MERRIMACK VALLEY FOOT SPECIALISTS

62 Brown St Suite 203 Haverhill MA 01830

Phone 978-556-9700 Fax 978-521-8542

AUTORIZATION/FINANCIAL RESPONSIBILITIES

- **Medical Records**

There is a fee charged for all copies of medical records. Please make this request in writing 5 business days prior to the date and payment must be made at time of request. I understand that records are the permanent property of Merrimack Valley Foot Specialists

INITIAL _____

- **Purchase Policy**

Please note that any products purchased from Merrimac Valley Foot Specialist are non-returnable and non-refundable (except in the case of Manufacturer's defect)

INITIAL _____

- **Cancellations / No Show**

We understand emergencies happen and we hope you can appreciate that we require a 24-hour notice, when possible, for cancellations of all scheduled appointments. If you no show a schedule appointment you will be charged a $50.00 fee for time lost.

INITIAL _____

- **Insurance agreement**

I understand health insurance agreements are between insurance companies and myself. I authorize Merrimack Valley Foot Specialists to submit fees for service to my insurance carrier. I understand once claims are processed, I am primarily responsible for any amount of the claim not covered by my carrier (deductibles, coinsurances etc.)

- ***Copays are due prior to services being rendered***
  (for your convenience we except credit, debit, checks and exact cash amount)

- **Merrimack Valley Foot Specialist and its staff are not responsible for knowing what specific procedures or amounts are covered by your insurance policy or the limits of your coverage.**

- **I understand that it is my responsibility to obtain a referral from my primary care physician and any services denied for not having a referral are my responsibility**

I have read and understand the above agreements and policies of Merrimack Valley Foot Specialists

Patient Name **(Print)** _____ Date _____

Guarantor Signature _____ Relationship _____

Merrimack Valley Foot Specialists
David Greenblott D.P.M & Debra Eisner D.P.M
Podiatric Medicine & Surgery
REGISTRATION FORM

PATIENT INFORMATION

Patient Name (Print) _____ Birthdate ____/____/____

Address _____ City _____ State_____ Zip_____

Home phone ( ) _____ Cell phone ( ) _____

E- mail (18 older only) _____ Sex ☐ M ☐ F

Race: ☐ Asian ☐ Black/African American ☐ White Other _____

Ethnicity: ☐ Hispanic or Latino Language: ☐ English Other: _____

EMERGENCY CONTACT

Name _____ Relationship _____

Best Number to be reached ( ) _____

INSURANCE **(FILL IN ONLY IF FILLING OUT AT HOME)**

PRIMARY INSURANCE

Insurance Company _____ ID# _____

ADDITIONAL INSURANCE

Insurance Company _____ ID# _____

GUARANTOR (responsible party only if different from patient)

Name _____ Relationship _____ Date of birth ____/____/____

Address if different from patient _____

PRIMARY CARE

Name_____ Address _____ST _____ Zip _____

Phone ( ) _____ Date last seen by PCP _____/_____/_____

PHARMACY

Name Address City Phone

Signature Patient/Guarantor_____ **Date** _____

MERRIMACK VALLEY FOOT SPECIALISTS

I understand that all questions contained on this form are strictly confidential and will become part of my medical record.

Patient Name (PRINT) _____ Date _____

PODIATRY HISTORY

How did you hear about us ☐ Friend ☐ Social media ☐ Relative ☐ PCP ☐ Other _____

Chief complaint (reason for this visit) _____

_____

How long have you had this problem Days ____ Weeks ____ Months ____

Please indicate which foot problems you have had in the past

☐ Ankle pain ☐ Athlete's foot ☐ Bunions ☐ Corns/ calluses ☐ Cramps/numbness (foot or legs) ☐ Flat feet ☐ Heel Pain ☐ Ingrown toenails ☐ Plantar warts ☐ Swelling ankles or feet

Any surgical procedures on foot or ankles ☐ Yes (If yes please list below) ☐ No

Surgery _____ Date _____

Surgery _____ Date _____

Shoe Size _____ **Special Shoes** _____

Do you use ☐ Walker ☐ Crutches ☐ Cane ☐ Wheelchair

MEDICAL HISTORY

Are you Diabetic ☐ Yes ☐ No When diagnosed _____

Current WT _____ **Height** _____

Any major surgeries in past 10 years (if yes please list below) ☐ **No**

_____

Any major illness in past 10 years (if yes please list below) ☐ **No**

_____

Are you presently under a specialist care ☐ Yes (if yes please list below) ☐ No

Condition _____ Physician _____

Condition _____ Physician _____

Condition _____ Physician _____

Are you allergic or sensitive to any medications (explain reaction) ☐ **No known allergies**

MEDICATIONS

Please use back page if more space is needed

_____ Dosage _____ Frequency _____

_____ Dosage _____ Frequency _____

_____ Dosage _____ Frequency _____

_____ Dosage _____ Frequency _____

MERRIMACK VALLEY FOOT SPECIALISTS

Please indicate if you have or have had any of the following.

Cardiovascular
- ☐ Ankle swelling
- ☐ Calf cramping
- ☐ Change in color
- ☐ Chest pain or tightness
- ☐ High blood pressure
- ☐ Shortness of breath

Immuno/Hemo
- ☐ Bleeding tendencies
- ☐ Clotting difficulties
- ☐ Environmental allergies
- ☐ Gout attacks
- ☐ Viral infections

Integument
- ☐ Blisters
- ☐ Dry/ scaly skin
- ☐ Ingrown nail
- ☐ Itching
- ☐ Foot ulcers
- ☐ Slow healing

Neurological
- ☐ Burning/tingling
- ☐ Hypersensitivity
- ☐ Numbness
- ☐ Paralysis
- ☐ Tremors
- ☐ Vertigo

Endocrine
- ☐ Cuts take longer to heal
- ☐ Excessive urination
- ☐ High blood sugar
- ☐ Low blood sugar
- ☐ Unusual fatigue

Gastro
- ☐ Diarrhea
- ☐ Liver Disease
- ☐ Nausea
- ☐ Reflux

Lymph
- ☐ Enlarged nodes
- ☐ Leg swelling
- ☐ Cancer

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Memory loss
- ☐ Panic attacks

Eye/ Ent
- ☐ Difficulty swallowing
- ☐ Hearing loss
- ☐ Legally blind
- ☐ Retina disease
- ☐ Sinus infection/ congestion

Urinary
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Weak bladder
- ☐ Weak Kidney

Musculoskeletal
- ☐ Back pain
- ☐ Restricted range of motion
- ☐ Heel pain
- ☐ Joint pain
- ☐ Morning stiffness
- ☐ Weakness

Respiratory
- ☐ Asthma
- ☐ Breathing diff.
- ☐ Cough
- ☐ Short. of breath
- ☐ Smoker

FAMILY HISTORY

Mother Living ☐ Deceased ☐ Cause of death _____

Father Living ☐ Deceased ☐ Cause of death _____

Please indicate family history of diseases below (M= Mother / F= Father)

Arthritis ☐M ☐F Bleeding disorder ☐M ☐F Cancer ☐M ☐F Circulation Problems ☐M ☐F

Diabetes ☐M ☐F Heart Disease ☐M ☐F High blood pressure ☐M ☐F

Neuro. disorder ☐M ☐F Stroke☐M ☐F Vascular disorders ☐M ☐F

SOCIAL HISTORY

Employment status ☐ FT ☐ PT ☐ Unemployed ☐ Retired

Do you smoke ☐ Yes ☐ No If yes number of packs per day _____

Have you previously smoked ☐ Yes ☐No When did you quit _____ How many packs per day_____

Do you smoke cigars, pipes, or use smokeless tobacco products ☐ Yes ☐ No

Do you use recreational drugs ☐ Yes ☐ No

Do you exercise ☐ Yes ☐ No If yes describe activities and frequencies

I attest that the information given is true to the best of my knowledge

Patient Name (PRINT)_____ **Date** _____

Guarantor Signature _____