New England Foot & Ankle Specialists

Brian D Tedesco, DPM FACFAS, Carl Conui, DPM, Daphne Robert, DPM

NEW PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

TODAY'S DATE: ____/____/_____ E-MAIL ADDRESS: _____

LAST NAME: _____ FIRST NAME:_____

ADDRESS: _____ APT#_____ CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH: _____/_____/_____ GENDER: MALE / FEMALE RACE: _____

HOME PHONE # (_____) _____ -_____ CELL PHONE # (_____) _____ -_____ OK TO LEAVE MESSAGE Y / N

PLEASE NOTE EMERGENCY CONTACT _____

RELATIONSHIP TO PATIENT_____ PHONE #_____Cell / Home

EMPLOYMENT,PRIMARY CARE PHYSICIAN AND PHARMACY INFORMATION

OCCUPATION:_____ WHO REFERRED YOU TO US?_____

PRIMARY CARE PHYSICIAN: LAST NAME:_____FIRST NAME:_____

ADDRESS:_____PHONE # (_____) _____ -_____ FAX # (_____) _____ -_____

_____DATE OF LAST VISIT WITH YOUR PCP: _____/_____/_____

Providing Pharmacy Information will allow us to send prescriptions directly to your pharmacy

PHARMACY NAME:_____ PHONE # (_____) _____ -_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

INSURANCE INFORMATION

INSURANCE COMPANY: _____

POLICY/ID #:_____GROUP #:_____

SUBSCRIBER: _____

SECONDARY INSURANCE (IF APPLICABLE) _____

WORKERS COMP CASE?_____

REASON FOR APPOINTMENT: _____

_____ONSET OF PROBLEM_____

ANY OTHER FOOT OR LEG PROBLEMS? _____

FORMER PODIATRIST: _____LAST VISIT DATE:____/____/_____

Mark the scale to indicate your average pain due to your foot and ankle condition

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Are you taking any **Medication** at the present time? If so, please list below

_____ _____
_____ _____
_____ _____
_____ _____

Allergies (Please check all that apply)

____No Known Drug Allergies ____Cortisone ____Latex ____Sulfa
____Adhesive Tape ____Demerol ____Local Anesthetics ____Other_____
____Aspirin ____Iodine ____Novocain
____Codeine ____IV Dye ____Penicillin

Past Medical History (Please check all that apply)

____Acid Reflux (Gerd ____AIDS/HIV ____Anemia
____ Arthritis/Osteoarthritis/Rheumatoid ____Lyme Disease ____Asthma
____Back Problems ____Bleeding Disorder ____Broken Bones (in foot/legs)
____Cancer ____Cramps or numbness (in foot or legs) ____Depression
____Dermatologic Condition (Skin) ____Diabetes ____DVT (Blood Clot in leg)
____Epilepsy ____Emphysema/COPD ____Fibromyalgia
____Gout ____Heart Disease ____Hepatitis
____High Blood Pressure ____High Cholesterol ____Kidney Disease
____Liver Disease/Hepatitis/Cirrhosis ____Multiple Sclerosis ____Osteoporosis
____Parkinson's ____Peripheral Arterial Disease ____Peripheral Neuropathy
____Phlebitis ____Raynaud's Disease ____ Rheumatoid Arthritis
____Sickle Cell Anemia/Trait ____Sleep Apnea ____Stroke
____Thyroid Condition ____Varicose Veins ____Other _____

Your HEIGHT: _____ Your WEIGHT: _____ SHOE SIZE:_____

Are you a smoker? _____Yes _____No If so, how many packs a day? _____

Alcohol consumption _____Light _____Moderate _____Heavy _____None

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Past Surgical History (please list including approx. dates) _____

_____

_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

Acknowledgement of receipt of Notice of Privacy Practices
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read
(or had the opportunity to read, If I so chose) and understood the notice.

X Signature: _____Date:_____

ASSIGNMENT OF BENEFITS:

I, the undersigned, have health insurance. I assign directly to: Brian D Tedesco, DPM & George A Abboud, DPM Dba/New England Foot & Ankle Specialists, all medical benefits, If 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 of my insurance submissions whether manual or electronic to any insurance I have at this point or in the future.

X Signature: _____ **Date:** _____

MEDICAL RELEASE AUTHORIZATION:

I give permission to release my medical information to: (such as a family member, friend, other doctor, etc.)

1. _____
   (First & Last Name)

2. _____
   (First & Last Name)

3. _____
   (First & Last Name)

X Signature: _____ **Date:**_____

APPOINTMENT CANCELLATION, NO-SHOWS AND RESCHEDULE POLICY

Our practice is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, it prevents another patient from being seen. In order to be respectful of the medical needs of other patients we ask that you kindly adhere to our cancellation policy.

Please call us at least twenty-four hours prior to your scheduled appointment to notify us of any changes or cancellations. For example, if you have a 10:00 am appointment, you must call by 10:00 am the day before your appointment. To cancel a Monday appointment, please call our office by 3:00 pm the Friday before. **If you cancel or reschedule with less than a 24-hours' notice, you will be charged a fee of $50 for the missed appointment.**

Please sign below to consent to these terms.

X Signature: _____ **Date:**_____