# MERRELL PODIATRY

DR. TRACY MERRELL, D.P.M.
DR. JILLIAN TESLOW, D.P.M.

NAME _____

DOB _____ SOCIAL SECURITY # _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE (HOME) _____ (CELL) _____ (WORK) _____

EMAIL _____

EMERGENCY CONTACT _____ PHONE _____

EMPLOYER_____ PHONE _____

INSURANCE CO._____ ID # _____

NAME OF INSURED _____

DOB (IF NAME ON CARD IS NOT PATIENT'S) _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

PHARMACY_____ LOCATION _____

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We will file primary and secondary claims at no charge. Delinquent accounts will be responsible for collection expense and attorney fees.

__ I authorize use of this form on all my insurance submissions.
__ I authorize release of information to all my insurance companies.
__ I understand that I am responsible for my bill.
__ I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
__ I authorize payment direct to my doctor.
__ I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____ Date: _____

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AGE: _____ HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____

Where is the pain? Left foot_____ Right foot_____ Both feet_____ No pain_____ Other_____

Describe the pain: (sharp, dull, shooting, throbbing, aches) _____

When is it painful? _____

How long has it been painful? _____ Is it related to an injury? _____

What medications have you tried for this problem? Did they help? _____

_____

What treatments have you tried for this problem? Did they help? _____

_____

Current medications: (Dosage and how often) _____

_____

Drug allergies: _____

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Past Medical History: (circle all that apply)

| | |
|---|---|
| Diabetes Type 1/Type 2 | HIV/AIDS |
| High Blood Pressure | Gout |
| Heart Problems | Cancer |
| Osteoarthritis | Asthma |
| Blood Clots | Bleeding Disorder |
| Stomach Problems | Liver Disease |
| Kidney Problems | Circulatory Problems |

Social History

Tobacco Use _____pk/day _____yrs
Alcohol Use _____ per day/week
Recreational Drug Use _____
Exercise _____
Occupation _____

Past Surgical History:

_____

_____

Family Medical History:

Mother: _____

Father: _____

Patient Signature: _____ Date: _____

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- NEW PATIENTS MUST PRESENT ALL INSURANCE CARDS AND PHOTO ID AT THE TIME OF THEIR APPOINTMENTS. WITHOUT THIS INFORMATION, YOU WILL NOT BE ABLE TO BE SEEN THAT DAY.

- IF IT HAS BEEN A YEAR OR MORE SINCE YOUR LAST VISIT YOU MUST UPDATE YOUR INFORMATION AND PRESENT YOUR INSURANCE CARDS AND PHOTO ID SO WE CAN MAKE A NEW COPY.

## CANCELLATION AND NO-SHOW POLICY

We understand that circumstances could prevent a patient from cancelling their appointment within a 24-hour period. If you do need to cancel, please cancel as soon as possible so we can reschedule your time slot. “No-shows” will be sent a bill for $50 – no exception.

Patient Signature: _____ Date: _____

## CONSENT TO RECEIVE CALLS/TEXT TO CONFIRM APPOINTMENTS

I give my consent to receive automated text messages or calls to remind me of scheduled upcoming appointments at Merrell Podiatry. *Please provide a correct phone number for this service. *

Patient Signature: _____ Date: _____

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Merrell Podiatry’s NOTICE OF PRIVACY PRACTICES. The notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Drs. Merrell and Teslow’s health care operations. The notice of privacy practices also describes my right and Drs. Merrell and Teslow’s duties with respect to protected health information. The notice of privacy practices is posted in the office waiting area.

Merrell Podiatry reserves the right to change the privacy practices that are described in the notice of privacy practices. I may obtain a notice of privacy practices by calling the office and requesting a revised copy by mail or at the time of next appointment.

Patient Signature: _____ Date: _____