# Atlantic Foot & Ankle Specialists, PC

11706 Mercy Blvd. Plaza A Bldg 8 Savannah, GA 31419 Tel: (912) 355-4557
803 E 68th St. Savannah, GA 31405 Tel: (912) 355-4557
300 New River Pkwy Suite 21 Hardeeville, SC 29927 Tel: (843) 208-3338
110 Hill Pond Lane Statesboro, GA 30458 Tel: (912) 489-3668
601 E General Stewart Way Hinesville, GA 31313 Tel: (912) 463-4517
114 Canal St Suite 703 Pooler, GA 31322 Tel: (912) 355-4557

**Patient Name**: _____ **Birth Date**: _____ **Age**: _____

**Address:** _____ **City, State, Zip:** _____

**Home Phone**: (____) _____ Cell / Work Phone: (_____) _____

**E-Mail Address:** _____

**Sex**: M F **Marital Status**: S M W D **SS#** _____

**Emergency Contact**:_____ **Phone**: _____ **Relationship**: _____

*** Please choose both a Race and an Ethnicity ****

**Race:** O Native Hawaiian/Other Pacific Islander O Caucasian
O American Indian/Alaska Native O Asian
O African American O Decline to answer

**Ethnicity:** O Hispanic/Latino
O Non-Hispanic/Latino **Preferred Language:** _____
O Decline to answer

**Employer** (Yours or Responsible Party): _____**Work Phone**: (____) _____

**Address**: _____ **City, State, Zip**: _____

**Responsible Party**:_____ **Relationship**: _____
(or policy holder)
**Birth Date**:_____ **SS#**_____

**Address**: _____ **City, State, Zip**: _____

**Home Phone**: (____) _____ **Cell Phone**: (____) _____

**[ ] Primary Insurance**_____**Insured**_____

**Policy #**_____ **Group #** _____

**[ ] Secondary Insurance**_____**Insured**_____

**Policy #**_____

**[ ] I do not have any secondary insurance**

**I acknowledge that this is the only insurance I have. Information regarding my insurance is accurate and correct. It is my responsibility to update AFAS of any changes in my insurance. Failure to provide this information will result in my assumption of responsibility for all charges incurred for that date of service.**

_____ _____
**Signature of Patient or Responsible Party** **Date**

**Who can we thank for your referral**? *(Please Check One, List On Line Below)*

□ **Physician** □ **Patient** □ **Internet** □ **Insurance Company** □ **Advertisement**
□ **Health Fair/Event** □ **Atlantic Foot Employee** □ **Phonebook** □**Other***(Specify)*

***Details(doctors name, patient name, etc.) :***_____

**Who is your Primary Physician: _____ Phone**:_____

**What brought you in to see the doctor? _____**

_____

**Date of first symptom**:_____
**If injury:**
**Date of Injury**:_____ **Auto accident**: Y N **Work related**: Y N

**What have you done for your foot problem?**_____

_____

**Have you seen another doctor for your foot problems?** _____ Yes _____ No

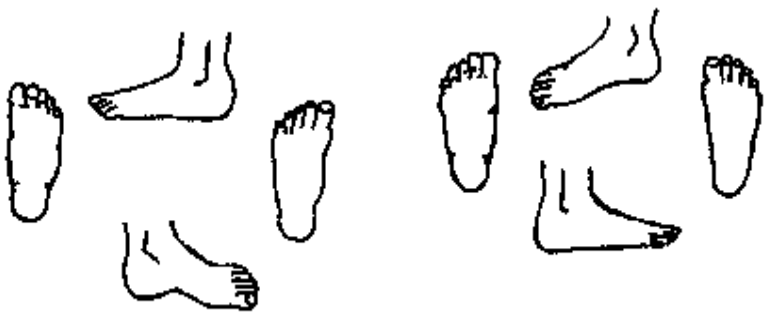
**Was the doctor a Podiatrist?** _____ Yes _____ No

**Name and telephone number of previous doctor(s) who treated your foot problem(s)**

_____

**On the diagram below, please mark the place(s) where you are experiencing pain in you're your feet:**

**Left foot** **Right Foot**



**Regarding the place(s) you marked above, describe the pain you experience, for instance, mild, moderate, severe, throbbing, burning, etc. and the time of day it occurs.**

_____

_____

**Do you currently wear or have you ever worn orthotics(inserts)?**
**If yes,** were they prescribed to you by a physician or health care provider? ___Yes ___No
**If yes,** were they over the counter or bought from the store? ___Yes ___No
**If yes,** did you find that they helped you to any significant degree? ___Yes ___No

**If you are a runner or athlete please tell us about your sport. Include how often you run/ exercise?**

_____

_____

**In your employment do you:** _____ sit at the job ____ stand at the job ____ stand and walk

**Does the employer require any particular type of shoes?** ____ No ____ Steel Toes

____ Boots ____ Heels ____ Other _____

**What do you do after work?** ___ Go home and sit ___ Go home and Exercise ___ Other

**Please explain:** _____

_____

**ALLERGIES:**

**No Known Drug Allergies**
**Hay Fever, Grass, Mold, Dust**
**Seasonal Allergies**
**Penicillin**
**Adhesive tape**
**Novacain**
**Mercurials**
**Cortisone**
**Codeine**
**Sulfa Drugs**
**Local Anesthetic**
**Aspirin or NSAID's**
**Latex**
**Iodine/Betadine**
**Other(s)**

Please list any medication you take, prescription and over the counter:

| Name of Medication | Reason for taking it | How often do you take it? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**What pharmacy do you use**?_____ Location: _____

Phone # _____ Fax # _____

**Please check each item as it applies to you:**

Anemia
Arthritis
Asthma or COPD
Autoimmune Disorder
_____
Back pain
Bleeding disorders
Cancer_____
Chest Pain
Circulation issues
Diabetes:
o Type 1
o Type 2
o Unknown
Fainting or Convulsions
Gall Bladder
Gout
Chronic Hip pain:
o Left Right Both
Headaches or Migraines
Heart disease/attack
High Blood Pressure
Hearing trouble
Joint Pain or Stiffness
Kidney disease or Stones
Chronic Knee pain:
o Left / Right / Both
Liver disease or jaundice
Lungs (pneumonia/ TB)
Mitral Valve Prolapse/Heart Murmur
Psychiatric disorder
o _____
Scarring tendency
Shortness of breath (cough, pleurisy, wheezing)
Skin disorder
o _____
Kidney Disease or Stones
Stomach trouble
o _____
Stroke
Thyroid disorder
o Hypo- or
o hyper-
Vision trouble
Weight change
Other health concerns
o_____
o_____
o_____

**Is there a family history of Diabetes? ____Yes ____No** **High Blood Pressure: ____Yes ____No**

**If there is a family history of any of the problems checked above please indicate:**

_____

_____

_____

**Have you ever been or are your currently under the care of a pain management specialist?** YES / NO

If so, what was the result? _____

**Have you ever seen an Orthopedist or Chiropractor for back, hip, knee or related pain?** YES / NO

If so, what was the result? _____

**Have you ever received treatment for back, hip, knee or related pain?** YES / NO

Please describe the treatment: _____

**Does back, hip and/or knee pain affect your activity level currently?** YES / NO

**If yes:** severe / moderate / mild / minimal

**Circle the number which describes you best:**

1. I can walk / stand for 1 hour with no back, hip or knee pain.
2. I can walk / stand for 30 minutes with no back, hip or knee pain.
3. I can walk / stand for 15 minutes with no back, hip or knee pain.
4. I have back, hip, knee pain which limits my activity level significantly.

**Back, hip, knee pain has affected my ability to:** *(Circle all that apply)*

Run Walk Stand Sit Climb Bend over

Lift/Carry Dance Exercise

**Please list any previous surgeries or hospitalizations, dates and** reasons.

| Surgery / Hospitalization | Approximate dates | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| | | |
|---|---|---|
| **Do you smoke?** | Yes | No |
| **Previously Smoked?** | Yes | No |
| **If yes, how often?** | Less than 1 pack daily | 1 pack or more daily |
| **Do you drink?** | Yes | No |
| **If yes, how often? (circle)** | 2 or more daily<br>Once daily<br>On occasion | |
| **Do You Use Caffeine?** | | |
| **If yes, how often?** | | |

| | |
|---|---|
| **Height** | |
| **Weight** | |
| **Blood Pressure** (circle) | Generally Normal<br>Generally High<br>Generally Low |
| **Shoe Size** | |

**<u>Diabetes/Circulation</u>**

**Are you under active care for diabetes and/or circulation problems**? Yes ____ No ____

If so, Doctors name_____ Phone # _____

Date you were last seen by the above doctor_____

Insulin dependent diabetic? Yes _____ No _____

Diet controlled? Yes _____ No _____

Number of years being a diabetic _____

Average blood sugar range _____

A1C _____

# IMPORTANT

**PLEASE READ BEFORE YOU SIGN**

## PATIENT FINANCIAL POLICY

- Patients who carry health insurance should remember that professional services are rendered and charged to the patient and not the insurance companies. Your insurance is a personal contract between you and your insurance company. If you would like us to file your claim for you, please provide your card to the receptionist. Without your card or proof of insurance, your claims can not be filed. **Payment is due in full on the date of service,** unless other arrangements have been made or we have a contract stating otherwise with your insurance company. We accept cash, check, Visa, Master Card, and American Express.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney and court fees shall become your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.
- There is a service fee of $50.00 for missed appointments. 24 hour notification is required for cancellations.
- You must inform the office of all insurance changes, authorization and referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- There are certain surgical procedures that require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.

I hereby authorize payment directly to Atlantic Foot and Ankle Specialists for the surgical and or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance

I authorize Atlantic Foot and Ankle Specialists to release any information, for insurances purposes, required in the course of my treatment.

## AUTHORIZATION OF TREATMENT

I the undersigned hereby authorize Atlantic Foot and Ankle Specialist and all covering physicians to render treatment and/or therapy to myself that deems medically necessary in order to treat the condition and or conditions I have requested from them and their staff.

## LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly to **Atlantic Foot and Ankle Specialist** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 90 days from the date of insurance payment and/or denial and if outside collection attempts are necessary, I will also be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named facility the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement

_____ _____

**Signature of Insured/Guardian** **Date**

**Relationship of Guardian to minor child** _____

# Atlantic Foot and Ankle Specialist, PC

## Patient Record of Disclosures

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have been afforded the opportunity to read and understand the Notice if I so choose.

_____ _____

Patient Name (printed) Date

_____

Parent or Authorized Representative (if applicable)

_____

Patient Signature

You may leave messages with, discuss my treatment, appointment or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that Atlantic Foot and Ankle Specialist, PC will **refuse to discuss** my information with anyone **NOT** listed below, except in a
life-threatening emergency. **I also understand that this consent does not apply to medical providers.**

PLEASE PRINT

**1.**_____ **Phone:**_____

**2.**_____ **Phone:**_____

**3.**_____ **Phone:**_____

**4.**_____ **Phone:**_____

_____ _____

Patient's Signature Date