ATHENS PODIATRY GROUP/FLAT ROCK FOOT SPECIALISTS

Patient Information

Please Print

Date: ____/____/____ Driver's License #: _____

Name: Last _____ First _____ Initial _____

Age: _____ Sex: _____ Date of Birth: ____/____/____ Social Security # ____-____-____

Referred By: _____ Primary Care Physician: _____

Home Address: _____ City: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone #: _____

Marital Status: _____ Spouses Name: _____

Party Responsible for Account: _____

Subscriber Name: _____

Subscriber Birthdate: _____ Social Security #: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

In case of emergency

Notify: _____ Telephone: _____

Current Foot or Ankle Problems: (Location, Duration, Onset, Course, Aggravating Factors, Previous Treatment)

_____

_____

_____

_____

_____

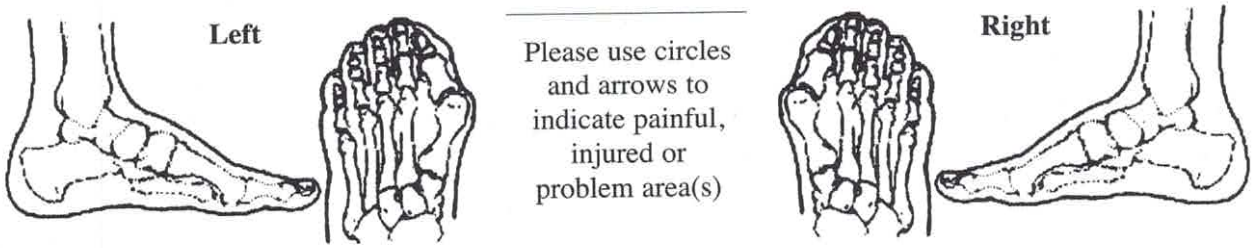
_____

_____

_____

Length of time for current problem:

_____ Days
Weeks
Months
Years



Please use circles and arrows to indicate painful, injured or problem area(s)

Height: _____ Weight: _____ Shoe Size: _____

Current Medications:
(Include any herbal supplements, diet pills, prescription lotions or inhalers)

_____

_____

_____

Allergies: _____

_____

Previous Surgeries: _____

Are you Pregnant? ( ) Yes ( ) No

Are you a Diabetic? ( ) Yes ( ) No

Family History of Diabetes? ( ) Yes ( ) No

If Yes, Who? _____

Do You Smoke ? _____

Do You Drink Alcohol ? _____

Race: ____ American Indian or Alaskan Native ____ Asian ____ Black or African American

____ Native Hawaiian or other Pacific Islander ____ White

Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino

Pharmacy: _____

Email: _____

I hereby give permission to Athens Podiatry Group to treat and / or photograph my feet.

CONSENT OF PATIENT (ADVOCATE, LEGAL GUARDIAN, OR NEAREST RELATIVE - IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR.)

Signature of Patient, Advocate,
Guardian or Nearest Relative: _____

Date / Time: _____ Relationship: _____

Address: _____

City: _____ Zip Code: _____ Phone Number: _____

Signature of Witness: _____

ATHENS PODIATRY GROUP

Name _____ Date _____

Social History

Do you smoke? ☐ Yes ☐ No How much _____

Do you drink alcohol? ☐ Yes ☐ No How much _____

What type of job do you have? _____

Family History Do any illnesses run in your family? _____

_____

_____

Review of Systems Please check if you have any of the following

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight loss
- ☐ Lethargy

EAR, NOSE, MOUTH & THROAT
- ☐ Tinnitis
- ☐ Nose bleeds
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Difficulty swallowing

GENITOURINARY
- ☐ Frequency
- ☐ Blood in urine
- ☐ Abnormal urine color
- ☐ Painful urination
- ☐ Awaken to urinate
- ☐ Unable to fully empty bladder
- ☐ Incontinence

HEMATOLOGIC / LYMPHATIC
- ☐ Easy bruising
- ☐ Anemia
- ☐ Blood abnormalities
- ☐ Blood thinners
- ☐ Lymph node enlargement

EYES
- ☐ Blurred vision
- ☐ Cataracts
- ☐ Glasses

RESPIRATORY
- ☐ Chronic cough
- ☐ Wheezing
- ☐ Emphysema
- ☐ Cough blood
- ☐ Productive cough
- ☐ Asthma

MUSCULOSKELETAL
- ☐ Pain
- ☐ Limited range of motion
- ☐ Limited strength
- ☐ Arthritis

NEUROLOGICAL
- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Memory loss
- ☐ Numbness

CARDIOVASCULAR
- ☐ Shortness of breath
- ☐ Chest pain (angina)
- ☐ Heart palpitations
- ☐ Heart attack
- ☐ Stroke
- ☐ Cold extremities
- ☐ Hypertension

GASTROINTESTINAL
- ☐ Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Mucus in stool
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomit blood
- ☐ Heartburn
- ☐ Change in stool
- ☐ Food intolerance
- ☐ Loss of appetite

INTEGUMENTARY
- ☐ Rash
- ☐ Itching
- ☐ Dry skin

ENDOCRINE
- ☐ Night sweats
- ☐ Thyroid disease
- ☐ Diabetes

Reviewed _____

ATHENS PODIATRY GROUP

and

FLAT ROCK FOOT SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and in the course of providing care; providers will share either written or electronic patient information with other providers who are involved in the patients care, as appropriate. I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

COUNTRY PRINTING • (734) 782-4044

ATHENS PODIATRY GROUP/FLAT ROCK FOOT SPECIALISTS

THIS IS OUR OFFICE FINANCIAL POLICY

We at Athens Podiatry Group are committed to providing you with the best possible care. If you have Medical Insurance we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Unless Insurance Arrangements have been approved in advance by our staff, payment for services is due at the time services are rendered. This includes copays, deductibles or supplies received. We accept payment in the form of cash, check. Mastercard, Visa, American Express, or Discover. There is a $20 charge for returned checks. There is a charge of $20 per form that is requested to be filled out by the patient for insurance or work. There is a $3.00 per CD charge for copying x-rays. There is a charge of 25¢ per page + $5.00 service fee for copying medical records. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Insurance is a contract between YOU and your INSURANCE COMPANY.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily refuse to cover certain services. We have no control over this.
3. MEDICARE PATIENTS: We would like you to understand that taking ASSIGNMENT means that YOU are responsible for the YEARLY DEDUCTIBLE and for the 20% (CO-INSURANCE) of what Medicare allows. You are responsible for services that your co-insurance doesn't cover. If your co-insurance doesn't pay this amount, YOU are responsible for it.

Unlike some offices, the FILING OF INSURANCE CLAIMS is a COURTESY that we have always extended to our patients. However, all charges are YOUR responsibility, NOT your Insurance Company's. We will make our BEST EFFORT to collect from them, but if, despite our best efforts, we are NOT SUCCESSFUL, YOU are responsible for the unpaid balance.

We realize that temporary financial problems may affect timely payment of your account. We don't want any financial problems to get in the way of our good relationship with you. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I authorize payment of MEDICAL BENEFITS be made on my behalf to Dr. Vicki Anton-Athens, for any services furnished to me by the doctors of Athens Podiatry Group or Flat Rock Foot Specialists. I authorize the release of any medical information held by Dr. Vicki Anton-Athens to the health care financing administration and its agent, to process my claims.

_____ _____

Your Signature Date

Athens Podiatry Group

Patient's Designation of Preferred Manner of Contact

Patient: _____ DOB: _____
Last First

I wish to be contacted in the following manner (check all that apply):

Oral Communication:

_ Home telephone: _____ _ Work telephone: _____

_ OK to leave message with detailed info _ OK to leave message with detailed info

_ Leave message with callback info only _ Leave message with callback info only

_ Other: _____

Written Communication:

_ OK to mail to my home address _ OK to fax to this number: _____

_ OK to email to: _____

_ Other: _____

I permit Athens Podiatry Group to discuss my personal health information with, and to disclose my personal health information to, the following individuals:

_ Spouse: _____

_ Adult child(ren): _____

_ My parent(s): _____

_ Other: _____

Signature: _____ **Date:** _____