NEW PATIENT ENROLLMENT FORM

MA Foot and Ankle Specialists, 53 Main St., Somerville, MA, 02145

NH FOOT AND ANKLE, 25 Buttrick Rd., Londonderry, NH, 03053

Patient Information

Name:_________________________DOB____________

Address:_______________________________________

Telephone Contact:______________________________

In Case of Emergency,

Please Contact:_____________________Relationship:_______________________

Home Phone: _____________________

Insurance Information

I certify that I do currently have insurance coverage with:______________________and assign directly to Dr. ______________________. I understand that I am financially responsible for all charges whether or not paid by my insurance plan. The above named physician my use my medical information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr. ________________________ for any services rendered to me by my provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Medicare Beneficiary, Guardian or Representative_______________________Date: _________________

Name (Please Print) of Medicare Beneficiary, Guardian or Representative______________________________

MEDICAL HISTORY: Please List Below any Medical Condition for which you are under any form of treatment or taking any type of medication, whether prescribed, over the counter (OTC), or homeopathic remedy or supplement.

______________________________ ___________________________

______________________________ ___________________________

______________________________ ____________________________

______________________________ ____________________________

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SUGICAL PROCEDURES: Please list all medical procedures you have had.

_____________________________ ___________________________

_____________________________ ___________________________

_____________________________ ___________________________

MEDICATIONS

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TOBACCO USE: ___Y ___N

Alcohol: ___Y ___N

Recreational Drugs: ___Y___N

ALLERGIES

No Known Drug Allergies (NKDA)_____

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TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

DATE: ____________ Name of Patient, Guardian or Representative:_____________________

Signature of Patient, Guardian or Representative:_________________________________