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) <u>it is your responsibility (as patient or guardian) to be sure that this office receives all necessary referral or authorizations PRIOR to treatment</u>. 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: ______________

37 1/2 FORRESTER STREET PROFESSIONAL BUILDING • NEWBURYPORT, MASSACHUSETTS • 01950
PHONE: 978-465-2122 • FAX: 978-465-0450

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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):______________________

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

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N E W B U R Y P O R T O F F I C E O F D R D I R E S T A A N D A S S O C I A T E S

D R J A M E S J D I R E S T A D P M , M P H
D R A N G E L A M B A R N E S D P M

FINANCIAL POLICY

The **copayment** and **deductible responsibility** is due at the time that services are rendered.

Patient payment responsibilities are estimated from the information your insurance benefit company provides.

Please keep in mind **you** are responsible for **your** total obligation should your insurance benefits result in less coverage than anticipated.

We **require** that you pay **your** responsibility at each visit or your appointment may be rescheduled.

We accept: Cash, Check, Visa, Mastercard,

Discover & Care Credit

By my signature below, I am stating that I have read and understand and will comply with this financial policy.

____________________________________ ____________________

Signature Date

3 7 ½ F O R R E S T E R S T R E E T P R O F E S S I O N A L B U I L D I N G • N E W B U R Y P O R T , M A S S A C H U S E T T S • 0 1 9 5 0
P H O N E : 9 7 8 4 6 5 2 1 2 2 • F A X : 9 7 8 4 6 5 0 4 5 0