New England Foot & Ankle Specialists

Brian D Tedesco, DPM FACFAS, Carl Conui DPM & Dorothy Kurtz Phelan, DPM FACFAS

PATIENT REGISTRATION INFORMATION

PLEASE PRINT CLEARLY

TODAY'S DATE: ____/____/_____ E-MAIL ADDRESS: _____

LAST NAME: _____ FIRST NAME:_____

ADDRESS: _____ APT#_____ CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH: _____/_____/_____ GENDER: MALE / FEMALE RACE: _____

HOME PHONE # (_____) _____ -_____ CELL PHONE # (_____) _____ -_____ OK TO LEAVE MESSAGE Y / N

BEST PHONE TO REACH YOU

PLEASE NOTE EMERGENCY CONTACT _____

RELATIONSHIP TO PATIENT_____ PHONE #_____Cell / Home

EMPLOYMENT,PRIMARY CARE PHYSICIAN AND PHARMACY INFORMATION

OCCUPATION:_____ WHO REFERRED YOU TO US?_____

PRIMARY CARE PHYSICIAN: LAST NAME:_____FIRST NAME:_____

ADDRESS:_____PHONE # (_____) _____ -_____ FAX # (_____) _____ -_____

_____DATE OF LAST VISIT WITH YOUR PCP: _____/_____/_____

Providing Pharmacy Information will allow us to email the prescription directly to your pharmacy

PHARMACY NAME:_____ PHONE # (_____) _____ -_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY:_____

POLICY #_____ GROUP #_____

SUBSCRIBER (IF OTHER THAN PATIENT)

LAST NAME: _____FIRST NAME:_____

ADDRESS: If different_____CITY:_____ STATE: _____ ZIP:_____

PHONE # (_____) _____ -_____ DATE OF BIRTH: _____/_____/_____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____ POLICY #_____

IF THIS IS A WORKERS COMP CASE:

PLEASE PROVIDE CASE #_____

DATE OF INJURY_____ CONTACT PERSON_____

CONTACT PHONE#_____ CONTACT FAX#_____

ADDRESS OF INURANCE_____

COMPANY YOU WORK FOR_____

WHAT THE REASON FOR VISIT?_____

_____ONSET OF PROBLEM_____

ARE THERE ANY OTHER FOOT OR LEG PROBLEMS?_____

FORMER PODIATRIST:_____LAST VISIT DATE: ____/____/_____

Mark the scale to indicate your average pain due to your foot and ankle condition

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

How is your general health? ☐ Good ☐ Fair ☐ Poor

Are you taking any **Medication** at the present time?

_____ _____

_____ _____

_____ _____

_____ _____

Allergies (Please check all that apply)

____No Known Drug Allergies ____Cortisone ____Latex ____Sulfa

____Adhesive Tape ____Demerol ____Local Anesthetics ____Other_____

____Aspirin ____Iodine ____Novocain

____Codeine ____IV Dye ____Penicillin

Past Medical History (Please check all that apply)

____Acid Reflux (Gerd ____AIDS/HIV ____Anemia

____ Arthritis/Osteoarthritis ____ Arthritis/Rheumatoid ____Asthma

____Back Problems ____Bleeding Disorder ____Broken Bones (in foot or legs)

____Cancer ____Cramps or numbness (in foot or legs) ____Depression

____Dermatologic Condition (Skin) ____Diabetes ____DVT (Blood Clot in leg)

____Epilepsy ____Emphysema/COPD ____Fibromyalgia

____Gout ____Heart Disease ____Hepatitis

____High Blood Pressure ____High Cholesterol ____Kidney Trouble_____

____Liver Disease/Hepatitis/Cirrhosis ____Multiple Sclerosis ____Osteoporosis

____Parkinson's ____Peripheral Arterial Disease ____Peripheral Neuropathy

____Phlebitis ____Raynaud's Disease ____Rheumatoid Arthritis

____Sickle Cell Anemia/Trait ____Sleep Apnea ____Stroke

____Thyroid Condition ____Varicose Veins ____Other _____

Your HEIGHT:_____ Your WEIGHT:_____ SHOE SIZE:_____

Have your ever been hospitalized: _____ Yes _____No

Do you smoke?_____ Yes _____No If so, how many a day?_____

Alcohol consumption _____Light _____Moderate _____Heavy _____None

Have you ever had surgery: _____Yes _____No If YES, what type of surgery and when_____

Is there a family history of:

DIABETES _____YES _____NO HEART DISEASE _____YES _____NO CANCER_____YES _____NO

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Acknowledgement of receipt of Notice of Privacy Practices

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.

Patient Name:_____
(Please Print)

Date:_____

Parent or Authorized Representative:_____
(If applicable)

X Signature:_____

Assignment of Benefits:

I, the undersigned, have health insurance. I assign directly to: Brian D Tedesco, DPM & George A Abboud, DPM Dba/New England Foot & Ankle Specialists, all medical benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic to any insurance I have at this point or in the future.

X Signature:_____ **Date:**_____

MEDICAL RELEASE AUTHORIZATION

I give permission to release my medical information to: (such as a family member, friend, other doctor, etc.)

1. _____
   (First & Last Name)

2. _____
   (First & Last Name)

3. _____
   (First & Last Name)

X Signature:_____ **Date:**_____

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Phone: (781) 944-4044 Fax: (781) 944-4050

255 Main Street, Unit 1, Nashua, NH 03060
Phone: (603)459-8760 Fax: (603) 459-8758

APPOINTMENT CANCELLATION, NO-SHOWS AND RESCHEDULE POLICY

Our practice is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. In order to be respectful of the medical needs of other patients we ask that you kindly adhere to our cancellation policy.

Please call us at at least twenty-four hours prior to your scheduled appointment to notify us of any changes or cancellations. For example, If you have a 10:00 am appointment, you must call by 10:00 am the day before your appointment. To cancel a Monday appointment, please call our office by 3:00 pm the Friday before. **If you cancel or reschedule with less than a 24-hours' notice, you will be charged a fee of $50 for the missed appointment.**

Please sign below to consent to these terms.

_____ _____

Print Name Signature

_____

Date