

# 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	____ Heart Trouble	____ High Blood Pressure
____ Rheumatic Fever	____ Asthma	____ Tuberculosis
____ Hepatitis	____ Jaundice	____ Kidney Disease
____ Diabetes	____ Epilepsy	____ Nervous Disorder
____ Arthritis	____ Gout	____ Stomach Ulcers
____ Low Back Pain	____ Knee Pain	____ 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.

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**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.

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**Patient Signature**

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**Date**