WELCOME TO
MARK T. GRUSSO, D.P.M.
FOOT & ANKLE SPECIALIST

Mark T Grusso, DPM

409 Coventry Drive
Phillipsburg, NJ 08865
(908) 213-0029
(908) 213-9393 Fax

Marc J Berman, DPM

315 Rt. 31 South
Washington, NJ 07882
(908) 213-0029
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____
Patient's Name **Sex** **(Age)**

____
Home Address **City** **State** **Zip**

________________________ ________________________ ________________________
Phone # **Work #** **Cell #**

____
Social Security # **Date of Birth**

Email address____

____ ______________________
Responsible Party if Patient is a Minor **Relationship**

____ ______________________
Address **City, State, Zip** **Phone**

____ ________________________ ____________
Spouse's Name **Spouse's Phone** **Date of Birth**

____ ______________________
Spouse's Address if Different **City, State, Zip** **Phone#**

Who Referred You to this Office?
Primary Physician_____ Relative_____ Friend______ Website ____
Advertisement _____ Other_____

__________________________ ________________________ ______________________
Emergency Contact **Phone #** **Relationship**

Marital Status ___Single ____Married ____Widowed ____Divorced

Race (optional) ____Caucasian ___Hispanic ____African American ____Asian

Nationality ____American ____Puerto Rican ____Italian ____Indian ___Other

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NEW PATIENT HISTORY

Patient Name ____ Date ______________

Briefly describe your foot problem ____

____

Duration of this problem ____

Have you been treated for this problem before? ___ Yes ____No

If yes, briefly describe past treatment____

____

Have you ever had foot surgeries? ____Yes ___No If yes, when________________________

Please provide us with the contact information of the other doctors that you see on a regular basis so we can send them reports about your condition and the treatment you are receiving here. Please fill in as much of the information as you can so we can easily communicate with your other doctors.

Family Doctor: ____Last Seen: _______________

Address: ____

Phone #: ____

Rheumatologist: ____

Endocrinologist: ____

Other Specialist: ____

Pharmacy: ____________________________________ Location__________________________________

Participating Laboratory: ____

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MEDICAL HISTORY

Place a mark on “Yes” or “No” to indicate if you have had any of the following:

	YES	NO
AIDS/HIV	____	____
Allergies to Medicine or Drugs	____	____
Allergies to Anesthetics	____	____
Anemia	____	____
Arthritis	____	____
Angina/Cardiac Problems	____	____
Artificial Heart Valves or Joints	____	____
Circulatory Problems	____	____
Diabetes	____	____
Foot or leg Cramps/Sciatica	____	____
Hemophilia	____	____
High Blood Pressure	____	____
Hepatitis or Jaundice	____	____
Liver Disease	____	____
Kidney Problems	____	____
Phlebitis	____	____
Stroke	____	____
Tuberculosis	____	____
Ulcers	____	____
Varicose Veins	____	____
Venereal Disease	____	____
Current Smoker	____	____
Ever a smoker	____	____

ALLERGIES

Place a mark on “Yes” or “No” to indicate if you allergic to:

	YES	NO
Adhesive/Tape	____	____
Aspirin	____	____
Local Anesthetics	____	____
Latex	____	____
Penicillin	____	____
Codeine	____	____
Iodine	____	____
Novocain	____	____
Sulfa	____	____
Seafood	____	____

Other____

Please list all current medications, prescription and over-the-counter medications and vitamins you take (Please include oral contraceptives)

____

____

____

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OUR FINANCIAL POLICY

Thank you for choosing us as your podiatric health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of Our Financial Policy which we require you to read and sign prior to any treatment. Financial arrangements can be made in one of the following two ways:

INSURANCE

As a courtesy to you, we will bill your insurance company for services rendered. **60 days are allowed for processing by the insurance company, any unpaid claims are your financial responsibility.** For regular office visits and treatments, we require payment of your co-payment and/or unpaid deductibles at the time of services are rendered. If you become delinquent, your account(s) are subject to collection procedures.

CASH

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, check, or credit card.

SUPPLIES

All patients are financially responsible for dispensed supplies.

I understand and certify that I (or my dependent) have insurance coverage and assign directly to Mark Grusso, D.P.M., P.C. all insurance benefits, in 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 insurance submissions.

Signature of Insured or Responsible Party ____

Date ____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Co ____

Subscriber ___**Self** ____**Spouse** ____**Other**

Subscriber Name____

Subscriber Address____

____

Subscriber DOB_________________________ **Subscriber SS#**_____________________________________

Subscriber Employer____

Employer Address____

Employer Phone #____

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Co____

Subscriber ___**Self** ____**Spouse** ____**Other**

Subscriber Name____

Subscriber Address____

____

Subscriber DOB_________________________ **Subscriber SS#**_____________________________________

Subscriber Employer____

Employer Address____

Employer Phone #____