MERRIMACK VALLEY FOOT SPECIALISTS
DR GREENBLOTT D.P.M / DR EISNER D.P.M
62 BROWN ST #203 MERRIMACK MEDICAL CENTER
HAVERHILL MA 01830
Phone (978) 556-9700 Fax (978) 521-8542

NOTICE OF PRIVACY PRACTICES

This note describes how medical information about you can be used and how you can get access to this information. Please read carefully.

Your medical record is protected under HIPPA federal law. There are limitations upon whom and under what circumstances your medical information can be disclosed. **We do not share your private medical information with anyone including your spouse, parent, child, or employer unless you request it or unless required by law.**

The law allows us to share your medical information with your insurance company to verify eligibility and that payment is appropriated for the visit. They may also review your record to ensure that we meet quality standards. We share information with other providers who treat you or who refer you to us for consultation or treatment. We also provide information about your care and diagnosis when we request tests at the hospital or labs, such as x-ray or laboratory testing. These providers are also required to protect the confidentiality of your health information under HIPPA.

We may consult you by mail or leave general messages by phone, but we will not give your test results or other private information to a family member without your permission. We are not affiliated with any drug companies or other marketing services and will not release your health information to anyone for the purpose of marketing services to you. We may, however, give you a reminder call by phone or text of an upcoming appointment. We may disclose information to the FDA in the event of an adverse drug reaction, as required by law, to the Dept of Public Health in the event of certain communicable diseases.

You may review your medical records or obtain a copy of them upon request. There is a charge for copying depending on the number of pages involved. HIPPA also allows you to make additions or corrections to your medical records. If you have questions about our policy of protecting your private medical records, you may discuss them with our office manager.

CANCELLATION POLICY

I Understand the office requires 24-hour notice for appointment cancellations. If 24-hour notice is not provided, I understand I may be charged a $25 No Show/ Cancellation Fee.

PERMISSION TO TREAT

I give permission to Merrimack Valley Foot Specialists to examine and/or administer treatment as necessary in the diagnosis & treatment of my foot problem(s). I certify that I and /or my dependents have insurance coverage or will pay privately & assign directly to Merrimack Valley Foot Specialists all insurance benefits, if any, for services rendered. I understand I am financially responsible for all charges including Copays, Deductibles and/or Coinsurances not covered by my insurance.

_____I Accept _____I Decline the NOTICE OF PRIVACY PRACTICES.
_____I Accept _____I Decline the CANCELLATION POLICY
_____ _I Accept _____I Decline the PERMISSION TO TREAT

Signature _____ **Date** _____

Relationship to Patient _____

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 Contact Number ( ) _____

PRIMARY CARE

Name_____ Address _____ST _____ Zip _____

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

PHARMACY

Name Address City Phone

INSURANCE

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 _____

Signature _____ **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** _____

MEDICAL HISTORY

Are you Diabetic ☐ Yes ☐ No When diagnosed _____ **Medication Name** _____

Current WT _____ **Height** _____

Are you on any blood thinners? **Medication Name** _____ ☐ **No**

Any major surgeries in past 5 years (if yes please list below) ☐ **No**

_____

Any major illness in past 5 years (if yes please list below) ☐ **No**

_____

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

_____

_____

MEDICATIONS (Other than above) **Use** back page if more space is needed

_____ Dosage _____ Frequency _____

_____ Dosage _____ Frequency _____

_____ 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
- ☐ Chest pain or tightness
- ☐ High blood pressure

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

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

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

Endocrine
- ☐ Cuts take longer to heal
- ☐ High blood sugar
- ☐ Low bold 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

Urinary
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Weak Kidney or bladder

Musculoskeletal
- ☐ Back pain
- ☐ Restricted range of motion
- ☐ Joint pain
- ☐ Heel pain

Respiratory
- ☐ Asthma
- ☐ Breathing diff.
- ☐ Cough

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

Signiture_____**Date**_____

Relationship to Patient _____