

NORTH GEORGIA FOOT & ANKLE CLINICS

PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Person to Contact in Case of Emergency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

INSURANCE INFORMATION

Do you have Medicare? NO YES Do you have Medicaid: NO YES

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Family Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

INSURANCE AUTHORIZATION & ASSIGNMENT

Referrals: Should your insurance company require a referral from your primary care physician before you can be seen, it is your responsibility to obtain your referral prior to your appointment. If you are seen without a referral, you must be prepared to pay for all services in full at the time they are rendered.

WE WILL GLADLY BILL YOUR INSURANCE IF WE ARE PROVIDERS.

I understand that SPENCO inserts (\$25) SURGICAL SHOES (\$25), and AMERIGEL (\$20) are my responsibility, and will not be billed to my insurance. 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 understand the Notice. I hereby give my permission for the doctor to render the Podiatric examination and treatment. I understand that I am financially responsible to the Physician for all charges incurred by me or my dependents. I authorize the release of any medical information necessary to process a claim and request payment of insurance benefits due to be paid to the Physician. I am financially responsible for any collection and/or attorney fees incurred if my account becomes delinquent. I am financially responsible for any service charges incurred on all returned checks.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND AGREE TO FINANCIAL RESPONSIBILITY AS DESCRIBED.

Responsible Party Signature

Date

**NORTH GEORGIA FOOT & ANKLE CLINICS**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

**What Problems Are You Having?** \_\_\_\_\_  
\_\_\_\_\_

**LEFT OR RIGHT OR BOTH**

How long have your symptoms been present? \_\_\_\_\_

Was this an on the job injury?      NO      YES      If yes, provide the workers compensation information.  
Motor Vehicle Accident?      NO      YES      If yes, please give date of accident. \_\_\_\_\_

**List All Current Medications** (both prescription and over the counter): \_\_\_\_\_  
\_\_\_\_\_

**List all prior surgeries:**  
\_\_\_\_\_

**ALLERGIES – List Drug Allergies:**  
\_\_\_\_\_

**Please Circle YES or NO, if YES Circle Disorder**

- YES    NO    Have you ever had problems with anesthesia?
- YES    NO    Do you have trouble healing?
- YES    NO    Do you have trouble bleeding?
- YES    NO    Do you have any allergies to soy or egg products?
- YES    NO    Are you allergic to Latex?
- YES    NO    Are you aware of any member of your family having had malignant hyperthermia (i.e. a high fever associated with anesthesia)?
- YES    NO    Do you have any heart problems: High Blood Pressure, Mitral Valve Prolapse, Heart Disease, Heart Attack, Angina?
- YES    NO    Do you have any gastrointestinal problems including: Hepatitis, Heartburn, Hiatal Hernia, Ulcers, Gallstones?
- YES    NO    Do you have any skin problems including: Herpes, Rashes, Eczema?
- YES    NO    Do you have any blood disorders including: Sickle Cell, Anemia, Mono, Clotting Disorder, Deep Vein Thrombosis?
- YES    NO    **Do you have Diabetes?** If YES, list Diabetic Doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_
- YES    NO    Do you have a Thyroid Disorder?
- YES    NO    Have you ever had a Seizure, Stroke, or Aneurysm?
- YES    NO    Do you have any breathing problems including: Asthma, COPD, or Emphysema?
- YES    NO    After climbing a flight of stairs, are you short of breath?
- YES    NO    Do you have any kidney problems including: Renal Failure, Urinary Tract Infections, Kidney Stones?
- YES    NO    Do you have any limitations on the use of any joints, especially the neck and jaw?
- YES    NO    Do you have Arthritis?
- YES    NO    Do you have any fractures?
- YES    NO    Do you have Cancer?
- YES    NO    Have you ever had an HIV test? If yes, was it positive or negative?

If YES to any of the above questions please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you had or do you have any other medical conditions not covered above? \_\_\_\_\_

- YES    NO    Do you smoke? \_\_\_\_\_ Packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_  
If quit, how long ago? \_\_\_\_\_
- YES    NO    Do you use alcohol? If yes, how much? \_\_\_\_\_
- YES    NO    Do you have an emotional condition? \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_

**FEMALE PATIENTS ONLY:**

YES    NO    Could you be pregnant?

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date