NEW PATIENT REGISTRATION FORM

Staff Use Only:	
BP: _____	P: _____
Wt: _____	Ht: _____
Flu V.: _____	P.V.: _____

Today's Date: ____/____ /_____

Name: _____ D.O.B: ____/____/_____

Address: _____

Preferred email: _____

Phone Number: _____ Cell number: _____

SS #: _____

Gender: M F

Race: Caucasian African American Hispanic

Pacific Islander Asian Other

Preferred method of communication for appointment confirmation & reminders?
Phone Email Text

Do we have permission to leave voice message?
Yes No

Your **Primary Care Doctor (PCP)**: _____

Where is the PCP located: _____

PCP phone: _____ Last date seen: _____

Preferred **Pharmacy**: _____ Phone:_____

Address: _____

Were you referred to us? If yes;

Doctor (please specify): _____

How did you hear about us: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

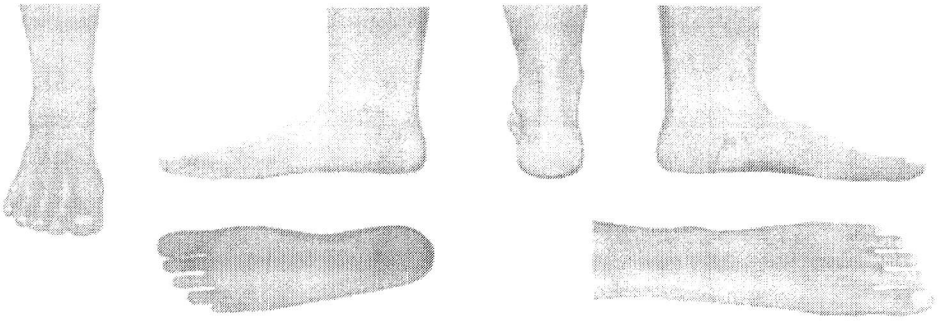
D.O.B: _____ D.O.B: _____

Relationship: _____ Relationship: _____

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE FRONT DESK FOR OUR RECORDS. THANK YOU.

SITE OF PAIN/INJURY

Please **circle** the site of pain/discomfort below:



On a scale of 1 to 10, 10 being severe pain; please rate your pain: _____

Was the onset of the problem sudden? Or gradual? _____

How would you describe the pain/discomfort? (Circle one)

SHARP **DULL** **THROBBING** **TINGLING** **BURNING**

OTHER: _____

Does the pain radiate? _____

What makes it better? _____

What makes it worse? _____

How long has it been a problem? _____

What treatments have you tried so far?

_____

_____

Did you get any imaging(s) done? **Ultrasound** **X-RAY** **MRI** **CT SCAN**

OTHER: _____

MEDICATION LIST

Check a box, if applicable:

☐ Not taking any medications ☐ See attached list

Please list your medications below including name of drug, dosage, and how often you take it:

DRUG	DOSE	HOW OFTEN

Are you **allergic** to any **medication/food/substance**(s)? Yes No

If yes, list the allergy **AND** reaction(s):

_____

_____

ANY TIME YOUR MEDICATION CHANGES, PLEASE LET OUR STAFF KNOW, SO WE CAN UPDATE YOUR CHART ACCORDINGLY. THANK YOU!

SOCIAL HISTORY

Any chance you could be **pregnant**?	Yes	No	
Do you **smoke**?	Yes	No	Quit? When: _____
How many pack/day? _____.			
Do you **Vape/JUUL**?	Yes	No	Quit? When: _____
Do you use **chewing tobacco**?	Yes	No	Quit? When: _____
Do you use **CBD products**?	Yes	No	
Do you drink **alcohol**?	Yes	No	Seldom
Have you **traveled** recently?	Yes	No	Yes? Where: _____

Were you ever sick during your travels? _____

MEDICAL HISTORY

Are you **Adopted**? Yes No

Height: _____ Weight: _____ Shoe size/Width: _____

REVIEW OF SYSTEMS

Are you **CURRENTLY** experiencing any of the following symptoms? (Please circle all that apply)

General Health (Constitutional)	❑ No Problems	- Weight gain/loss - Loss of appetite - Fever	- Nausea - Vomiting
Ears, Nose, Mouth & Throat	❑ No Problems	- Difficulty hearing - Runny nose	- Ringing in ears
Cardio (Heart & Blood Vessels)	❑ No Problems	- Irregular heartbeat - Chest pains	- Swelling of feet
Resp. (Lungs & Breathing)	❑ No Problems	- Shortness of breath - Prolonged cough	- Wheezing
G.I. (Stomach & Intestines)	❑ No Problems	- Constipation - Diarrhea	- Abdominal pain - Blood in stools
Musc. (Muscles & Joints)	❑ No Problems	- Joint pain - Heel pain	- Joint swelling - Uneven leg length
Neurologic (Brain & Nerves)	❑ No Problems	- Headaches - Double vision	- Dizziness - Tremors
Integumentary. (Skin & Hair)	❑ No Problems	- Rash - Itching	- New skin lesion - Hair loss
Hematologic (Blood/Lymph)	❑ No Problems	- Excess bleeding - Easy bruising	- Anemia

DIABETIC PATIENTS ONLY

Name of Provider (managing your diabetes):

Name of **Eye** Doctor: _____ Last eye exam: _____

Name of **Kidney** Doctor: _____ Last visit: _____

Your last **Hg A1c**: _____ Date: _____

SURGICAL HISTORY

List **any and all** past surgeries with their respective dates:

Type of surgery:	**Month/Year**

Any surgical complication(s): _____

HOSPITALIZATIONS

Please list **all** prior hospitalizations:

Date	Reason for Admission

FAMILY HISTORY

Please fill out to the best of your knowledge:

DISEASE/CONDITION	YOU	FAMILY MEMBER(s)? (Mother, Father, Grandparents, Siblings)
High Blood pressure		
High Cholesterol		
Diabetes Mellitus Type 1? OR Type 2?		
Heart Disease		
Stroke / Seizures		
Poor Circulation		
Asthma / COPD		
Liver Disease		
Kidney Disease		
Arthritis / Osteoporosis		
Hypothyroid / Hyperthyroid		
Gout		
HIV/ AIDS		

Please list any other medical conditions not stated in the chart above:

_____

_____

Acknowledgement & consent: I certify that the above information is true and complete to the best of my knowledge. I give permission to **Kinex Podiatry Foot & Ankle Clinic** to administer and perform procedures deemed necessary in my diagnosis and treatment.

_____ _____

Patient/Parent/Guardian Signature Date/Time

KINEX PODIATRY FOOT & ANKLE CLINIC

General Consent for Treatment

You have the right to be informed about your condition, so that you may make the decision whether or not to undergo any of the recommended surgical, medical or diagnostic treatments, after knowing the risks and complications involved. At this point in time, no specific treatment plan has been advised or recommended. This consent is simply to ask for your permission to conduct an evaluation necessary to determine the appropriate treatment(s) for any pertinent condition(s).

By signing below you are indicating that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a podiatrist, and/or mid level provider (Medical Assistant, Nurse Practitioner or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me in to seek care at this practice.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Personal Representative	Relationship to Patient
_____	_____
Signature of Witness	Employee Job Title
_____	_____
Printed Name of Witness	Date

Dr. Faiza Khan, DPM
Dr. Syed H. Mohiuddin, DPM
Kinex Podiatry, Foot & Ankle Clinic
P: 972-709-7556 | F: 972-709-7611

Agreement of Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which our providers are **in-network,** if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we are **in-network (in contract)** with your insurance company we will bill your insurance company first, minus any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we are **out-of-network (not in contract)** with your insurance company, you will be expected to pay for **all services rendered** at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

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- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card **does not** confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have **out-of-network benefits** that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an out-of-network benefit, your portion of financial responsibility may be higher than the in-network rate.
- **There is a NO SHOW fee/Late Cancellation fee of $25 dollars, if you fail to show for an appointment or fail to cancel 24 hours prior to your appointment time.** Our staff sends email reminders and call reminders prior to your appointment date to help you avoid these charges.

Patient Statement of Agreement:

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

1740 W. Virginia St. Ste. 100. Mckinney, TX 75069
kinexpod@gmail.com

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Authorization to process Credit Card on File

I, _____ authorize Kinex Podiatry to process my Credit Card on file to collect in absence or over the phone for services rendered, such as appointments, DME, copayments, coinsurance, balances, deductibles, orthotics/inserts, shoes, equipment rentals, etc.

I understand that Kinex podiatry will bill my insurance company for services rendered and I will be responsible for any dues or balances unpaid by my insurance company.

If I am seen today as a Self-Pay patient, Kinex Podiatry will not file a claim with my insurance and I will not file for reimbursement with my insurance company either.

Name of Card: _____

Card Number: _____

Expiry: _____/_____

CVS: _____

Signature of the card Holder: _____

Patient Name: _____Date: _____

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