ **Subscriber**__________________________

Employer ____

Are you being treated for a WORK or ACCIDENT related injury? No Yes Date of injury: ____________________

Medical Information

PCP / Date Last Seen ____

Height / Weight ________/_________ **Allergies** _________________________

Medications

____________________________ ________________________________
____________________________ ________________________________
____________________________ ________________________________

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Medical History

Asthma
Autoimmune disease
Arthritis (rheumatoid, psoriatic, other)
Dermatitis
Back pain
Bleeding disorder
Blood clots (DVT, PE)
Cancer
Visual problems (Cataracts, glaucoma)
Circulatory / vascular disease
COPD
Coronary artery disease
Heart attack
Heart murmur
Diabetes
Fibromyalgia
Gastric ulcers
Headaches / migraine
High blood pressure
Kidney disease
Liver disease
Lung or respiratory disease
Neuropathy
Organ transplant
Osteoporosis
Pacemaker
Raynaud's
Seizures/Epilepsy
Stroke
Thyroid disorder
Other ______________________
____
____
____

Social History

Alcohol use: daily social occasional rare none
Tobacco use: never former current
Recreational drug use: yes no

Surgical History

____
____

Family History

Mother____
Father____
Additional____

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Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service."

Insurance Liability for Payment:
Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have procedures, routine foot care, prescription orthotics, and all other podiatric services preauthorized by your health insurance company as it is required from each plan. If your health insurance company determines that this device/service is not reasonable and necessary, or that a particular device/service is not covered under the plan, your insurer will deny payment for that device/service.

Beneficiary Agreement:
I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment.
I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Patient signature ____

Date____

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Patient Acknowledgment

Thank you for taking the time to review our Notice of Privacy Practices. If you have any questions, please let us know and we will make every effort to clarify the information.

We’d appreciate your acknowledging receipt of this Notice of Privacy by signing and dating below.

Also, if there is a family member or another person you would like us to share your health information with, please list them below.

Please share my health information with:

____

____

____

Print Patient Name

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Missed Appointment Policy (Effective 10/01/2023)

All patients are required to give at least 24 hours advance notice when canceling an appointment.

A missed appointment is defined as any appointment for which a patient does not arrive for a scheduled ("no show"), or is canceled without a minimum of 24 hours notice (same day cancellation).

Failure to give 24 hours notice ("Same Day Cancellation") or giving no notice at all ("No Show") will result in a penalty.

- 1st Missed Appointment: Verbal Notice
- 2nd Missed Appointment: $50.00 missed appointment fee
- 3rd Missed Appointment: $50.00 missed appointment fee
- 4th Missed Appointment: Discharge from Practice

I understand the effective changes to the no show policy and understand I could be charge for a no-show to my appointment.

____________________________________ __________________________

Signature Date