

New England Foot & Ankle Specialists
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 INSURANCE _____

COMPANY YOU WORK FOR _____

WHAT IS THE CHIEF COMPLAINT? _____

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)

- | | | | |
|--|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> No Known Drug Allergies | <input type="checkbox"/> Cortisone | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Demerol | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Novocain | |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> IV Dye | <input type="checkbox"/> Penicillin | |

Past Medical History (Please check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Acid Reflux (Gerd) | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Arthritis/Osteoarthritis | <input type="checkbox"/> Arthritis/Rheumatoid | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Broken Bones (in foot or legs) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cramps or numbness (in foot or legs) | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Dermatologic Condition (Skin) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> DVT (Blood Clot in leg) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Trouble _____ |
| <input type="checkbox"/> Liver Disease/Hepatitis/Cirrhosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Peripheral Arterial Disease | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Sickle Cell Anemia/Trait | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Other _____ |

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

Have you 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:** _____

New England Foot & Ankle Specialists
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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 (781) 944-4044 ext 1 at least twenty-four hours prior to your scheduled appointment to notify us of any changes or cancellations. 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