



New Patient Registration

First Name	Last Name	Middle Initial	
Date Of Birth	SSN#	Gender(M/F)	
Home Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Email	Employment Status	Employer	
Emergency contact First Name	Last Name	Relationship To Patient	
Emergency Contact Address	City	State	Zip Code
Emergency Contact Home Phone	Work Phone	Cell Phone	

Do we have your permission to obtain your medication list from your pharmacy? Yes ___ No ___.

Who is your primary care physician? _____ Phone: _____

Marital Status: Married ___ Single ___ Separated ___ Divorced ___ Widowed ___ Other _____

Race: Black/Non-Hispanic ___ American Indian/ Alaskan Native ___ Hispanic ___

Asian Pacific/Islander ___ White/Non-Hispanic ___ Other ____.

Insurance Information

(Please Provide us with your insurance card)

Policy Holder Name: _____ DOB: _____

Primary Insurance Name: _____ ID#: _____

Secondary insurance Name: _____ ID#: _____

How did you hear about us? _____

Past Medical History(check all that apply or write N/A)

Cancer:Lung___Skin___Cervical___Prostate___
Neurological:Stroke___neuropathy___Vertigo___Seizures___Migraines___
Skin:Eczema___Psoriasis___Ulcers___Vitiligo___Dermatitis___Hives___
Psychiatric:Bipolar___Depression___Anxiety___Claustrophobia___Dementia___
Respiratory:Emphysema___Asthma___Shortness of Breath___COPD___
Eyes/Ears/Nose/Mouth/Throat:Cataracts___Glaucoma___Hearing Loss___
Cardiovascular:Heart Attack___Coronary Disease___Highblood Pressure___Irregular Heart Beat___
Musculoskeletal:Lupus___Osteoarthritis___Rheumatoid Arthritis___Fibromyalgia___Gout___
Back Pain___
Metabolic:Hypoglycemia___Diabetes___Hypothyroidism___Hyperlipidemia___
Other:_____

Past Surgeries and Hospitalization(check all that apply or write N/A)

Tonsils/Adenoids___Amputations___Other Vascular Bypass___Appendiz___Gallbladder___
Hysterectomy___Hernia___Angioplasty___Coronary/Heart Bypass___
Other:_____

Please list or attach a complete list of all **Current Medications**(include how much and how often taken), including vitamins and supplements._____

Allergies:None___Narcotics___NSAIDS___Penicillin___Asprin___Contrast___Laxtex___Iodine___
Shellfish___Tape___Gluten___Food Allergies___Metal___Other_____

Family History(Mom and Dad):_____

Social History:

Do You Smoke?Yes___No___, If so how many packs a day?_____
Do You Take Illegal Drugs?Yes___No___, If so what kind are you taking?_____
Do you drink?Yes___No___,If so how often?_____?

Vaccine:

Flu Vaccine:Yes___No___,If so when?_____
COVID Vaccine:Yes___No___,If so 1st Dose_____2nd Dose_____
COVID Booster:Yes___No___,if so when?_____

Injury History:

Is There History Of Injury?Yes___No___,If yes date of injury?_____
Is This A Work Related Injury?Yes___No___,If yes has claim been made?Yes___No___Date Of Injury_____
Is This Injury An Auto Accident?Yes___No___,If yes has claim been made?Yes___NO___Date_____

What name do you prefer to go by? _____

What is your chief complaint today? _____

Where is your pain? Right Foot ___ Left Foot ___ Both Feet ___ Right Ankle ___ Left Ankle ___ Both Ankle's ___
Both feet and ankle's ___ Right Leg ___ Left Leg ___ Both Legs ___ Toenails ___

When Did this condition begin? Years ___ Months ___ Days ___

What is the nature of the pain? Stabbing ___ Radiating ___ Sharp ___ Dull ___ Burning ___ Aching ___
itching ___ Other _____.

Is your condition getting better or worse? Yes ___ No ___ Rate your Pain 1 thru 10 ___

What seems to make your condition/pain worse? _____

What seems to make your condition/pain better? _____

Have you seen another doctor for this problem? Yes ___ No ___

If Yes, Doctors

Name _____ Facility? _____

Address _____ Phone number _____

Has this condition/pain affected your ability to work, exercise or perform daily activities? Yes ___ No ___
If yes, how? _____

Women: Breastfeeding? Yes ___ No ___

Are you Pregnant? Yes ___ No ___ If so, how many weeks are you? _____ Due Date _____

What Pharmacy do you use? Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Do you have a primary care physician? Yes ___ No ___, If yes Name of Doctor _____

Name of Practice _____ Address _____

Phone _____ Fax _____.

Any Other Information we need to know? _____



The following sets forth the general billing policy of Georgia Blue Foot And Ankle, LLC(GBFA) And or Soles To Heel Foot And Ankle,LLC Location(STH). Please review this information and initial and/or sign where indicated.

- I understand that it is my responsibility to provide the office of Georgia Blue Foot And Ankle,LLC as well as Soles To Heel Foot And Ankle,LLC information at the time of check in and to notify these offices of any changes to my medical or personal information._____
- I understand that it is my responsibility to know my specialty Co_pays,deductibles and coinsurance(which could be different from Primary care benefits)and to pay for service being rendered. I understand that contractual agreement with my health plan is to collect Co-pays, deductibles and coinsurance at the time of service._____
- I understand that there is a \$65 fee to initially complete disability paperwork associated with the care, Additional pages will cost \$5 per page. I will provide a standard form of charge however, if additional disability forms require completion, I understand that a \$65 fee is required._____
- I understand that GBFA and/or STH will verify insurance eligibility, deductible amounts and coinsurance amounts prior to any elective surgery that you may have. I further understand that the fee I am quoted is an estimate based on anticipated surgery to be performed and current information given to GBFA and/or STH by my insurance carrier._____
- I understand that I will be billed for any amounts due from my co-payment, coinsurance and deductible that my insurance may later hold me responsible for. I am aware that I have a financial responsibility to pay these amounts. I understand that I will be provided with three statements and an automated text message statement for any balance due. I further understand that if I have not made a payment in full prior to being sent a third statement, my balance due will be sent to collections. I also understand that I will be responsible for all costs and fees incurred in the collection process, including attorney fees and cost. I understand that, if my balance due is sent to collects, i will be charged an additional 30% of balance due.(addition to original balance)._____
- I understand that any remaining balance stated at time of follow up visit is due before seeing a physician, if said balance can not be paid in full at the time of appointment, I am aware that a card will be held on file and a payment arrangement will need to be set up. I am aware that no service will be provided with an outstanding balance, or without a payment arrangement being set up._____
- I understand that GBFA and or STH will obtain the necessary prior authorization to render treatment, I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bill not paid by my insurance carrier._____

I have personally reviewed the above information and agree to the terms:

Patient Signature

Date



HIPAA Acknowledgement

I understand that I have the right to review Georgia Blue Foot And Ankle, LLC(GBFA) and Soles To Heel Foot And Ankle(STH) notice of privacy practices prior to this content. I understand that GBFA reserves the right to change their notice of practices, and I will be given a new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used to carry out my treatment, payment or health care operations, and the organization is not required to agree to restrictions when requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I am releasing all or any part of my medical records for the purpose of treatment, payment, or practice operations. This release may include records containing information regarding diagnosis and/or practice operations. This release may include records containing information regarding diagnosis and or treatment of HIV/AIDS, mental illness and or drugs, alcohol abuse to any person or corporation which is or may be liable under contract for all or part of the medical changes, including but not limited to: Medicare, Medicaid, DSHS, or private or public health insurance programs, reviewing agencies, workers compensation carriers, welfare agencies or patients employer. The records may be needed in order to process a claim or medical services.

I Authorize GBFA and/or STH to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories.

Patient's Signature Printed Name Date

Signature Of Guardian/Representative Printed Name Date

Release Of Medical Information To Family Member(s):

During your treatment, it may become necessary or desirable to discuss your condition with a family member or family friend. Below, please indicate with whom we may discuss your condition and or treatment. Names not stated on the form will not have access to information and/or discussion will be had until the patient updates HIPPA Form.

1 _____, 2 _____, 3 _____
Family Member(s)/Friend(s) Name

1 _____, 2 _____, 3 _____
Phone Number

Please Do Not Discuss My Treatment With: _____
Name Of Family Member/Friend

Documentation of failure to obtain signed acknowledgement:

I presented this acknowledgement to the patient. The patient refused to provide a signature when requested.

Staff Member Signature _____ Printed Date _____



Late Arrivals/Cancellations/Missed Appointments Policy

Late Arrivals:

While we will attempt to accommodate patients who arrive late, later patients will have to be worked into the existing schedule. Patients are given a 15 minute grace period. If the patient cannot wait to be worked in or if they are exceedingly late, the patient will be rescheduled. Patients who are continuously late may be subject to a fee equivalent to a canceled appointment.

Last Minute Cancellations and Missed Appointment:

We do require a minimum of 24 hour notice of cancellations, we do recognize that situations may arise that are out of your control, however, it is imperative that you contact our office immediately to notify us of any cancellations.

Patients who miss or cancel a clinical appointment less than 24 hours notice are subject to a \$50 no show fee. All fees will be collected at the next scheduled appointment. Patients who have a third offense will not be scheduled again.

Signature Of Patient

Date

Patient Printed Name