



The Newburyport Office of Dr. James J. DiResta & Associates

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
Home phone: _____ Cell: _____
Pharmacy: _____ Address: _____
Sex: ___M___F Weight: _____ Height: _____ Shoe Size: _____
Race: _____ Ethnicity: _____ Language: _____
Primary Doctor: _____ Phone: _____ Date of last visit: _____
Employer: _____ Occupation: _____
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/PAYMENTS/PRIVACY

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, Visa or Discover.
- 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) 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.
- 4) I acknowledge that I am aware of the Notice of Privacy Practices/HIPPA and that I understand these practices. I am aware that I may be provided a copy of such notice upon request.
- 5) I hereby give my permission to Dr. DiResta & Dr. Barnes 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:

Three horizontal lines for additional medical problems.

FAMILY MEDICAL HISTORY

Mother: Alive Deceased(cause of death):
Father: Alive Deceased(cause of death):

What is your foot/ankle complaint today? (Left) (Right)

Any treatment for this condition to date?

How long has it been present? weeks months years

Previous Podiatrist: Last Visit:

Please list all medications you are taking

Please list all surgeries you have had

Are you allergic to any of the following?

- Latex, Novocain, 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