



Patient Registration Form

Date: _____ Home Phone: _____ Cell: _____

Patient: _____
(Last) (First) (Middle Initial)

Street Address: _____

City: _____ State: _____ Zip: _____

Sex M F Birthday: _____ Age: _____ Single Married Other

Employer: _____ Occupation: _____

Employer Phone: _____

Responsible Party (if minor): _____

Responsible Party Employer: _____

Employer Phone: _____ Occupation: _____

Patient's SS#: _____ Responsible Party SS# _____

Email Address: _____

Name of Medical Insurance (primary) _____

Subscriber Name: _____ Date of Birth: _____

Name of Medical Insurance (secondary) _____

Subscriber Name: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____

Primary Care Doctor: _____ Last visit date: _____

How did you learn of our practice? Yellow Pages Internet Yellowbook USA TV Radio

Friend/Family Member name: _____ Physician name: _____

Billboard Other (please specify): _____

Authorizations

I hereby authorize the processing of the medical insurance either by electronic or manual method by Foot & Ankle of West Georgia, P.C. 2751 warm Springs Rd., Suite "A", Columbus, GA 31904. My signature authorizes payment(s) of all major medical and/or surgical benefits to which I am entitled, to the physician I recognize my financial obligation of any co-insurance, deductibles and non-covered services that may be required. I understand that I am responsible for any portion of my bill not covered by my insurance company. I also understand that if my insurance requires a referral, I will obtain one, or I will be billed in full for my visit. This agreement will remain in effect until revoked by me in writing. A copy of this document is considered as valid as an original.

Release of Information

I hereby authorize release of information for insurance claim purposes. The information authorized for release may include confidential medical information. I consent to foot/ankle photographs, which may become part of my permanent record and/or sent to other physicians and insurance companies as maybe needed for my care.

My signature below also confirms that I have received the Notice of Privacy Practices from Foot & Ankle of West Ga.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signature of Patient and/or Guarantor (Responsible Party)

Date

Witness

Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on by behalf to: **Foot & Ankle of West Georgia, P.C.** for any services furnished by that physician/supplier. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "the other health insurance" is indicated in box 9 of my HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient and/or Guarantor

Date

Witness

Date

Recent Surgeries:

Procedure	Date

Allergies:

Adhesive Tape Betadine Codeine Demerol Local Anesthesia Penicillin Sulfa Drugs

Other (please list): _____

Social History:

Do you smoke? Yes No If YES, how many packs a day? _____ for how long? _____

Have you smoked in the past but quit? Yes No If YES, how long ago did you quit? _____

Do you drink alcohol/beer? Yes No If yes, how often? _____

Do you use illegal drugs? Yes No If YES, please list: _____

Do you participate in any physical activities on a regular basis? Yes No

Has your foot/ankle problem interfered with your ability to perform these activities? Yes No

Family History:

Mother Diabetes High Blood Pressure Heart Disease Stroke Deceased
Father Diabetes High Blood Pressure Heart Disease Stroke Deceased
Siblings Diabetes High Blood Pressure Heart Disease Stroke Deceased

Reviewed By: _____ Date: _____

Dr. Bartley Dr. Shah Dr. Schreck Dr. Hyneman

Physician Notes: _____
