PATIENT REGISTRATION FORM

Todays Date:_______________

Patient Name:____

First M Last

Date of Birth:___________________

Address:____

Social Security# ___ ___ ___ - ___ ___ -___ ___ ___

Home Phone: ( )__ ___ ___ - ____ ____ ____ ____

Cell Phone: ( )__ ___ ___ - ____ ____ ____ ____

Consent to TEXT or CALL for Appointment and or Portal updates? YES // NO

Email Address:____

Pharmacy:____

Primary Care Physician:____

Insurance Provider:______________________________**ID#**______________________________

Secondary Insurance Provider:______________________________**ID#**______________________________

In case of Emergency contact Name:_______________________________________

Relationship to patient:_____________________ **Phone#:(** **)** __ __ __- __ __ __ __

The above information is to the best of my knowledge. I authorize my insurance benefits will be paid directly to the Physician(s). I understand that I am financially responsible for any balance remaining. I also authorize New Age Foot & Ankle Surgery L.L.C or insurance company to release any information required to process my claims.

Patient/Legal Guardian Signature:____**DATE:**__________________

HEALTH HISTORY QUESTIONNAIRE

Patient Name:____________________________________ **Date of Service:**_________________
Patient DOB:______________________ **Please choose provider:** Dr. Avery Dr. Khan Dr. Shah

REASON FOR VISIT:____

VITALS : Height:_________ **Weight:**_________

SHOE SIZE:____________ **FIT:** REG NARROW WIDE

ALLERGIES:____

____

PATIENT MEDICAL HISTORY:
High Blood Pressure Diabetes TYPE 1 Diabetes TYPE 2 Cancer High Cholesterol Arthritis Heart Disease Asthma
MEDICATIONS:____

____

FAMILY MEDICAL HISTORY:
MOTHER: High Blood Pressure Diabetes TYPE 1 Diabetes TYPE 2 Cancer High Cholesterol Arthritis Heart Disease Asthma
FATHER: High Blood Pressure Diabetes TYPE 1 Diabetes TYPE 2 Cancer High Cholesterol Arthritis Heart Disease Asthma
GRANDPARENTS: High Blood Pressure Diabetes TYPE 1 Diabetes TYPE 2 Cancer High Cholesterol Arthritis Heart Disease Asthma
SIBLING(S): High Blood Pressure Diabetes TYPE 1 Diabetes TYPE 2 Cancer High Cholesterol Arthritis Heart Disease Asthma

Smoking Status: YES // NO **(If yes, how long?)**________________________________

Alcohol Status: HEAVY OCCASSIONAL MODERATE NONE

SURGICAL HISTORY:____

____

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name:_______________________ **Date Of Birth:**________________
First MI Last

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to New Age Foot & Ankle Surgery or the physician for my services rendered to my dependents or me by the physician or under their supervision. I understand that it is my responsibility to know my insurance benefits. I understand and agree that I will be responsible for any co-pay or balance due to New Age Foot & Ankle Surgery.

MEDICARE/MEDICAID/ CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me under these programs is correct. I authorize the release of any of my, or my dependent's records to New Age Foot & Ankle Surgery that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to New Age Foot & Ankle Surgery or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the New Age Foot & Ankle Surgery Patient Information Privacy Policy. I hereby authorize New Age or the physician to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of mail, phone calls and email. I hereby authorize New Age Foot & Ankle Surgery or physician to mail, call or email me with communications regarding my healthcare. This includes but not limited to appointment reminders, referral arraignments and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying New Age Foot & Ankle Surgery.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, X-RAY or other diagnostic services. I further understand that I am financially responsible for any co-pay balance due for those services.

CONSENT TO TREATMENT:
I hereby consent to an evaluation, testing and treatment as directed by New Age Foot & Ankle Surgery physician or his designee.

PATIENT SIGNATURE:_____________________________ DATE:_________________
GUARANTOR SIGNATURE:__________________________ DATE:_________________
GUARANTOR NAME (PRINT):_______________________

NEW AGE
FOOT & ANKLE
SURGERY

NAFA Participant
Arrival Screening for COVID-19

Patient Name & DOB:________________________________	Date of Service:______________

Q1	In the last 2 weeks, have you been in contact with someone who was confirmed or suspected to have COVID-19?	Yes or No
Q2	Have you traveled outside of VA in the last 2 weeks?	Yes or No
Q3	Have you had any Flu/Cold like symptoms in the past 10 days?	Yes or No
Q4	Do you or someone you live with have a respiratory illness?	Yes or No

NEW AGE
FOOT & ANKLE
SURGERY

Patient Name: DOB:	
1. Do you experience any pain in your legs or feet while at rest?	Yes No
2. Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip, or thigh during walking/exercising?	Yes No
3. IF yes to question TWO, does the pain go away when you stop walking/exercising?	Yes No
4. Do your feet get pale, discolored, or bluish at any time during the day?	Yes No
5. Do you have an infection, skin wound, or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	Yes No
6. Are you over the age of 65?	Yes No
7. Are you over the age of 50?	Yes No
8. Do you have high cholesterol or other lipid (fat) problems or require cholesterol medication?	Yes No
9. Do you have high blood pressure or take medication to reduce blood pressure?	Yes No
10. Do you have diabetes?	Yes No
11. Do you have a history of chronic kidney disease?	Yes No
12. Do you currently or have you ever smoked?	Yes No
13. Do you have history of stroke or mini-stroke (TIA)	Yes No
14. Do you have a history of carotid stenosis, AA (Abdominal aortic aneurysm), and/or stent placement?	Yes No
15. Other:	