

New England Foot & Ankle Specialists

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

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:** \_\_\_\_\_