Foot Health Center of Merrimack Valley, PC

451 Andover Street
Suite 209
North Andover, MA 01845
Phone: (978) 686-7623

1565 Main Street
Suite 102
Tewksbury, MA 01876
Phone: (978) 640-1010

Fax: (978) 683-9911

First Name	MI	Last Name	Generation (Jr, Sr, etc)	Sex at Birth
Date of Birth	Age	Marital Status (Check One) Single ___ Married ___ Divorce ____ Widowed ___		
Street Address		City	State	Zip
Home Phone		Cell Phone	Preferred Contact Method	
Email Address		Primary Language	Race	Ethnicity
Pharmacy Name	Address: Street and City			Phone #
Primary Care Physician	Date Last Seen	Location	Hospital Affiliation	
Who can we thank for referring you to our practice?				
Legal Representative/Responsible Person		Email	Phone Contact #	Contact Preference
Emergency Contact Name		Relationship	Emergency Contact #	

OFFICE POLICY REGARDING INSURANCE

In order to preserve the best possible relationship with you, our patient, and to prevent any misunderstanding, the following is an explanation of our office policy regarding insurance and payment for services rendered.

1. We expect and appreciate payment for office visits at the time of service. We will accept cash, check, Mastercard, Visa, or debit cards.
2. For any insurance plan that requires authorization from a Primary Physician, (HMO, PPO, etc), it is your responsibility, as the patient or guardian, to ensure this office receives all necessary referrals or authorizations prior to treatment. If the insurance carrier denies any charges due to lack of referral authorization, the patient is responsible for all charges incurred.
3. If any supplies are dispensed during your treatment, (i.e. orthotics, accommodative pads, creams, etc.), payment is due at the time of service. We cannot bill you or your insurance company for these supplies.
4. Please note that there is a $45 cancellation fee for failure to cancel 24 hours prior to your scheduled appointment.
5. I have read, understand, and agree with the above policies. I understand that I am financially responsible for any balance due on my account.
6. I acknowledge that I was provided a copy of the Notice of Privacy Practices and was given the opportunity to read it if I so chose.

X _____ _____ _____

Signature of patient or responsible party | Relationship to patient | Date

MEDICAL HISTORY

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

HEART CONDITIONS

High Blood pressure ___ Heart Attack ___ High Cholesterol ___ Mitral Valve Prolapse ____
Pacemaker ___ Other Conditions _____

ARTHRITIS

Rheumatoid ___ Gout ___ Osteoarthritis ___

VASCULAR

Blood Clots/DVT ___ Poor Circulation/PAD ___ Stroke ___ Other _____

GASTROINTESTINAL

Acid Reflux ___ Ulcers ___ Bowel Disorders ___

PYSCHOLOGICAL

Anxiety ___ Depression ___ Drug Dependence ___ Alcohol dependence ___

NEUROLOGICAL

Parkinsons ___ Peripheral Neuropathy ___ Other _____

MISCELLANEOUS

HIV ___ Hepatitis ___ Thyroid Disease ___ Cancer (Type) _____
Kidney Disease ___ Are you on dialysis? ___
Are you Diabetic? ____ Insulin or Non-insulin _____ Last HgA1C _____
Are you Pregnant? Yes ____ No ___
Do you smoke? Yes ___ No ___ If yes, how many packs per day? ____ Date quit smoking _____
Do you drink alcohol? Yes ___ No ___ If yes: Daily ___ Socially ___
Height ____ **Weight** _____ **Shoe Size** ____

WHAT IS YOUR CHIEF FOOT COMPLAINT? _____

MEDICATIONS

Are you taking Aspirin? _____ Are you taking blood thinners? ____
List all medications, prescription and over the counter _____

_____

_____

ALLERGIES

Are you allergic to any of the following?:
Adhesives ___ Codeine ___ Iodine ___ Latex ___ Novacaine ___ Penicillin ___ Cephalosprins ___
Other Allergies _____

I hereby give my permission to the Foot Health Center of Merrimack Valley P. C. to administer treatment and perform such procedures deemed necessary for the diagnosis of my foot condition. I authorize, to the extent necessary, disclosure of medical information to assist in the processing of my insurance claim and to communicate with the treating Physicians. Furthermore, I assign all payment of medical benefits provided by my insurance company for medical/surgical care to the Foot Health Center of Merrimack Valley.
By signing below, I am also giving permission to use electronic systems to view and document my conditions and treatments, as well as, electronically prescribe and verify all medications.

Signature _____ Date _____
(Patient or legal guardian)