



***Newburyport office of  
Dr. James J. DiResta***

**WELCOME TO OUR OFFICE**

**(Please print this form before your appointment)**

Mr. Mrs. Ms. Dr: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Status: S M W Sep Other

Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_M\_\_\_F Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Medical Insurance Co.: \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do You Have Other Health Insurance Coverage? Yes/ No

Medical Insurance Co.: \_\_\_\_\_ Policy No. \_\_\_\_\_

**OFFICE POLICY REGARDING INSURANCE**

To preserve the best possible relationship with you, our patient, and to prevent any misunderstandings, we hope the following explanation of our office policy regarding insurance and payment for services is helpful.

1) We expect and appreciate payment for office visits at the time of service. We will accept cash, check, MasterCard or Visa.

2) For any insurance plan that requires authorization from a primary care physician (e.g. HMO, PPO, etc) it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referral or authorizations PRIOR to treatment. If the insurance carrier denies any charges due to lack of referral/authorization, you (the patient/guardian) are responsible for all charges incurred.

3) If any type of supplies are dispensed during the course of treatment, (e.g.arch support, accommodative pads, cream, surgical shoes, etc.) payment is due at the time of service. We cannot bill you or the insurance company for these supplies.

4) I have read, understand and agree to the above office policies and understand that I am financially responsible for any balance due on my account.

5) I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read ( or had the opportunity to read if I so chose) and understood the Notice.

6) I hereby give my permission to Dr. DiResta to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot condition

Signature (Patient/guardian): \_\_\_\_\_ Date: \_\_\_\_\_

# Medical Information

Have you ever had, or been treated for, any of the following?

## MAJOR DISEASE

- Diabetes
- High Blood Pressure
- Angina
- Heart Disease
- Heart Attack
- Arrhythmia
- Heart Murmur
- Mitral Valve Prolapse
- Stroke
- High Cholesterol

## HEENT

- Headaches
- Glaucoma
- Hearing Problems

## RESPIRATORY

- Asthma
- Tuberculosis
- Emphysema

## ARTHRITIS

- Osteoarthritis
- Rheumatoid
- Gout

## VASCULAR

- Anemia
- Prolonged Bleeding
- Pacemaker
- Poor Circulation
- Leg Pain When Walking
- Varicose Veins
- Blood Clots

## GASTROINTESTINAL

- Ulcers
- Acid Reflux (GERD)
- Stomach Problems
- Hiatal Hernia
- GI or Rectal Bleeding
- Bowel Disorders

## MISCELLANEOUS

- Epilepsy/Seizures
- Thyroid Disease
- Muscle Disease/Polio
- Kidney Problems
- Bladder Problems
- Prostate Problems
- HIV
- Hepatitis/Liver Disease
- Cancer (type: \_\_\_\_\_)

## PSYCHOLOGICAL

- Anxiety
- Depression
- Psychiatric Care
- Drug Dependence
- Alcohol Dependence

## OTHER MEDICAL PROBLEMS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## FAMILY MEDICAL HISTORY

Mother  Alive  Deceased (cause of death) \_\_\_\_\_

Father  Alive  Deceased (cause of death) \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Address: \_\_\_\_\_

Previous Podiatrist: \_\_\_\_\_ Last Visit: \_\_\_\_\_

What is your foot/ankle problem? \_\_\_\_\_

How long has it been present? \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

What surgeries or operations have you had? \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

What prescription medications are you now taking? \_\_\_\_\_

Are you allergic to any of the following?

- Latex
- Novocaine
- Iodine
- Penicillin
- Codeine
- Aspirin
- Adhesive tape
- Tetanus

Do you have any other allergies/sensitivities?  Yes  No If yes, what? \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes..... Socially  Daily

(Women) Are you pregnant?  Yes  No