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**	**Patient's Primary Language**	
Home Telephone		**Alternate Telephone**		
Emergency Contact Name		**Emergency Contact Telephone**		
Primary Care Physician		**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**

4. Assignment of Benefits/Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize this office to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians.

Signature of Patient or Legal Guardian:	**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 understand all of the above and hereby state that the information is correct to the best of my knowledge.

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

Glyn E. Lewis, DPM
Nathan H. Schwartz, DPM
Bruce A. Pichler, DPM
Diadra W. Biles, DPM

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

PATIENT RECORD ACCOUNT #_____

DATE_____

Please Fill Out Completely

Patient's full name:

Last_____ First_____ MI_____

Sex M F Date of Birth:_____

Primary Care Physician:_____

Please describe your medical problem and location of primary complaint:

_____

_____

How would you describe your pain?

Sharp aching throbbing shooting electrical sensation pins and needles burning

Pain Scale of 1-10: 1 2 3 4 5 6 7 8 9 0

How long has your problem been present? _____

Have you attempted any treatments to relieve your problem?

rest ice elevation change shoe gear OTC padding in home whirlpool stretching

OTC anti-inflammatory medication (Motrin, Aleve, Tylenol, Aspirin, etc)

What is your activity level at work / home: sitting standing walking considerable movement

*****PLEASE CIRCLE THE ONES THAT APPLY TO YOU AND DESCRIBE IF NEEDED*****

Do You Have: fatigue nausea chills

Vision - Do you have vision problems? Yes No

Hearing - Do you have: hearing loss frequent ear infections dizziness loss of balance

Nose - Do you have:

sinus problems/Allergies difficulty breathing deviated septum

frequent nose bleeds nasal polyps

Throat - Do you have: frequent throat infections hoarseness difficulties with speech

Respiratory - Do you have: asthma emphysema tuberculosis lung cancer
collapsed lung/atelectasis bronchitis shortness of breath pneumonia

Cardiovascular - Do you have:
Hypertension/high blood pressure pacemaker angina open heart/bypass surgery
Myocardial Infarct/Heart attack chest pain angioplasty
palpitations/irregular beats rheumatic fever valve prolapse/heart murmur

Vascular/Circulation - Do you have?
circulation disorder/decrease atherosclerosis/blocked arteries blood clot/deep vein thrombosis
leg pain at rest high cholesterol varicose veins
leg pain with walking phlebitis

Gastrointestinal - Do you have problems with:
reflux/heart burn abdominal pain liver disorder excessive hunger ulcer gallbladder colitis
excessive thirst hepatitis A hepatitis B hepatitis C loss of appetite

Genitourinary - Do you have:
renal failure frequent bladder/urinary tract infections
renal dialysis frequent urination kidney stone

Genitourinary - Have you had any of the following Sexually Transmitted Diseases?
gonorrhea syphilis chlamydia herpes HIV

Hematologic -Do you have: anemia cancer/leukemia sickle cell disease or trait blood transfusion

Hematologic - Have you been anticoagulant with any of the following blood thinners? (if so -please specify date)
Coumadin _____ Heparin _____
Aspirin _____ Plavix _____

Endocrine - Do you have: Diabetes Thyroid disease

Neurological - Do you have: seizures stroke neuro-muscular disease change in memory
numbness polio tremor frequent head aches muscle weakness

Musculoskeletal - Do you have: Arthritis/degenerative joint disease gout hip pain
frequent muscle/tendon pain rheumatoid arthritis sciatica back pain knee pain

Integument - Do you have: skin rashes psoriasis eczema color change to mole or wart skin cancer
skin growth itching to skin thick scar/keloid change in size of skin growth hives

Psychiatric - Do you have:
depression anxious/agitation memory loss concentration difficulties suicidal
nervousness phobias bipolar disease feelings of worthlessness/low self esteem

Family History of Illness –

_____

_____

_____

Social History - Do you:
smoke tobacco smoke marijuana use hallucinogenic drugs
drink alcohol use cocaine use other recreational drugs
If you smoke, number of packs per day?_____
Number of years of tobacco use:_____
If you drink, number of drinks per day?_____
Number of years of alcohol use: _____
If you use other recreational drugs - please list/specify:

_____

Women - Are you pregnant? No Yes (how many months?_____)

Please List ALL Previous Surgeries With Dates:

_____

_____

_____

Any complications/problems with surgery or anesthetics? *Or recurrent infections; ie, MRSA, or infection resistant to antibiotics?* **PLEASE SPECIFY.**

_____

Previous hospitalization – Month and Year_____

Medications - please list medications (including aspirin) currently taking:

_____

_____

_____

Allergies - Do you have allergies to any of the following:

drug allergies penicillin sulfa erythromycin

aspirin cortisone codeine adhesive tape

Other allergies to medications - please list:

_____

Do you have any **food** or plant allergies: If so, please list:

_____

What is your height? What is your weight? What is your shoe size?

_____ _____ _____

Who referred you to our office?

Please circle one of the following:

Physician: Friend Yellow Pages Internet Other_____

Dr._____