NEW AGE FOOT & ANKLE SURGERY

It is important that you fill out ***ALL INFORMATION*** to the best of your knowledge.

**PATIENT INFORMATION** **Today's Date**: ___________________

Name: ______________________________________________ Sex: ☐ Male ☐ Female
First Middle Last

Date of Birth: ____________________ Social Security Number: ______________________
*This must be provided in order to verify insurance*

Race: ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status: ☐ Single ☐ Widowed
☐ Married
☐ Divorced

Address 1: ______________________________________ (If PO Box, we also need street address)
Address 2: ______________________________________ Zip Code: ______________
Home: (___)________________ Work: (___)________________ Cell: (___)________________
Preferred Contact: ☐ Home ☐ Work ☐ Cell

Email Address: ______________________________________ (For sending records via Patient Portal)

**How did you hear of us?** ☐ Radio ☐ Facebook ☐ Friend ☐ TV ☐ Google ☐ Insurance Company
☐ Event: ______________________________
☐ Doctor/Office: ______________________________
☐ Other: ______________________________

Emergency Contact: ____________________ Phone: (___)__________ Relationship: ______________

Employer Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Retired ☐ Child ☐ Other
Employer Name: ____________________________ Employer Phone: ____________________
Employer Address: ____________________________ Employer Zip Code: ______________

**Pharmacy Name**: ____________________ Zip Code: __________ Phone: ______________

**REFERRING PYSICIAN**

PCP Name: ____________________ Phone: __________ Date Last Seen: __________
Address: ____________________ Organization Name: ____________________

**GUARANTOR INFORMATION** *Please complete if the patient is not the responsible party.*

Name: ______________________________________________ Sex: ☐ Male ☐ Female
Last First Middle

Date of Birth: ____________________ Social Security Number: ______________________
*This must be provided in order to verify insurance*

Address 1: ______________________________________ (If PO Box, we also need street address)
Address 2: ______________________________________ Zip Code: ______________
Home: (___)________________ Work: (___)________________ Cell: (___)________________

## INSURANCE INFORMATION

It is very important you provide us with correct information so we can bill insurance.

**Primary:** ________________________________________ **Effective Date** ________ **ID#:** ___________________

**Specialist Copay: $**_______________ **Deductible $** ___________________ **Is this HMO?** ☐ Yes ☐ No

**Is a referral/authorization required?** ☐ Yes ☐ No **What is the referral/authorization #** ________________________

**Secondary:** _____________________________________ **Effective Date** _______ **ID#:** ____________________

**Specialist Copay: $**______________ **Deductible $** _____________________ **Is this HMO?** ☐ Yes ☐ No

**Is a referral/authorization required?** ☐ Yes ☐ No **What is the referral/authorization #** ________________________

**Tertiary:** _____________________________________ **Effective Date** __________ **ID#:** ___________________

I certify that the above insurance information is accurate and truthful. If the information I have provided is incorrect, I understand that New Age Foot & Ankle Surgery can transfer any charges to self-pay and I will be responsible for full payment. I agree to provide my insurance cards to New Age Foot & Ankle Surgery for verification. I agree to pay the specialist copay set by my insurance company, as well as the deductible amount that my insurance company has left me responsible for.

Due to the Affordable Care Act, you may be responsible for a portion of your deductible if it has not already been met.

I understand and agree to the terms and conditions stated above.

| Print Name | Signature | Date |
|---|---|---|

**PERSONAL MEDICAL HISTORY**

Reason for today's visit: ___________________________________________

Is this a work related injury? ☐ Yes ☐ No Date of Injury ___________ Where did it occur? ____________________

Is this a sports related injury? ☐ Yes ☐ No Date of Injury ___________ What were you doing? ____________________

Weight: ______________________ Height: ___________ Shoe Size: ___________ ☐ Regular ☐ Narrow ☐ Wide

**Allergies** (Please check and state your reaction) ☐ **No known Allergies**

☐ Ace Inhibitor: __________ ☐ Amoxicillian: __________ ☐ Animal Hair: __________ ☐ Antihistamines: __________
☐ Cephalosporins: __________ ☐ Bee Sting: __________ ☐ Codeine: __________ ☐ Aspirin: __________
☐ Egg/Poultry: __________ ☐ Fish Products: __________ ☐ Gluten: __________ ☐ Flu Vaccines: __________
☐ Lactose: __________ ☐ Latex: __________ ☐ Levodopa: __________ ☐ Macrolides: __________
☐ Milk Products: __________ ☐ Mumpsvax: __________ ☐ Niacin: __________ ☐ Novocain: __________
☐ NSAIDS: __________ ☐ Olive Oil: __________ ☐ Peanuts: __________ ☐ Penicillin: __________
☐ Pollen: __________ ☐ Quinolones: __________ ☐ Salicylates: __________ ☐ Shellfish: __________
☐ St John's Warts: __________ ☐ Sulfa: __________ ☐ Tetanus: __________ ☐ Tetracyclines: __________
☐ Vitamin C: __________ ☐ Melon: __________ ☐ Tape: __________ ☐ Iodine: __________
☐ Valium: __________ ☐ Local Anesthesia: __________ ☐ Tricyclic Compounds: __________
☐ Other: ____________________________________________

**Personal History** (Please check all that apply)

☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ High B/P ☐ Low B/P ☐ Seizures ☐ Head Trauma
☐ Pacemaker ☐ Osteoporosis ☐ Asthma ☐ Gout ☐ Stroke ☐ Heart Trouble
☐ Sickle Cell Anemia ☐ Aids/HIV ☐ Hepatitis ☐ Arthritis ☐ Anemia ☐ Skin Disorders
☐ Sleep Disorders ☐ Liver Disease ☐ Cancer ☐ Ulcers ☐ Hernias' ☐ Slow Healer
☐ Blood Disorders ☐ Birth Defects ☐ Phlebitis ☐ Epilepsy ☐ Blood Clots ☐ Eye Disorders
☐ Rheumatic Fever ☐ High Cholesterol ☐ Flu Shot ☐ H1N1 Shot ☐ Blood Transfusion. Year? __________
☐ Muscle Weakness ☐ Chronic Dermatitis ☐ Migraines ☐ Constant burning or electrical pain

Please list all other medical problems not stated above: ______________________________
____________________________________________________________

Please check all that you have previously been treated for.

☐ Lower Back Pain ☐ Broken foot/ankle ☐ Bunions ☐ Rash ☐ Hammertoes'
☐ Ankle Injuries ☐ Plantar Warts ☐ Arch Pain ☐ Heel Pain ☐ Plantar Fascia
☐ Inherited Disease ☐ Ingrown Nails ☐ Neuroma ☐ Calluses ☐ In-toeing

Please explain any boxes you checked above: ______________________________
____________________________________________________________

Are you currently pregnant? ☐ Yes ☐ No If so, what trimester? __________

Are you experiencing pain in calves? ☐ Yes ☐ No If so, does the pain occur at rest or while walking? __________

Are you experiencing numbness to any areas? ☐ Yes ☐ No If so, where? ____________________

Have you ever been in a car accident? ☐ Yes ☐ No If so, what year and were you hospitalized? __________

Please list all recent diagnostic tests: ______________________________

Please list all surgeries and dates: ______________________________
____________________________________________________________

## FAMILY MEDICAL HISTORY

| Member | Age | | Medical Condition: Please check all that apply and circle any cause of death. |
|---|---|---|---|
| Mother | | □ Living<br>□ Deceased | □ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems<br>□ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects<br>□ Tuberculosis □ Osteoporosis<br>Please list any medical problems not stated above: ___________ |
| Father | | □ Living<br>□ Deceased | □ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems<br>□ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects<br>□ Tuberculosis □ Osteoporosis<br>Please list any medical problems not stated above: ___________ |
| Sister | | □ Living<br>□ Deceased | □ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems<br>□ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects<br>□ Tuberculosis □ Osteoporosis<br>Please list any medical problems not stated above: ___________ |
| Brother | | □ Living<br>□ Deceased | □ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems<br>□ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects<br>□ Tuberculosis □ Osteoporosis<br>Please list any medical problems not stated above: ___________ |
| | | □ Living<br>□ Deceased | □ Diabetes □ High B/P □ Low B/P □ Cancer □ Heart Problems<br>□ Arthritis □ Bunions □ Stroke □ Tumors □ Birth Defects<br>□ Tuberculosis □ Osteoporosis<br>Please list any medical problems not stated above: ___________ |

## SOCIAL HISTORY

Tobacco Use: □ Never □ Quit on (date) _________ □ Current Smoker. Packs/day? _________ Years used? ____________
Type of tobacco, if used: □ Chew □ Cigar □ Cigarettes □ Pipe □ Smokeless
Exposure to second-hand smoke? □ Yes □ No

Do you drink any of the following? □ Coffee □ Tea □ Caffeine If so, how many cups per day? ________________
Do you drink alcohol? □ Yes □ No If so, how often? ______________________________

Do you use street drugs? □ Yes □ No If so, what kind and how often? ______________________
Prescription abuse? □ Yes □ No

Diet Type: □ Balanced □ No Special Diet □ Vegetarian □ Vegan □ Other: ____________________
Do you exercise? □ Yes □ No If yes, how often and what type? ______________________________

## INSURANCE SECTION

I understand that it is my responsibility to provide New Age Foot & Ankle Surgery with the correct and accurate insurance information. If I have an HMO insurance, I will be responsible for payment in full if I did not get a referral for each visit and it is my responsibility to get that from my PCP, it is **NOT** the responsibility of *New Age Foot & Ankle Surgery, LLC*. If for any reason I am seen by any of the doctors at *New Age Foot & Ankle Surgery, LLC,* I take full responsibility for not reading this disclaimer nor understanding that they are not liable for this error. I agree to provide my driver's license, insurance cards, referrals, social security number at all visits for proof of my identity. This must be signed to see the doctor.

## AUTHORIZATION AND PAYMENT POLICY

I, the undersigned, certify that I (or my dependent, under the age of 18), have insurance with the above name(d) company(s), and assign directly to *NEW AGE FOOT AND ANKLE SURGERY, LLC, Dr. David Sappington, Dr. Asif Shah, Dr. Aerial Avery, or any other doctor associated with this company*- all insurance benefits and agree to reimburse if insurance pays me, the insured, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payments of benefits. I understand that I am responsible for any and all deductibles, co-pays, and out of pocket expenses. If I do not pay- I am subject to being placed in collections, I understand that further action, such as a judgment, can be placed on me and will pay all fees associated with collection and judgment status if payment is not received. I authorize the use of this signature on all insurance submissions. RETURN POLICY: If products are purchased and they have a return policy I will receive and sign the policy, and a copy will be placed in my file. MEDICARE/MEDICAID AUTHORIZATION (If applicable): I request that payment of benefits be made on my behalf to the above named doctors/company for any services by that physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorized release of medical information to pay the claim. If "other health insurance" is indicated in item 9 on the HCFA-1500 form or elsewhere on other approval claims forms, such as electronically submitted, my signature authorizes release of the information to the insure or agency. In Medicare/Medicaid assigned cases, the physician or supplier agrees to accept the charges/payments/allowed amounts determined by the contract with the insurance company, and the patient is responsible for the amount the insurance company leaves them responsible for, including deductibles, co-pays, co-ins, non-covered services/items, or what the EOB states as patient responsibility. PAYMENT POLICY: All co-pays, deductibles, and co-insurances are due at the time services are rendered. If I leave without making a payment, *NEW AGE FOOT & ANKLE SURGERY, LLC* will send me a statement, after 3 statements & non-payment, *NEW AGE FOOT & ANKLE SURGERY, LLC* can send me to collections without notice. If I belong to an HMO, I understand that my insurance company requires a referral from my PCP and if not received by my appointment time, I will be fully responsible for payment in full at time services are rendered or I may have to reschedule to another date and time. If for some reason, *NEW AGE FOOT & ANKLE SURGERY, LLC* does not realize or notice there is no referral on file, & I am seen as a patient for any appointment or any reason, it is still my responsibility for payment in full to the company. If I belong to a PPO, I understand that I have a co-pay, deductible, and co-insurance. I know that it is my responsibility as the patient to get authorization/referral is one is required and if it is not obtained, I am responsible. It is my responsibility to inform a staff member of any new insurance, changes in address, phone numbers, or health and medication changes, whether or not they ask for this information. INSURANCE RELEASE/AUTHORIZATION: I understand that for medical/legal purposes and by the Virginia State Law, x-rays and medical records taken/created by this office are the property of *NEW AGE FOOT ANKLE SURGERY, LLC* not mine. I also understand that all charges for services are due and payable at the time services are rendered. *NEW AGE FOOT & ANKLE SURGERY, LLC* accepts cash, checks, debit cards, MasterCard, Visa, Discover, and American Express. There will be a $35.00 NFS fee for returned checks and must be taken care of in a timely fashion (21 days) or charges may be filled against me. I agree to be responsible for all the above, where it applies to me.

## HIPPA

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. I UNDERSTAND THAT I MAY HAVE A COPY IF I CHOOSE.

I have seen a copy of the "Notice of Privacy Practice Act".

I have read all above sections and the HIPAA agreement and understand that with my signature I agree to the above terms and conditions. I certify that I have provided truthful and accurate information.

Signature: ________________________________________ Date: _______________________

# MEDICATION RECORD

Name: ____________________________________________ Today's Date: ____________________

| | Medication Name | Reason for Medication | Start Date | End Date | Dosage | Results | Reaction/Side Effects |
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