David H. Greenblott, D.P.M.

Podiatric Medicine & Surgery

PATIENT REGISTRATION FORM

Personal Information

Patient First Name: _____ Patient Last Name: _____
Street Address: _____ City/State/ Zip _____
Home Phone: ( ) ___-_____ Work/Cell Phone: ( ) ___-_____ ( ) ___-_____
Date of Birth ___-_____-_____ Social Security Number _____-_____-_____
Sex: M / F (circle one) E-Mail _____
How did you hear about Merrimack Valley Foot Specialists? PCP Friend Relative Yellow Pages Internet Other? _____
Primary Care Physician Name, Address and Phone # _____
_____
Person responsible for bill or parent (complete only if different from patient)
Guarantor Name: _____ Social Security Number ____-____-_____
Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent's date of birth ___-___-____
Street Address: _____ City/State/Zip _____

PRIMARY MEDICAL INSURANCE INFORMATION

Plan Name: _____ ID Number _____
Address: _____ Group Number _____
Policy Holder: _____ Effective Date _____

IS A REFERRAL REQUIRED BY YOUR INSURANCE COMPANY? _____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ ID Number _____
Address: _____ Group Number _____
Policy Holder: _____ Effective Date _____

I fully understand and agree that health insurance policy agreements are between insurance companies and myself. Furthermore I understand that David H. Greenblott D.P.M. will prepare and submit any necessary reports, forms, and other insurance information required by my carrier. Any amount authorized to be paid directly to David H. Greenblott D.P.M. will be credited to my account upon receipt.

I understand that it is my responsibility to obtain a referral from my primary care physician and any services that deny for not having a referral are my responsibility.

I authorize the release of any medical information necessary to process my claim to the insurance company only, to pay David H. Greenblott D.P.M. for his services rendered to me. I have read and agree that all the conditions in this document and attest to the truth of all information in this document.

Patient or Responsible Party Signature _____ Date _____

Merrimack Valley Foot specialists, Inc.
David Greenblott D.P.M.
Podiatric Medicine & Surgery

Insurance Agreement

I fully understand and agree that health insurance agreements are between insurance companies and myself. Furthermore understand that Dr. David Greenblott will prepare and submit any necessary forms, and other insurance information required by my carrier. Any amount authorized to be paid directly to Dr. David Greenblott will be credited to my account upon receipt for all visits.

I understand that it is my responsibility to obtain a referral from my primary care physician and any services that deny for not having a referral are my responsibility for all visits.
I authorize the release of any medical information necessary to process my claim to the insurance company only, to pay Merrimack Valley Foot Specialists for services rendered to me. I have read and agree that all the conditions in this document and attest the truth of all information in this Document.

Patient or Responsible Party Signature_____

Date_____

MEDICAL HISTORY INITIAL VISIT

PATIENT: _____ DATE_____

Describe your foot problems and/or symptoms:

1.) _____

How long have you had this problem? _____ Days Weeks Months

2.) Describe any past problems with your feet or ankles

_____

_____

List any past surgical procedures on your feet or ankles and approximate dates:

1.) _____ Date: _____
2.) _____ Date: _____
3.) _____ Date: _____

Shoe size: _____ Special shoes? _____ Current weight: _____ Height _____

Do you use (Y or N) Walker ____ Crutches ____ Cane ____ Wheel Chair _____

Are you allergic or sensitive to:

Antibiotics: (Penicillin, Sulfa drugs etc. if yes please list: _____

_____

Anti-inflammatory medicines: (Naprosyn, Vioxx, Voltaren, etc. _____

_____

Over the counter pain relievers: (Motrin, Aleve, Tylenol, Advil, etc. _____

_____

Other medicine allergies: _____

Any problems with local anesthetics (Novacaine, Lidocaine, etc. (Y) (N)

Patient: _____ Date: _____

Do you have or have you had any of the following conditions? Y N

_____ High Blood Pressure	_____ Arthritis	_____ Leg Cramps
_____ Heart Disease	_____ Gout	_____ Varicose veins
_____ Poor Circulation	_____ Visual problems	_____ Blood clots
_____ Stomach Ulcers	_____ Anemia	_____ Stroke
_____ Kidney Disease	_____ Skin Problems	_____ Cancer
_____ Toenail Problems	_____ Asthma	_____ Seizures
_____ Joint Replacement	_____ Night Sweats	_____ Cold Feet
_____ Ankle/Foot Swelling	_____ Foot Tingling	_____ Lung Disease

Do you have Diabetes? Y N If yes, do you take insulin? Y N

When diagnosed _____ Treating physician _____

Date of last treatment: _____

List any serious illness (last 10 years) _____

_____

_____

List any major surgeries (last 10 years) _____

_____

_____

Are you presently under a physician's care Y N If so, please List the condition being treated and the physician

Condition: _____ Physician _____

Condition _____ Physician _____

Patient _____ Date _____

What medications do you take regularly?_____

_____

_____

Social History: Marital Status S M W D
Employment status: FT PT Unemployed Retired
Do you smoke: Y N If so, number of packs per day _____
Have you previously smoked: Y N When did you quit _____ How many packs? _____
Do you smoke cigars, pipes or use smokeless tobacco products? Y N
Do you exercise? Y N If so, describe activities and frequencies

_____

_____

Family History:
Mother: Living _____ Deceased _____ Cause of death _____
Father: Living _____ Deceased _____ Cause of death _____
Brother: Living _____ How many living _____ Deceased _____ Causes of death _____
Sister: Living _____ How many living _____ Deceased _____ Causes of death _____

_____

_____

Any family history of the following diseases?	If so, which family member?		
Heart disease	M F B S	Arthritis	M F B S
Cancer	M F B S	Bleeding disorder	M F B S
Diabetes	M F B S	Stroke	M F B S
Neurologic disorder	M F B S	Circulation problems	M F B S
High Blood Pressure	M F B S	Vascular disorders	M F B S

Merrimack Valley Foot Specialists

Review of Symptoms
Please check any of the following that currently apply to you:

Constitutional:
( ) Fever
( ) Chills
( ) Head injury
( ) Weight loss, cause unknown
( ) Dizziness
( ) Appetite loss

HEENT:
( ) Glasses
( ) Double vision
( ) Ringing in ears
( ) Mouth sores
( ) Glaucoma
( ) Blurred vision
( ) Poor hearing
( ) Dry mouth
( ) Cataracts
( ) Balance loss
( ) Nose bleeds
( ) Sore throat

Cardiovascular
( ) Shortness of breath
( ) Chest pain
( ) Irregular heart beat
( ) High blood pressure
( ) Varicose veins
( ) Peripheral vascular disease
( ) Leg pain
( ) Palpitations
( ) Cold feet

Respiratory:
( ) Blood in sputum
( ) Night sweats
( ) Prolonged cough
( ) SOB on exertion
( ) Anorexia
( ) SOB lying down

Gastrointestinal:
( ) Nausea
( ) Hepatitis
( ) Blood in stool
( ) Vomiting
( ) Gallbladder disease
( ) Stomach pain
( ) Heartburn
( ) Ulcer (s)
( ) Hernia

Integumentary:
( ) Skin ulcers
( ) Skin discoloration
( ) Unexplained bruising
( ) Toenail problems
( ) Rash
( ) Open sores

Neurological:
( ) Loss of sensation
( ) Numbness
( ) Burning sensation
( ) Seizures
( ) Tingling
( ) Tremors

Initial history reviewed by: _____ Date: _____

Name_____ Date_____

Do I Need a Test For PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain and kidneys, become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing of leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly higher risk of stroke and heart attack. Answers to these questions will help determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check All Applicable Boxes

1. Do you have foot, calf, buttock, hip or thigh discomfort (aching, fatigue, tingling, cramping or pain) when you walk which is relieved by rest? 443.9 ☐
2. Do you have a history of cardiovascular disease or diabetes and experience any pain or swelling at rest in your lower legs or feet? 440.22 ☐
3. Do you have a history of cardiovascular disease or diabetes and experience any leg, foot, or toe pain that often disturbs your sleep? 440.22 ☐
3. Do you have an ulcer on your thigh, calf, ankle, foot or toe that is slow to heal? 707.14 ☐
4. Do you have diabetes and unusual hair loss or skin discoloration in your legs? 250.70 ☐
5. Do your fingers or toes feel numb or cold in response to temperature changes or stress? 443.0 ☐
6. Have you suffered a severe injury to your leg(s) or feet? 904.8 ☐
7. Do you have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)? 440.24 ☐

Other Comments or Notes: _____

_____

_____

Patient Signature:_____ Date:_____

Note: *Providers are advised that insurance carriers have medical necessity policies regarding when diagnostic services are considered medically necessary. These policies may vary between carriers and are subject to change at any time. Providers should check coverage requirements with specific insurance plans before testing.*