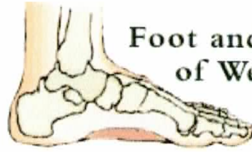

Foot and Ankle
of West Georgia, P.C.

Patient Registration Form

Date: ________________ Home Phone: ____________________ Cell Phone: ______________________

Patient: ____
(last) (first) (initial)

Responsible Party (if a minor): ____

Street Address: ____

City: ____ State: _______________ Zip: _____________

Sex ☐ M ☐ F Birthday:________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

AGE: ______ **Student ☐ No ☐ Yes** **☐ Full Time ☐ Part Time**

Patient Employed by: ____ Occupation: ______________

Employer Address: ____ Phone: ___________________

Spouse (or responsible party) Name: ____

Spouse Employed by: ____ Occupation: ______________

Employer Address: ____ Phone: ___________________

Patient's SS#: ___________________________ Spouses SS#:_________________________________

E-Mail Address : ____

Do you have medical insurance? ☐ No ☐ Yes
Name of Primary Insurance: ____
Subscriber DOB. ______________ **Group No.** ______________ **Contract No.** ______________

Name of Secondary Insurance: ____
Subscriber DOB. ______________ **Group No.** ______________ **Contract No.** ______________
☐ **Medicare** ☐ **Medicaid** **Claim ID No.** ______________________________________

In case of emergency, who should be notified?
Name: ________________________________ **Number:** __________________________________

Name of your Primary Care Physician: ____
Last visit date: _________________________
Please check one of the following:
How did you learn of our practice? ☐ Physician Name: _______________________________,
☐ Real Yellow Pages, ☐ Internet/Web, ☐ Yellow Book USA, ☐ Television, ☐ Radio Ad,
☐ Friend/Family: Name: __________________________ ☐ Other (please specify)_____________________
revised: 09012009 rjw

AUTHORIZATIONS

Benefits to Physician:

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 Road, 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, deductible 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 may be needed for my care.

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 my 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 the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare 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.

____ ____________
Patient's Signature (date)

____ ____________
Witness (date)

This is to confirm that I have received the Notice of Privacy Practices from Foot & Ankle of West Ga.

____ ____________
Patient's Signature (date)

Patient Medical History

Name: ____Date of Birth: ____________________

Describe your foot problem: ____

____

____

How long has it bothered you? _________________ Can you recall any type of injury? ___________

What makes the condition worse? ____

What makes the condition better? ____

Have you tried to treat the condition? (soaks, pads, changing shoes) YES______ NO_______
If YES, please list: ____
Have you been treated by another Doctor for this condition? YES ________ NO ________
If YES, Doctors Name: __________________________________ Date treated? ____________________

What treatment did you receive for this condition? ____

____

Physician Notes: ____

____

____

____

General Health Information
Shoe Size: __________ Height: __________ Weight: __________
Are you a DIABETIC? YES ______ NO ______ If YES, how long have you been a diabetic? _______

What is your AM blood sugar range? _________ Do you currently take insulin? _________________

Health Problems
___Asthma ___Arthritis ___Anemia ___Bladder ___Circulation ___Foot Ulcers
___Frequent Infection ___Gout ___High Blood Pressure ___Hypothyroidism ___Lung
___Stomach Ulcers ___Skin ___High Cholesterol ___Heart Disease ___Anti-Coagulant Therapy
___Reflux ___Other (Please List)

____

____

Please list: Current Medications

Name of Medication	Dose	Ordering Doctor

Please List: **Hospitalizations and Previous Surgeries**

Date of Procedure and/or Hospitalization	Type of Medical Problem or Surgery

Please list any previous complications with Surgery:

____

____

____

Allergies: ___ No known Allergies

____AdhesiveTape ____Betadine ____Codeine ____Demerol ____Local Anesthesia ____(PCN) Penicillin ___Sulfa Drugs ____Other (Please List) ________________________________

____

Social History:

Do you smoke? YES___ NO ___

If YES, how many packs per day? _____ For How long? ____ Months ____Years

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 much? ___1-2/day ___1-2/wk ___Other

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

Reviewed By: ____ **Date:** ____________________

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

Notes: ____

____

FOOT & ANKLE OF WEST GA 2751 Warm Springs Rd., Columbus, GA 31904

Patient Name: ____ Date: __________________

Review of Systems: Please indicate any personal history below. Although some of the questions below do not pertain specifically to your foot/ankle problem, please be as thorough as possible. This is essential for our permanent records and it allows your doctor to provide you with the most appropriate care in order to resolve your symptoms.

Constitutional Systems:
___Good General Health ___Recent Weight Change ___Fever ___Fatigue ___Headaches
Eyes:
___Eye disease or injury ___Wear glasses/contact lenses ___Blurred or double vision ___Glaucoma
Ears/Nose/Mouth/Throat:
___Hearing loss/ringing ___Earaches or drainage ___Chronic sinus problems ___Nose bleeds
___Mouth sores ___Bleeding Gums ___Swollen glands in neck
Cardiovascular:
___Heart Trouble ___Chest Pain or Angina ___Palpitations ___Shortness of breath-walking
___Swelling in feet/hands/ankle
Respiratory:
___Chronic or frequent cough ___Asthma or wheezing
Gastrointestinal:
___Loss of appetite ___Nausea/vomiting ___Frequent diarrhea ___Constipation ___Peptic ulcers
Genitourinary:
___Frequent urination ___Burning or painful urination ___Kidney stones
Musculoskeletal:
___Joint pain ___Joint stiffness/swelling ___Weakness of muscles ___Muscle pain or cramps
Integumentary:
___Rash/Itching ___Foot/leg ulcer ___Change in skin color ___Change in hair/nails
___Varicose veins

Neurological:

___Frequent headaches ___Light headed or dizzy ___Convulsions/seizures ___Numbness/tingling ___Tremors ___Paralysis ___Stroke

Psychiatric:

___Memory loss/confusion ___Nervousness ___Depression ___Insomnia

Endocrine:

___Hormonal problem ___Thyroid disease ___Diabetes ___Excessive heat/cold intolerance

___Skin becoming dryer

Hematological/Lymphatic:

___Slow to heal after cuts ___Bleeding /bruising tendencies ___Anemia ___Phlebitis

Physician Notes: ____

____

____

Dr. Bartley Dr. Shah Dr. Schreck Dr. Hyneman Revised 11/28/05 rjw