NEW AGE
FOOT & ANKLE
SURGERY

PATIENT REGISTRATION FORM

Date of Service:_____

Patient Name: _____

Date of Birth: _____/_____/_____

Social Security #: _____ - _____ - _____

Mailing Address: _____

Home Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____

Email Address: _____

Primary Care Physician: _____

Pharmacy Name: _____

Emergency Contact: _____

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 LLC or insurance company to release any information required to process my claims.

Patient/Legal Guardian Signature: _____ Date: _____

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HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ **Date of Service:** _____

Reason for your visit: _____

Height: _____ **Weight:** _____

Shoe Size: _____ **Fit:** **Normal** **Narrow** **Wide**

Allergies: _____

Patient Medical History:

High Blood Pressure **Diabetes Type 1** **Diabetes Type 2** **Cancer**

Asthma **Heart Disease** **High Cholesterol** **Arthritis**

Medications: _____

Surgical History: _____

Family Medical History:

Mother: **High Blood Pressure** **Diabetes Type 1** **Diabetes Type 2**
Cancer **Asthma** **Heart Disease** **High Cholesterol** **Arthritis**

Father: **High Blood Pressure** **Diabetes Type 1** **Diabetes Type 2**
Cancer **Asthma** **Heart Disease** **High Cholesterol** **Arthritis**

Siblings: **High Blood Pressure** **Diabetes Type 1** **Diabetes Type 2**
Cancer **Asthma** **Heart Disease** **High Cholesterol** **Arthritis**

Grandparents: **High Blood Pressure** **Diabetes Type 1** **Diabetes Type 2**
Cancer **Asthma** **Heart Disease** **High Cholesterol** **Arthritis**

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

Alcohol Status: **HEAVY** **OCCASSIONAL** **MODERATE** **NONE**

DISCLOSURES & CONSENTS

Patient Name: _____ DOB: _____

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 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 my, or my dependents records to New Age Foot & Ankle Surgery that these programs may request. I herby direct that payment of my, or my dependents 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 herby authorize New Age Foot & Ankle Surgery or physician to mail, call or email me with communication regarding my healthcare. This includes but is 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 for my medical care to include labs, 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 a New Age Foot & Ankle Surgery physician or his designee.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____

GUARANTOR NAME (PRINT): _____

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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 # 2, does the pain go away when you stop walking/exercising?	**YES NO**
4. Do your feet get pale, discolored or bluish at any time of 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 a 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:	