M·P·G MARIETTA PODIATRY GROUP

CHART#:_____

Marietta Podiatry Group
Patient Registration Form

1. Patient Information (Please Include all information as shown on insurance card.)

Patient's Last Name	**Patient's First Name**			**Date of Birth**
Street Address				**SSN**
Street Address 2				**Gender: M or F**
City	**State**	**Zip Code**	**County ***	**Preferred Language ***
Race *				
Home Telephone	**Alternate Telephone**			
Pharmacy Telephone	**Email Address ***			
Emergency Contact Name	**Emergency Contact Telephone**			
Primary Care Physician (Last Name, First Name)	**Referred By**			
Medicare Patients Only; Date of last visit with your Family Physician?				

2. Medical Insurance Policy Holder (Check if self and complete only Insurance Information)

Primary Insurance Company	**Policy Number**		**Group Number**
Policy Holder Last Name	**Policy Holder First Name**		**Policy Holder SSN**
Relationship to Patient			**Policy Holder Date of Birth**
Street Address			**Employer Name**
Street Address 2			**Work Telephone**
City	**State**	**Zip Code**	**Home Telephone**

3. Responsible Party/Guarantor (Check if self and complete only Employment Information)

Last Name	**First Name**			**Date of Birth**
Street Address				**SSN**
Street Address 2				**Relationship to Patient**
City	**State**	**Zip Code**	**Home Telephone**	
Employer Name	**Work Telephone**			
Complete Only If Patient is a Minor and Information Differs From Above.				
Parent's Last Name	**Parent's First Name**			
Street Address	**City**	**State**	**Zip Code**	

I acknowledge the above information is accurate.

Signature_____ **Date** _____

M·P·G
MARIETTA PODIATRY GROUP

792 Church Street
Suite 101
Marietta, GA 30060
Phone (770) 422-9856

MEDICAL INFORMATION

(This information is important for our records and your health)

INSURANCE POLICY

Some insurance requires prior authorization or referral numbers in order to be seen. If your contract requires a REFERRAL or PRIOR AUTHORIZATION, it is your responsibility as the patient to ensure that MPG has the correct referral/ authorization from your primary care physician on file. It is the patients' responsibility to obtain future referrals for additional visits and services from your primary physician. If you have signed advance directive it is your responsibility to provide our office with a copy of your medical chart.

As a courtesy, MPG files all applicable insurances. It is the patients' responsibility to inform MPG of all insurance changes. Any outstanding balances that go uncollected more than 90 days will become the patient's responsibility. *Any supplies you may receive that are not covered by your insurance will be your responsibility.*

If you are a worker's comp claim, it is the patient's responsibility to ensure that MPG has the correct claim number and the adjuster's complete contact information. If worker's comp ever controverts the patient's claim the entire balance will become patient responsibility.

All deductibles, co-pays, co-insurances and all out of pocket expenses will be collected at the time of service. Receipts and charge tickets will be given upon request at the time of service.

Our office reserves the right to charge a $25.00 **No Show/ No Cancellation Fee** to patients who fail to cancel appointments in a timely fashion. This fee will be billed directly to you and is not reimbursable by insurance. If it becomes necessary to refer your account to an outside collection agency, a 33% service fee will be added to your account balance.

AUTHORIZATIONS

Benefits to Physicians:

☐ *I hereby authorize payments directly to the physician of the surgical and/ or Medical Benefits.*
☐ *I also understand that I am responsible for any portion of my bill not covered by my insurance company.*

Release of Information:

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES.

☐ *The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.*

DO YOU AUTHORIZE ANYONE TO RECEIVE YOUR MEDICAL INFORMATION?_____ IF SO, NAME & RELATIONSHIP:

_____

I HEREBY AUTHORIZE THE PHYSICIANS AND THEIR ASSISTANTS OF MARIETA PODIATRY GROUP TO ADMINISTER TREATMENT AS THEY DEEM NECESSARY.

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

Date:_____ 2011 *Signed(Insured Person):_____*

Name: _____ **MR #:** _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice of Privacy Practices are provided individually upon request or will be at our front check-in desk for you to read.

I understand that Marietta Podiatry Group is a healthcare provider and may share my health information for treatment, payment and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Marietta Podiatry Group has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at 770-422-9856.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices.

If any person is physically unable to provide a signature OR signs with a mark, print his/her name on the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If patient/resident is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient/resident is a minor (_____ years of age) OR Patient/resident is unable to acknowledge because_____

_____

Patient or Legal Guardian Date Relationship if Applicable

CHART #: _____

Personal Medical History

Patient Name: DOB:

This office will hold this information in utmost confidence.

My primary foot or ankle problem today is:

_____

_____

Name of Primary Care Physician

Doctor's Name: Phone Number: ( ) -

Address:

Are you under the care of this physician now? YES NO

When was the date of your last medical examination? ____/____/____

Are you being treated for or have you ever been treated for any of the following? *Please Circle*.

ASTHMA	*YES NO*	ANEMIA	*YES NO*	ARTHRITIS	*YES NO*
DIABETES	*YES NO*	TUBERCULOSIS	*YES NO*	CANCER/TUMOR	*YES NO*
EPILEPSY/SEISURE	*YES NO*	SKIN RASH/HIVES	*YES NO*	EMPHYSEMA	*YES NO*
KIDNEY TROUBLE	*YES NO*	STOMACH ULCERS	*YES NO*	BRONCHITIS	*YES NO*
THYROID DISEASE	*YES NO*	RHEUMATIC FEVER	*YES NO*		

OTHER_____

DO YOU HAVE HIGH BLOOD PRESSURE? *YES NO* ***IF YES WHAT MEDICATION ARE YOU TAKING?*** _____

IF YOU ARE DIABETIC **WHAT WAS YOU LAST A1C LEVEL? _____**

IF YOU ARE DIABETIC WHEN WAS YOUR LAST EYE EXAM? **_____**

Please explain any YES answer(s) below:

Medical Condition	Date(s) of Treatment	Outcome	Hospital Name & Address	Primary Doctor Name & Address

Please list all surgeries that you have had and the date performed:

Surgery	Date	Surgery	Date
1.		**3.**	
2.		**4.**	

Patient Name: DOB:

Have you ever tested positive for the following:

HIV / AIDS YES NO Sickle Cell Disease YES NO Hepatitis YES NO

Social History:

Do you smoke? YES NO *If Yes, How much*?_____ How many years?_____

Do you drink? YES NO *If Yes, How much*?_____ How many years?_____

Are you pregnant: YES _____weeks NO

Height_____ Weight_____ Shoe Size _____

Please list any medications you are currently taking on a regular basis:

Medication Name	For Medical Condition	Start Date	Dosage	Reaction/Side Effects
1.				
2.				
3.				
4.				

Are you allergic or have you had an adverse reaction to any of the following:

PENICILLIN	YES	NO	OTHER ANTIBIOTICS	YES	NO
LOCAL ANESTHESIA	YES	NO	GENERAL ANESTHESIA	YES	NO
CODEINE	YES	NO	ASPIRIN	YES	NO
SULFA DRUGS	YES	NO	TAPE OR BAND-AIDS	YES	NO
IODINE	YES	NO	LATEX	YES	NO
SEDATIVES	YES	NO	SHELLFISH	YES	NO
OTHER _____	YES	NO	OTHER _____	YES	NO

Referred by: Doctor_____ Friend ___ Family___ Website____ Other _____

I hereby authorize the physicians and their assistants of the Marietta Podiatry Group to administer treatment as deemed necessary.

SIGNATURE (PATIENT OR RESPONSIBLE PARTY)

_____DATE:_____