

ALLIED ANKLE & FOOT CARE CENTERS, P.C.

Patient Registration Form

PATIENT	Patient's Name: Last			First (<i>legal</i>):			Middle Initial:		
	SSN#:								
	Address:				City:		State:		Zip:
	Home Phone #			Work #:			Cell #		
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			Date of Birth:			Age:		
	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed			Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Not-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Military Duty			Student Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not a Student		
	Employer:					Occupation:			
	Emergency Contact Name: _____								
	Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other								
	Phone: _____ <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell								
* Please present your insurance card(s) to the receptionist *									
INSURANCE	Primary Insurance: _____								
	Subscriber's Name: _____ Subscriber's DOB _____ Subscriber's SSN _____								
	Subscriber's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other								
	Secondary Insurance _____								
	Subscriber's Name: _____ Subscriber's DOB _____ Subscriber's SSN _____								
Subscriber's Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other									
FINANCIAL	Guarantor/ Responsible Party (Required for patients who are under age 18)								
	Guarantor Name-Last:			First:(legal)			Middle Initial:		
	Address: (if different than patient)								
	City:			State:		Zip:			
	Phone #:			Date of Birth:					
Relationship to patient: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian									
How did you hear about Allied Ankle & Foot Care Centers?			Providing your ethnicity/ race is optional, and will not affect the quality of care that you receive at our office. If you choose not to answer race or ethnicity, please check "Unreported/ Refused to Report".						
<input type="checkbox"/> Yellow Pages Book <input type="checkbox"/> Internet <input type="checkbox"/> Our Company Website <input type="checkbox"/> Former Patient <input type="checkbox"/> Doctor: _____ <input type="checkbox"/> Insurance Company <input type="checkbox"/> Family/Friend: _____ <input type="checkbox"/> Hospital/ER: _____ <input type="checkbox"/> Sign/ Driving by the Office <input type="checkbox"/> Health Fair <input type="checkbox"/> Other: _____			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unreported/Refused to Report			Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> More than one race <input type="checkbox"/> Unreported/Refused to Report			

Patient/Guardian Signature

Date

MEDICAL HISTORY

This complete record is confidential.

Patient's Name			Date of Birth -----
Last	First	Middle	MALE FEMALE
Name of Primary Physician		Primary Physician Phone number	May we contact your primary physician for your health records? <input type="checkbox"/> Yes <input type="checkbox"/> No
Former podiatrist name		Former podiatrist phone number	May we contact your former podiatrist for records?
If any, what kind of podiatric treatment did you have?			When did you have this treatment?
Major foot complaint today is?			
This condition(s) has existed for ____ days ____ weeks ____ months ____ years			

Check any of the following below that you have or have been treated for:

	Diabetes		Rheumatic Fever
	Leg or feet injuries/surgeries		Kidney Problems
	Bleeding Tendencies		Liver Problems
	Leg Cramps		Arthritis
	Heart Problems		Bursitis
	Asthma		High Blood Pressure
	Epilepsy		Low Blood Pressure
			Other-what?

Check any existing allergies: Novocaine Penicillin Sulfa Drugs Adhesive Tape
 Latex Other—Please specify? _____
 No Known Allergies

What medicines do you take regularly?

	YES	NO	Comment
Do you use alcohol? If yes, how much?			
Do you smoke? If yes, how much?			
Do you use caffeine? If yes, how much?			
Have any family members been treated for diabetes?			
Have you had any injuries or surgeries on your feet or legs?			

Height: _____ Weight: _____ Shoe Size: _____ Comments: _____

Preferred Notification Method for Preventive Health Reminders: Web Message Phone Postal Mail

Primary Language Spoken (Required): _____

I hereby give Allied Ankle & Foot Care Centers, P.C. permission to examine and to provide treatment.

Patient's Signature _____ Date _____

ALLIED ANKLE & FOOT CARE CENTERS, P.C.

MEDICINE AND SURGERY OF THE FOOT AND LEG

ATHENS (706) 548-2740 (770) 725-9894 Fax	DECATUR (404) 298-6050 (404) 508-0648 Fax	POWDER SPRINGS (770) 943-2121 (770) 943-3919 Fax	LAWRENCEVILLE (770) 277-7373 (770) 277-1755 Fax	ROSWELL (770) 992-998 (770) 641-0378 Fax	RIVERDALE (770) 907-7973 (770) 907-7975 Fax
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Patient Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- 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 an 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. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures that we 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.
- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees 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.

Signature of Patient/Responsible Party: _____

Printed Name: _____

Date: _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Allied Ankle & Foot Care Centers, P.C. "Notice of Privacy Practices", and that I have read and understand the Notice.

Patient's Name

Date of Birth

Parent or Authorized Representative (if applicable)

Signature

Date

Would you like to give Allied Ankle & Foot Care Centers P.C. permission to discuss your medical records and/or financial information to another person other than yourself? This can include, but is not limited to your spouse or another family member who might need to ask questions about your account. Please list the name(s) and relationship below.

