FAR GA
Foot and Ankle Reconstruction Center of Georgia

Patient Name: _____ Date of Birth: _____ Age: _____
Last First MI
Social Security No: _____ Gender: Male/ Female Marital Status: Single/Married/Divorced/Widow
Circle One Circle One
Ethnicity: _____ Preferred Language: _____ Race: _____

Address: _____
Street City State Zip
Phone Numbers: _____
Home Mobile Work
Email Address: _____ Spouse's Name: _____

Pharmacy: _____ Pharmacy Phone: _____

Employer: _____ Title/Job: _____

Primary Care Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

**PLEASE INCLUDE A COPY OF A PHOTO ID AND ALL INSURANCE CARDS**

**Primary** Insurance Name: _____
Policy/Contract #: _____Group #: _____
Name of Policy Holder: _____Policy Holder DOB:_____
Relationship to Patient: _____ Policy Holder SSN: _____

**Secondary** Insurance Name: _____
Policy/Contract #: _____Group #: _____
Name of Policy Holder:_____ Policy Holder DOB:_____
Relationship to Patient: _____ Policy Holder SSN: _____

Other Insurance Coverage (Auto/Worker's Compensation)
**Name of Company**: _____
Policy/Contract #: _____Group #: _____
Name of Policy Holder:_____ Policy Holder DOB:_____
Relationship to Patient: _____ Policy Holder SSN: _____
Claim #: _____
Adjustor: _____ Phone: _____
Case Manager: _____ Phone: _____

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How did you *learn* about Foot and Ankle Reconstruction Center of Georgia? (Please circle one)

- I was referred by Dr. _____
- A friend or another patient referred me: _____
- Insurance Website: _____
- Internet Search: Google Yahoo Bing Other:_____
- I saw your practice sign/driving by
- Other Source: _____

What is your chief complaint today? _____ Where? _____

When did this condition start? ____Years ____Months _____ Weeks_____ Days ago

What is the nature of you pain? (Circle one): Stabbing / Radiating / Sharp/ Dull /Burning / Aching/ Itching / Numbness / Tingling / Electrical / Pins and needles / Throbbing / Other _____

Is your condition getting better or worse? _____ Rate your pain: 0 1 2 3 4 5 6 7 8 9 10 (severe) – Circle one

What seems to make your condition, pain worse? _____

What seems to make your condition, pain better? _____

Have you seen another physician for this problem? YES/NO; If yes, doctor's name? : _____

What treatment did they give you? (Splint, Brace, Meds, injections)_____

Were X-rays, MRI, CT, EMG/NCV or other Studies done? _____
Did you bring these films/CD or reports? YES or NO

Is there a history of injury? YES/NO; If yes, date of injury? _____

Is this a work-related injury? YES/NO; If yes, have you missed any work for this injury? YES/NO

Are you under the care or obtaining treatment with a Pain Management Physician? YES/NO
IF YES: Physician name: _____ Phone: _____

Are you Diabetic? YES/NO; If YES, who is treating you? _____
Last Appointment Date: _____ Most Recent A1C_____Most Recent Blood Sugar_____

***List or attach a complete list of all CURRENT MEDICATIONS (Include how much and how often taken), including vitamins/supplements:***

| | | | | |
|---|---|---|---|---|
| | | | | |
| | | | | |

***Allergies:*** (circle) NONE /Narcotics/NSAIDS/Penicillin / Sulfa / Aspirin / Contrast / Latex / Iodine / Shellfish / Tape
Gluten Intolerance / Food Allergies / Metal / Other: _____

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***PAST MEDICAL HISTORY (circle all that apply)*** *NONE*

**Cancer:** lung skin breast cervical prostate other: _____
**Neurological:** stroke seizures neuropathy
**Skin:** eczema dermatitis psoriasis ulcers
**Psychiatric:** bipolar depression anxiety dementia
**Respiratory:** emphysema asthma COPD
**Eyes/Ears/Noses/Mouth and Throat:** cataracts glaucoma hearing loss
**Genitourinary:** HIV STD: _____ UTI kidney stones kidney disease dialysis
**Hematologic/Immunologic:** anemia sickle cell bleeding disorder
**Gastrointestinal**: stomach ulcers acid reflux/GERD gallbladder disease hernia hepatitis
**Cardiovascular:** heart attack coronary disease irregular heart rhythm high blood pressure high cholesterol
Raynaud's disease deep vein thrombosis pulmonary embolism peripheral vascular disease
**Musculoskeletal:** osteoarthritis rheumatoid arthritis fibromyalgia gout back pain foot deformity
**Metabolic:** diabetes hypothyroidism hyperthyroidism osteoporosis

**Other**: _____

***PAST SURGERIES AND HOSPITALIZATIONS (circle all that apply)*** *NONE*

Amputations Other Vascular Bypass Coronary/Heart Bypass Angioplasty

Appendix Gallbladder Hysterectomy Hernia

Foot/Ankle Surgery (Please Be Specific): _____

Other: _____

***SOCIAL HISTORY***

Height: _____ Weight: _____ Shoe Size: _____

Do you currently use illicit drugs (pain pills, marijuana, cocaine etc.)? YES/NO

Do you have a history of alcohol or drug abuse including prescription medications? YES/NO

Have you have ever used tobacco? YES/NO If yes, amount per day_____ Age began: _____ Age quit: _____

Do you ever drink alcohol? YES/NO If yes, How often: _____How much: _____

Is there a **family history** of any specific medical conditions or diseases? _____

_____

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***REVIEW OF SYSTEMS: (circle any symptom that you have had in the last 6 months)*** *NONE*

**Constitutional/Endocrine**: fever night sweats weight gain weight loss exercise intolerance chills malaise
**Eyes:** dry eyes irritation vision changes eye disease/injury _____ wearing glasses/contact lenses
**Ears:** difficulty hearing ear pain
**Nose:** frequent nosebleeds nose problems sinus problems
**Mouth/Throat:** sore throat bleeding gums snoring dry mouth oral abnormalities mouth ulcer teeth abnormalities mouth breathing ringing in ears sinusitis
**Cardiovascular:** chest pain on exertion arm pain on exertion shortness of breath when walking shortness of breath when lying down palpitations heart murmur light-headed on standing ankle swelling
**Respiratory:** cough wheezing shortness of breath coughing up blood sleep apnea
**Gastrointestinal**: abdominal pain nausea vomiting constipation change in appetite black/tarry stools diarrhea vomiting blood dyspepsia GERD
**Genitourinary:** urinary loss of control difficulty urinating increased urinary frequency hematuria incomplete emptying
**Musculoskeletal:** muscle aches muscle weakness arthralgias/joint pain back pain swelling in the extremities neck pain difficulty walking leg cramps osteoporosis fractures
**Skin:** abnormal mole jaundice rash itching dry skin skin lesion laceration non-healing wounds/areas changes in hair/nails psoriasis change in skin color breast lump
**Neurologic:** loss of consciousness weakness numbness seizures dizziness headaches migraines restless legs tremor gait dysfunction paralysis
**Psychiatric:** depression sleep disturbances feeling unsafe in a relationship restless sleep alcohol abuse anxiety hallucination suicidal thoughts mood swings memory loss agitation dementia delirium
**Endocrine:** fatigue increased thirst hair loss increased hair growth cold intolerance
**Hematologic/Lymphatic:** swollen glands easy bruising excessive bleeding anemia m. phlebitis
**Allergy/Immunologic:** runny nose sinus pressure itching hives frequent sneezing

**Other:** _____

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and staff of any changes in my medical status. I, the undersigned or as parent, legal guardian, or power of attorney of the undersigned hereby authorize the physicians and their assistants of the Foot and Ankle Reconstruction Center of Georgia to administer treatment as deemed necessary to myself or the patient below for whom I am responsible.

_____
**Print Name of Patient**

_____
**Signature of Patient/Parent/Guardian/Power of Attorney**

_____
**Date**

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**Release of Medical Records/Information and HIPAA Compliance/Confidentiality**

Foot and Ankle Reconstruction Center of Georgia is HIPAA compliant. We make every effort to protect your privacy. We feel it is important you understand your patient rights to confidentiality. If you have any concerns, please see the manager. I understand that the Foot and Ankle Reconstruction Center of Georgia complies with HIPAA regulation. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Georgia law, I have the right to my medical records. I also understand that I may request my records be released to a physician and/or medical facility; however, this request must be made in writing. I understand that by law this office may only release medical records they generate as Foot and Ankle Reconstruction Center of Georgia; they cannot release medical records from any other physician, hospital or facility. I agree to accept responsibility for any copying fees as provided by Georgia statues. I understand that employees have no responsibility or liability regarding this authorization. Furthermore, I have the right to complain to this practice or to secretary of HHS if I feel my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against a patient that files a complaint.

- ☐ I **authorize** Foot and Ankle Reconstruction Center of Georgia to leave medical information on my answering machine and/or give my spouse my medical information. **Initials _____**

**OR**

- ☐ I **do not authorize** Foot and Ankle Reconstruction Center of Georgia to release any part of your medical records to anyone in your family or leave any medical information on you answering machine. **Initials _____**

By signing below you acknowledge that you have read, agree with and understand the above statements.

I understand that by signing this form, I am also authorizing that any holder of my medical information be able to release my medical information to the insurance carrier(s), the Social Security Administration, the health care financing administration, its intermediaries, carriers for this or any medical related claim. I, the undersigned, authorize the release of my medical records to other physicians, hospitals and/ or healthcare facilities as needed to provide me with medical care. **Initials _____**

_____
**Print Name Patient**

_____
**Signature of Patient/Parent/Guardian/Power of Attorney**

_____
**Date**

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**Method of Payment and Financial Policy**

I, the undersigned, understand that the Foot and Ankle Reconstruction Center of Georgia has agreed to accept medical and/or health insurance for payment of my medical bills. Payment is required at the time that services are rendered. Foot and Ankle Reconstruction Center of Georgia is a participating provider of Medicare, BCBS, Cigna, Aetna, United Health Care, Tri-Care, Humana and many PPO and HMO plans. Please check with the receptionist to see if we are participating with your insurance plan. Our office will file the insurance claims automatically. I understand that I am responsible for any co-pays, co-insurances or deductible amounts at the time of service. By my signature below, I acknowledge that I am fully responsible for any balances after my health insurance company has paid the Foot and Ankle Reconstruction Center of Georgia. This may be a result of my yearly deductible, co-insurance and/or co-payment. I also understand that any benefits given to Foot and Ankle Reconstruction Center of Georgia by my insurance carrier is not a guarantee of my benefits as it may be subject to change. I also understand that it is my responsibility as the patient to get a referral if my policy requires a referral. I also understand that if I do not present a referral and it is necessary, my insurance company may deny the claim as a result of not having the referral. **Initials _____**

It is the policy of our office that all fees are due at the time of services are rendered whether by check, cash, or credit card unless prior arrangements have been made. We welcome frank discussion of services and fees at the time of treatment in order to avoid any misunderstandings. We are happy to file your insurance for you. However, regardless of insurance coverage, you are responsible for payment of your account abiding with the credit policy of this office. If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient. We accept MasterCard, Visa, American Express, and Discover as well as cash or checks. Please note that if you write a check and it is returned, we will charge your account $35 for a non-sufficient fund fee. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility and if timely payment is not received, the account may be referred to a collection agency or attorney. In the event that your account needs to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. **Initials _____**

I authorize the release of any medical/surgical information necessary to process medical claims and authorize payment of medical/surgical/medical equipment benefits to be made directly to Foot and Ankle Reconstruction Center of Georgia. After all insurance payments have been paid, I fully understand that I am responsible for the remaining balance of my account.
**Initials _____**

_____
**Print Name**

_____
**Signature of Responsible Party**

_____
**Date**

**Responsible Party Mailing Address: (if different from patient)**

_____

**Responsible Party Home Phone: _____Cell:_____**