M·P·G
Marietta Podiatry Group

Marietta Podiatry Group
Patient Registration Form

CHART #_____

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				
Street Address 2				**Gender: M or F**
City	**State**	**Zip Code**	**County***	**Preferred Language***
Race*		**Ethnicity***		
Home Telephone			**Cellphone #**	
Pharmacy Telephone			**E-mail 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			**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**_____

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MEDICAL INFORMATION

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

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 patient's responsibility to obtain future referrals for additional visits and services from your primary physician. If you have signed an advanced 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 patient's responsibility to inform MPG of all insurance changes. **Any outstanding balances that are uncollected more than 90 days will become the patient's responsibility.** *Any supplies you receive that are not covered by your insurance will be your responsibility at the time of receipt.*

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

All deductibles, co-pays, co-insurance and all out of pocket expenses will be collected at the time of service.

Our office reserves the right to charge a NO SHOW FEE to patients who fail to call 24 hours prior to their appointment, and do not show for the appointment. This fee is not reimbursable by insurance.

Any account referred out for Collections due to non-payment, will be assessed an additional 33% fee by the Collection company.

AUTHORIZATIONS

Benefits to Physicians

☐ *I hereby authorize payments directly to the physician/Marietta Podiatry Group/Cobb Foot & Leg*

☐*I also understand that I am responsible for any portion of my bill not covered by my insurance company*

Release of Information

☐*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 MARIETTA 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.

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

DATE **PATIENT/GUARDIAN IF PATIENT IS A MINOR**

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Name:_____ CHART/MR #_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice of Privacy Practices are provided individually upon request or we will provide a copy to read at our check in desk at time of arrival.

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 Office 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 _____.

_____

LEGAL GUARDIAN SIGNATURE DATE RELATIONSHIP

_____

PATIENT SIGNATURE DATE

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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/SEIZURE	*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*	HEART	YES *NO*

OTHER_____

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

IF YOU ARE DIABETIC WHAT WAS YOUR 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 you have had and the date preformed:

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

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165 Vann Street · Marietta Georgia 30066 · Phone (770) 422-9856 · Fax (770) 984-0303 CHART#_____

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: **MUST PRINT MEDICATIONS LEGIBLY**

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_____			OTHER_____		

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) _____

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DATE:_____

Patient Name: _____

REVIEW OF SYSTEMS FORM

PLEASE CIRCLE IF ANY APPLY; OR INITIAL ANYWHERE ON PAGE IF NONE

Constitutional: fever weight gain weight loss appetite change night sweats fatigue chills

Eyes: blurry /double vision vision loss tearing redness pain sensitivity to light glaucoma

Ears, Nose, Mouth, Throat: hearing loss ringing in ears ear pain nasal congestion nasal drainage nosebleeds mouth/throat irritation tooth problem

Cardiovascular: chest pain/pressure heart racing palpitations sweating leg swelling high/low blood pressure

Pulmonary: cough yellow/green sputum blood in sputum shortness of breath wheezing

Gastrointestinal: nausea vomiting diarrhea constipation pain blood in stool or vomitus heartburn difficulty swallowing

Genitourinary: incontinence abnormal bleeding abnormal discharge urinary frequency urinary hesitancy pain impotence sexual problem infection urinary retention

Musculoskeletal: pain stiffness joint redness/warmth arthritis back pain weakness muscle wasting sprain/fracture

Neuro: headache weakness dizziness change in voice change in taste change in vision change in hearing loss/change sensation trouble walking balance problem coordination problem shaking speech problem

Endocrine: cold or heat intolerance blood sugar problem weight gain/loss missed periods hot flashes/sweats change in body hair change in libido increased thirst increased urination

Heme/Lymph: swelling bleeding problem anemia bruising enlarged lymph node

Allergic/Immunologic: itch post-nasal drip watery/itchy eyes nasal drainage immunosuppressed