ATHENS PODIATRY GROUP / FLAT ROCK FOOT SPECIALISTS

Patient Information

Date: ____/____/____ Name: _____
LAST FIRST M.I.

Age: _____ Birthdate: ____/____/____ Sex: _____ Social Security Number: _____-_____-_____

Referred by: _____ Primary Care Physician: _____

Home Address: _____
IF DIFFERENT THAN ON DRIVER'S LICENSE

Phone Number(s): _____ _____ _____
PRIMARY SECONDARY WORK

Email Address: _____

Marital Status: _____ Spouse's Name: _____

INSURANCE POLICYHOLDER

Name: _____ Birthdate: ____/____/____ SSN: _____-_____-_____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

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

__ OK to leave detailed message at my primary # __ Leave message with callback info only at my primary #

I PERMIT ATHENS PODIATRY GROUP TO DISCLOSE MY PERSONAL HEALTH INFORMATION TO, AND TO DISCUSS MY PERSONAL HEALTH INFORMATION WITH, TO THE FOLLOWING INDIVIDUALS:

__ Spouse: _____

__ Adult child(ren): _____

__ My parent(s): _____

__ Other: _____

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

CONSENT OF PATIENT:

(If patient is a minor or is otherwise unable to consent, patient's advocate, legal guardian or nearest relative.)

_____ _____
SIGNATURE OF PATIENT, OR PATIENT'S ADVOCATE, LEGAL GUARDIAN, OR NEAREST RELATIVE ** FOR OFFICE USE ONLY: WITNESS SIGNATURE

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

_____ _____
PATIENT'S NAME (PRINTED) PARENT OR AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

_____ _____
SIGNATURE DATE

ATHENS PODIATRY GROUP / FLAT ROCK FOOT SPECIALISTS

OFFICE FINANCIAL POLICY

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 service is due at the time services are rendered.

- There is a $25 charge for returned checks.
- There is a $5 per CD charge for copying x-rays.
- There is a $25 service fee for copying medical records, as a patient, + $1.25/page for pages 1-20, $0.63/page for pages 21-50 and $0.25/page for pages 51 and higher.
- There is a $30 fee for completion of forms.

This includes copays, deductibles and supplies received in addition to the fees listed above. We accept payment in the form of cash, check, Mastercard, Visa, American Express or Discover. 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.
   YOU ARE RESPONSIBLE FOR ALL COPAYS AND DEDUCTIBLES applied by your insurance.
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 does not cover. If your co-insurance does not 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 responsibility. 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 do not want any financial problems to get in the way of our good relationship. Therefore, if such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

I authorize payment of MEDICAL BENEFITS to 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 healthcare financing administration and its agent to process my claims.

YOUR SIGNATURE _____ DATE _____

Preferred Pharmacy: _____
NAME OF PHARMACY CITY/INTERSECTION OF PHARMACY

CURRENT MEDICATIONS, including supplements:

_____

_____

_____

ALLERGIES: ☐ No Known Allergies
☐ Adhesive/tape ☐ Latex ☐ Codeine ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin
☐ Metals: _____ ☐ Foods: _____
☐ Other: _____

Social History

Occupation: _____ Employer: _____

What type of job do you have? _____ It primarily requires: ☐ sitting ☐ standing

Do you smoke? ☐ Never

☐ Former user - # years: _____ When did you stop? _____

☐ Current user of: ☐ cigarettes ☐ vaping/e-cigarettes ☐ cigars ☐ other: _____

How much per day? _____ How many years? _____

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

Family History – Has a member of your family been diagnosed with any of the of the following? If so, please indicate relationship of family member(s) who have had these problems.

☐ Diabetes – mother / father
☐ Heart disease – mother / father
☐ Other: _____
☐ Cancer – mother / father
☐ High blood pressure – mother / father

Past Medical History – Do you currently have, have you ever had, have you ever been treated for, or have you ever taken any medications for any of the following?

☐ Heart disease
☐ Heart attack
☐ Hypertension
☐ Stroke
☐ Bleeding disorders
☐ Blood clot
☐ Chest pain
☐ Diabetes – type I / II
☐ Thyroid disease
☐ Eye disease
☐ Rheumatic fever
☐ Scarlet fever
☐ Tuberculosis
☐ Numbness
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Pneumonia
☐ Epilepsy
☐ Arthritis
☐ Back problems
☐ STD
☐ Pregnancy – currently? Y / N
☐ Cramping/Coldness in legs/feet
☐ Stomach ulcer
☐ Acid reflux
☐ Urinary infection
☐ Kidney stones
☐ Kidney disease
☐ Jaundice
☐ Hepatitis
☐ Anemia
☐ Gout
☐ AIDS
☐ Cancer: _____
☐ Other: _____
_____
_____

Past Surgical History – Have you ever had any surgery? If yes, please list below, with dates:

_____

_____

Height: _____ Weight: _____ Shoe Size: _____

** FOR OFFICE USE ONLY:

BP: _____

Review of Systems – Please check all that apply to you:

CONSTITUTIONAL
- ☐ Fever
- ☐ Recent Weight Changes
- ☐ Lethargy

EAR, NOSE, MOUTH & THROAT
- ☐ Tinnitus
- ☐ Nose bleeds
- ☐ Nasal Congestion
- ☐ Sore throat
- ☐ Difficulty Swallowing

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

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

EYES
- ☐ Blurred vision
- ☐ Cataracts
- ☐ Glasses

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

ENDOCRINE
- ☐ Night sweats

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
- ☐ Cold extremities

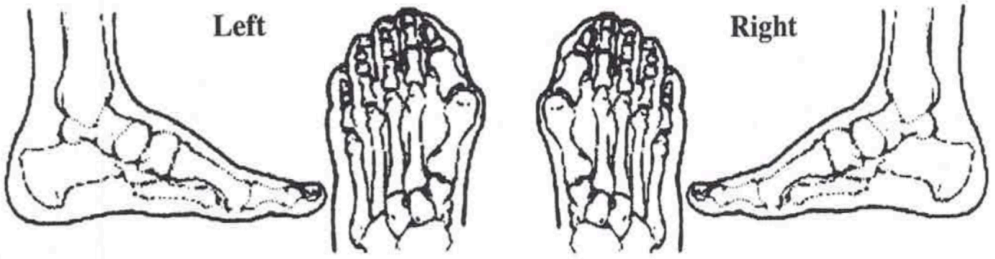
GASTROINTESTINAL
- ☐ Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Mucous in stool
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Heartburn
- ☐ Change in stool
- ☐ Food intolerance
- ☐ Loss of appetite

INTEGUMENTARY
- ☐ Rash
- ☐ Itching
- ☐ Dry skin

CURRENT FOOT OR ANKLE PROBLEMS:

What brings you in today? _____

Please indicate the area(s) of concern using arrows or circles:



When did your symptom(s) begin?

_____

What caused the symptom(s)? An injury?

_____

How would you describe your discomfort?

☐ aching ☐ throbbing ☐ stabbing ☐ sharp
☐ dull ☐ cramping ☐ burning ☐ numb
☐ other: _____

Please rate your pain level:

0 1 2 3 4 5 6 7 8 9 10
NONE WORST

What makes your symptoms better?

_____

What makes your symptoms worse?

_____

What previous testing have you had for this concern?

_____

What previous treatment have you done to address your concern(s)? _____

_____

For diabetic patients only:

Blood Sugar today: _____ mg/dL

Most recent HbA1c: _____ % When did you last see your primary care doctor? _____