Affiliated Foot & Ankle, P.C.
Buckhead: 3025 Maple Drive - Suite 2, Atlanta, GA 30305; Midtown: 619 Rankin Street NE, Atlanta, GA 30308
Buckhead/Midtown phone: 404-231-1227; fax: 404-364-0834; www.GApodiatry.com
Duluth: 3071 Peachtree Ind. Blvd - Suite 110, Duluth, GA 30097
Duluth phone: 770-232-9778; fax: 770-232-9776; www.GApodiatry.com

PATIENT INFORMATION

DATE: _____

PATIENT FULL NAME: _____

Address_____

City _____State_____Zip_____

Home Phone _____ Work or Cell Phone_____

Employer _____ Occupation_____

Employers Address _____

_____

Social Security #_____Date of Birth_____Sex: ☐ M ☐ F

Pharmacy Name _____Pharmacy Address and City_____
Pharmacy Phone Number_____

Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐
Spouse/Partner's full name_____

If under 18 years old, parent's name_____

Insurance Company Name_____

Policy Holder_____ Policy Number_____

Date of birth of Policy Holder_____ Group Number_____

Emergency Contact Name_____Relationship_____

Address_____Apt#_____

City_____State_____ZipCode_____

Home Phone#_____Work Phone#_____

WHOM MAY WE THANK FOR REFERRING YOU? _____Phone#_____

PRIMARY CARE PHYSICIAN:_____Phone#_____
First name Last name

PRIMARY CARE PHYSICIAN'S OFFICE LOCATION: _____

DATE LAST SEEN IN PHYSICIAN'S OFFICE: _____ (please give a specific date if possible)

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN **DATE**

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AFFILIATED FOOT & ANKLE - Medical Health History Form

PLEASE COMPLETE ALL PARTS OF THIS FORM, IT IS IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL QUESTIONS

Name:_____ Age:_____ Gender: ☐ Male ☐ Female
Date of Birth:_____ Height:_____ Weight: _____
Race:_____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Preferred Language: ☐ English ☐ Other _____
Shoe size:_____ What type of shoes do you wear? _____

What is the reason for your visit today? _____
Where on your foot/ankle is your problem? _____
How long has it been a problem (days, weeks, months, years)? _____
Is it getting better, staying the same, or is it worse? _____
How did it start, did you have an injury or any other inciting event/trauma? _____
What makes it better? _____
What makes it worse? _____
What treatment have you or another doctor tried, if any? _____
_____
If you had to rank your pain from 0 to 10, (0 = no pain, 10 = severe pain), how would you rank your current pain?_____
Was this a work related accident? ☐ Yes ☐ No If so, date of accident? _____
What activities do you participate in (sports, gardening, etc.)? _____
Any other relevant information pertaining to your problem today? _____

Past Medical History: Please check if you have, or have ever had, any of the following conditions

☐ High blood pressure	☐ Hypothyroid (low)	☐ Intestinal disease
☐ Heart attack / MI	☐ Hormone gland problems	☐ Cancer (type?)
☐ Heart disease	☐ Hepatitis	☐ Anemia (type?)
☐ Angina	☐ Liver cirrhosis	☐ Bleeding problems
☐ Heart failure	☐ Liver jaundice	☐ High cholesterol
☐ Bypass (heart or leg?)	☐ Liver cancer	☐ Circulation problems
☐ Mitral Valve Prolapse	☐ Gallbladder disease	☐ Blood clots in legs / lungs
☐ Irregular heartbeat (type?)	☐ Kidney infection	☐ Arthritis (type?)
☐ Murmur (what type?)	☐ Kidney stones	☐ Gout
☐ Seizures / Epilepsy	☐ Kidney failure /insufficiency	☐ Psoriasis
☐ Nervous system disorder	☐ Urinary/Bladder infection	☐ Skin disorder (type?)
☐ Tuberculosis	☐ Prostate disease	☐ Immune disorder
☐ Asthma or Bronchitis	☐ Gynecological disorders	☐ AIDS or HIV+
☐ Pneumonia	☐ Stomach ulcers	☐ Joint pain / stiffness
☐ Emphysema	☐ Stomach bleeds	☐ Stroke
☐ Sleep Apnea	☐ Hiatal hernia	☐ Psychiatric disorders (type?)
☐ Diabetes Type1☐ Type 2☐	☐ Gastro-esophageal reflux	☐ Depression or Anxiety
☐ Hyperthyroid (high)	☐ Colon cancer	☐ Problems with anesthesia

List any medical conditions not listed above:_____
_____

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Please provide details, e.g. type, severity, for items checked on previous page, and list any additional medical conditions not included: _____

_____

_____

_____

Surgical History: Please list ALL surgeries and recent hospitalizations you have had & what year:

_____

_____

_____

Allergies: Please list any allergies to **medications** or **food** and what **type of reaction** you had -
(Penicillin? Sulfa? Latex? Metal? Shellfish? Iodine? Adhesive tape? Codeine?) _____

_____

_____

Medications: Please list ALL current medications you are taking, include dose and how often – (include all prescription and over-the-counter medications, vitamins, and herbal supplements):

_____

_____

_____

_____

_____

_____

_____

_____

Social History: How frequently do you **drink** beer, wine, and/or liquor? _____
Do you **smoke**? ☐ Yes ☐ No How many **packs/cigars** a day?_____ For how many years?_____
Are you a current non-smoker, but used tobacco in the past? ☐ Yes ☐ No If you smoked previously, how long ago did you quit?_____
Do you take any illicit drugs? _____
Occupation:_____ At your job you mostly: ☐ Sit ☐ Stand ☐ Walk ☐
Marital status:_____
Women only: Is there any chance you could be pregnant? ☐ Yes ☐ No

Family History: Please list your parents' health problems and if alive or deceased -
Mother:_____
Father:_____
List Any Family Health Problems? (Diabetes? Heart disease?)_____

"I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feet and/or ankles."

PLEASE SIGN FORM HERE: Patient: _____Date:_____

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

HEALTH INFORMATION USE AND DISCLOSURE

The offices of Dr. Mistretta, Dr. Bahnson, and Dr. Filiatrault understand that medical information about you and your health is personal and we are committed to protecting that information. With that understanding, we will use and disclose your health information for the following purposes: to treat you, to assist other health care providers in treating you, to allow insurance companies to process insurance claims for services rendered to you, to obtain payment for services rendered to you and for certain limited operational activities such as quality assessment, licensing, accreditation and training of students. We will not use or disclose your health information without your written authorization, except as stated in more detail in the Notice of Privacy Practices. We reserve the right to change this notice and will post a copy of the current notices in effect in our facility.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, if you would like to authorize the disclosure of your protected health information to another person(s) please specify by answering the questions below.

In regards to your protected health information, are we allowed to speak with (please circle):

Any member of your immediate family? **YES** ☐ **NO** ☐

Your spouse/partner? Name _____ **YES** ☐ **NO** ☐

Other? Name _____ **YES** ☐ **NO** ☐

Can we leave messages regarding your health information on your voicemail / answering machine? **YES** ☐ **NO** ☐

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print): _____

Name of Guardian/Authorized Representative (if applicable): _____

Signature of Patient or Guardian: _____ **Date**_____

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FINANCIAL POLICY FOR AFFILIATED FOOT & ANKLE, PC

INSURANCE PATICIPATION

In an effort to accommodate our patients, Affiliated Foot & Ankle participates with most insurance plans. Although we are pleased to provide services to our patients, it is impossible for our office staff to be aware of the specific benefits and requirements of each and every plan. There may be limitations under your plan on numbers of office visits, laboratories you may use, referrals and authorizations for certain procedures. We ask that you please be familiar with your insurance contract regarding services, exclusions, and expiration dates for referrals. Unfortunately, if you do not inform us of special guidelines and limitations of your plan, and we subsequently order services or procedures, these may be considered non-covered and will not be paid by the insurance company. Any service determined to be non- covered by your plan will be your responsibility. You are responsible for any and all co-payments, deductibles, and coinsurances. Co-payments are due at the time of service. Once your insurance carrier has processed your insurance claim, you are responsible for ALL remaining balances. A statement will be sent and you will be responsible to remit ALL balances in full. Any special financial arrangements must be approved in writing from our business office.

LATE FEE: There is a $25.00 late fee for all unpaid balances after 45 days past the date of service.

RETURNED CHECK FEE: A fee of $30.00 will be assessed on any checks returned for insufficient funds. If we find it necessary to take collection action on your outstanding balance, you will be assessed an additional 30% to that amount or a minimum of $30.00.

CANCELLATION OF APPOINTMENT: Our office requires 24 hours notice if you are unable to make your appointment. Please notify us as soon as you are aware of any schedule changes. There will be a $35.00 fee for not complying with this policy. Your courtesy is deeply appreciated so that we may serve you and other patients more efficiently.

I have read the above payment policy, understand the contents thereof, and agree by the terms set forth.

Printed Patient Name_____ Date_____

Patient Signature _____