FOOT & ANKLE

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I.,Last:*) _____

Date of Birth: _____ Age: _____ M / F Marital Status: S / M / W / D

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Social Security #: _____-_____-_____

Referring Physician (if applicable): _____

Emergency Contact: _____ Relation: _____ Phone Number: _____

Responsible Party(if other than patient)

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Address (if different):_____ City: _____ State: _____ Zip Code: _____

Phone Number: _____

Employer: _____ Phone Number: _____

Primary Insurance Information

Insurance Company: _____ Phone Number: _____

ID or Member Number: _____ Group Number: _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

Secondary Insurance Information

Insurance Company: _____ Phone Number: _____

ID or Member Number: _____ Group Number: _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

I hereby assign, transfer, and set over to Foot & Ankle Surgery of New Braunfels all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____

Foot & Ankle Surgery of New Braunfels
2115 Stephens Place, Ste. 930
New Braunfels, TX 7810

Phone: (830) 387-4427 Fax: (830) 387-4328

OFFICE AND COLLECTION POLICIES

Office Visits *Office Hours*: Monday-Friday: 8:00am-5:00pm, closed for lunch 12:00pm-1:00pm

We request that you make appointments for all your visits and be aware of the office hours. Our philosophy is to provide you the highest quality care. Always bring a current list of all your medications with the exact dosages, to each office visit. We know that your time is as valuable as ours and we make every effort to keep our schedule on time. Please notify us in advance if you are unable to keep your appointment. Appointments not cancelled 24 hours in advance to the scheduled appointment time may be subject to a cancellation fee of $25 per office visit. Extenuating circumstances will be taken into consideration. After three "No Shows" for your scheduled appointments, you will be considered noncompliant and qualify for termination from the practice.

Telephone Calls: Our staff will be happy to answer your questions about office policy and scheduling. A receptionist however does not answer calls before or after hours or during lunch. Medical questions will be referred to one of our experienced medical assistants or one of the doctors. During clinic a medical assistant is NOT available to speak with, but will return messages as soon as possible. Extended phone consults or after hours and weekend calls resulting in telephone treatment may be billed a telephone visit from $10.00-$35.00. After Hours Calls: All routine matters should be handled during regular office hours. However, a physician from our call group can be reached at all times. If you believe your situation is critical, always go to an emergency room where the physicians there can assist you. Otherwise, call our office first before going to the emergency room – many problems can be handled over the telephone.

Refill Request: Please contact your pharmacy for prescription refill requests. Each request may take 24-48 hours to complete. You will be notified if an appointment is required for a medication refill. A standard 90 day follow-up is required for certain prescriptions we choose to monitor. We are NOT a liberal prescribing practice and do intensely monitor the prescriptions that we issue. Please be aware that we will delay a prescription until we feel it is safe and needed.

Privacy and Security: Foot & Ankle Surgery of New Braunfels holds all information pertaining to the care and treatment of our patients in the strictest confidence. All information in the patient's medical record is maintained with the utmost care and respect to preserve privacy and confidentiality. The practice fully complies with the Federal Government's mandated HIPAA requirements and all guidelines for patient confidentiality and privacy of healthcare and financial information. As a new patient, you will be asked to review and acknowledge receipt of our Notice of HIPAA Privacy Practice that outlines the circumstances for which we can disclose protected health information without authorization. Only patient can provide the authorization to release records necessary for the practice to disclose protected health information for instances not related to your ongoing treatment and/or payment of claims. A patient may request to view a copy of their medical records in the office. We do also require consent to discuss or release any information to any member of your extended family, spouse, or children.

Self-Pay: Payment in full is due at time of service if you do not have health insurance. Foot & Ankle Surgery of New Braunfels is offering a prompt pay discount.

Collection Policy: All payments are due at the time of services rendered. Foot & Ankle Surgery of New Braunfels has a legal obligation to the insurance companies they are contracted with to collect co-payments. Once a balance reaches 90 days old with our quality communication and/or a payment arrangement, it may qualify to be transferred to a third party for further collections or other actions. If the balance is transferred to a third party for collections there will be a $35.00 fee in addition to the outstanding balance.

Forms: There will be a charge of $7.00 per page on forms or $20.00 per letter for paperwork that require more than a signature and writing letter. There will be a $35.00 charge for any FMLA/Disability paperwork. To have your records transferred to another physician's office there is no charge. To receive a hard copy of your records there is a $25.00 charge for the first 20 pages and $0.15 per page thereafter. Additional x-rays will be a $25.00 charge.

Sunshine ACT Disclosure: In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufacturers in conjunction with product education. We do not receive direct financial compensation from any of our vendors.

I have read and understand the office/collection policies of Foot & Ankle Surgery of New Braunfels.

Patient Signature	Patient Printed Name	Date

Foot & Ankle Surgery of New Braunfels

ACKNOWLEDGEMENT OR RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative's Authority

AUTHORIZATION TO RELEASE ANY INFORMATION TO EXTENDED FAMILY AND/OR SPOUSE AND CHILDREN

Please think about anyone who may be calling in for information or for billing purposes. Without their name appearing on this form, we will NOT be authorized to release ANY information.

I authorize _____ to receive private medical information on my behalf regarding my care and billing details or arrangements.

_____ _____

Authorizing Signature Date

PARENTAL PREAUTHORIZATION FOR MINORS

For families who have established relationships with our practice, it may be convenient to have on file prior authorization for medical care for children when a parent cannot be present for treatment. Please complete the following form if you want to authorize the treatment in advance.

I request and authorize Foot & Ankle Surgery of New Braunfels and its personnel to deliver medical care to my child listed below:

Child Name: _____ Date of Birth: _____

Please try to contact us regarding the health care of our child at the following number(s):

Parent Name: _____ Phone: _____

Parent Name: _____ Phone: _____

Other: _____ Phone: _____

Note: If any special parental or custodial relationship exists (such as child has one parent only or if legal custody is held by guardians in the absence of both parents), please explain the situation below, along with your signature, printed name, and a contact phone number.

Parent or Guardian Name: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Relationship to Patient: _____

FOOT & ANKLE

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Your Information	
Full Name:	**Date of Birth:**_____/_____/_____ **Age:** _____
Preferred Language: Occupation:	Email:
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Disabled ☐ Military	
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Life Partner	
Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic	
Living Status: ☐ Lives Alone ☐ With Spouse Skilled Nursing With other Family-Who:	
Primary Care Physician:	**Phone Number:**
Who referred you: ☐ Physician:	☐ Friend: ☐ Other:

Your Medications

☐ No Medications List all the medications you take, both prescription & Nonprescription below:

Are you taking Aspirin or any other blood thinners? Yes No

Medication	Dose	Medication	Dose

Your Allergies

☐ **No Allergies** **Indicate all the allergies you have to medications and/or food below:**

Common reactions Include-Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble Breathing

_____

_____

Your Past Medical History

☐ **No Relevant Medical History**

Disease Type:	Date Onset:	Disease Type:	Date Onset:
☐ Hypertension	____/____/____	☐ Obesity	____/____/____
☐ Kidney Disease	____/____/____	☐ Peripheral Vascular Disease	____/____/____
☐ Heart Disease:_____	____/____/____	☐ Anxiety	____/____/____
☐ Diabetes Type I or II	____/____/____	☐ Depression	____/____/____
☐ Osteoarthritis	____/____/____	☐ DVT/Blood Clots	____/____/____
☐ High Cholesterol	____/____/____	☐ Ulcers	____/____/____
☐ Stroke	____/____/____	☐ AIDS/HIV	____/____/____
☐ Other:_____	____/____/____	☐ Other:_____	____/____/____

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NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

☐ **No Surgical History**

Surgery Type	Year of Surgery	Surgery Type	Year of Surgery

Your Family History

☐ **Family History Unknown**

Mother	Father	Siblings	Grandparents
☐ Alive and Well	☐ Alive and Well	☐ Alive and Well	☐ Alive and Well
☐ Cancer-Type:_____	☐ Cancer-Type:_____	☐ Cancer-Type:_____	☐ Cancer-Type:_____
☐ CVA/Stroke	☐ CVA/Stroke	☐ CVA/Stoke	☐ CVA/Stroke
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Deceased	☐ Deceased	☐ Deceased	☐ Deceased
Other:_____	Other:_____	Other:_____	Other:_____

Your Social History

Tobacco Use:
☐ **Current** ☐ **Former** ☐ **Never**
How Often:_____
Years Used:_____
Type:_____

Alcohol Use: ☐ No ☐ Yes ☐ Socially
Type: ☐ Beer ☐ Wine ☐ Liquor
Frequency:_____
Amount Per Sitting:_____
Last Drink:_____

Illicit Drug Use: ☐ No ☐ Yes
Type, such as: Marijuana, Cocaine...
Please Explain:_____
_____
_____

Review of Systems

☐ **All is Negative Below** **Check all that apply**

Constitutional	Cardiovascular	Musculoskeletal	Integument
☐ Headache	☐ Heart Murmur	☐ Joint Ache/Pain	☐ Rash/Skin Infection
☐ Dizziness/Vertigo	☐ Leg swelling/Edema	☐ Lower Back Pain	☐ Lesions/Ulcers
☐ Appetite Increase	☐ Syncope/Fainting	☐ Chronic Ankle Pain	☐ Dry/Itchy Skin
☐ Appetite Decrease	☐ Chest/Arm Pain	☐ Swelling of the Joints	☐ Scar Easily

Gastrointestinal	Endocrine	Hematology	Neurological
☐ Nausea	☐ Increase/Decrease Urine	☐ Hemophilia	☐ Tingling
☐ Vomiting	☐ Diabetes Mellitus	☐ Anemia	☐ Numbness
☐ Diarrhea	☐ Post Menopause	☐ Bruise Easily	☐ Pins & Needles
☐ Constipation	☐ Dysuria	☐ Weakness	☐ Burning/Shooting Pain

FOOT & ANKLE

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Dr. You are seeing today: Dr. Brandon James Dr. Sarah James (Please Circle One)

Chief Complaint

Please describe the condition(s) that brought you in today:_____

_____

_____

_____

Rating of Today's Pain

Mil☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unbearable

History of Present Illness

When did your problem begin: _____ Days _____ Weeks _____ Months _____ Years

Onset: ☐ Gradual ☐ Sudden Explain: _____

Is the Problem getting worse, better or staying the same? ☐ Worse ☐ Better ☐ Same

What seems to affect the problem:

When is it Better: _____

When is it worse: _____

Vital Signs

Weight:	Height:	Shoe size:

Have you had this treated before?

☐ Not Treated ☐ Another Dr. Treated this Condition ☐ Treated condition at home

Are you Pregnant? ☐ Yes ☐ No ☐ I am Male

Are you in good health? ☐ Good Health ☐ Fair Health ☐ Poor Health

Your Pharmacy Information

Do you have a preferred pharmacy that you use? ☐ Yes ☐ No

Pharmacy Name: _____ Pharmacy Phone #: _____

Street Address: _____ City/State/Zip: _____

Your Attestation

I attest that the information provided is complete & accurate as it will be utilized as part of my care and treatment plan.

Patient Signature: **Print:**

If Minor, Guardian Signature: **Date:**