Antioch Foot & Ankle Group

Patient Registration Form

Patient's Name: Last_____First_____MI_____

Address: _____City_____State_____Zip_____

Home Phone: _____ Cell Phone: _____

Please take a moment and text the word Antioch to 55469 on your cell phone to receive Antioch Foot & Ankle Group Text Alerts about promotions, events and more.

Birth Date: _____/_____/_____Age: _____SSN:_____/_____/_____ Sex: M _____ F_____

Email Address: _____

Race/Ethnicity (optional): White___ African American___ American Indian___ Asian___ Native Hawaiian___ Hispanic____

Marital Status: Married_____Single_____Widow_____Separated_____Divorced_____

Place of Employment_____
Address:_____Work Phone:_____
Emergency Contact_____Relationship_____
Phone #1: _____ Phone #2: _____

Primary Care Physician:_____Phone:_____
Address_____Date Last Seen:_____

INSURANCE INFORMATION – Please Complete Correctly
Primary Insurance – Company_____
Policy Holder: Self_____Spouse_____Parent_____Other_____
Name of Policy Holder:_____Policy #_____
Policy Holder's SSN: _____ DOB: _____
Employer of Policy Holder:_____ Phone:_____

Secondary Insurance – Company_____
Policy Holder: Self_____Spouse_____Parent_____Other_____
Name of Policy Holder: _____Policy #_____
Policy Holder's SSN: _____ DOB: _____
Employer of Policy Holder: _____Phone:_____

Who can we thank for referring you to Antioch Foot and Ankle Group?
Patient ____ Physician____ Insurance____ Internet____ Advertisement____ Event____ Other_____
Name of referring source _____

By signing, I agree that to my knowledge all of the above information is accurate and that I am responsible for any and all billings associated with my account with Antioch Foot & Ankle Group.

Signature of Responsible Party _____Date_____

Antioch Foot & Ankle Group

Patient History

Patient Name: _____

Pharmacy: _____ Phone#: _____

Have you had or have any of the following conditions?

( ) Diabetes
( ) Heart Problems
( ) Stroke
( ) Epilepsy
( ) High Blood Pressure
( ) Cancer
( ) Broken Bones
( ) Blood Disease
( ) Kidney Problems
( ) Lung Problems
( ) Tuberculosis
( ) Gout
( ) Stomach Problems/Ulcers
( ) Arthritis
( ) Eye Problems
( ) Leg Cramps
( ) Artificial Parts
( ) Bleeding Problems
( ) HIV/AIDS

Medical allergies and reaction: NKDA (no known allergies) _____ LATEX Allergy_____
I am allergic to:

( ) Penicillin
( ) Aspirin
( ) Codeine
( ) Demerol
( ) Novocain
( ) Other Antibiotic
( ) Iodine
( ) Sulfa
( ) Cortisone
( ) Adhesive Tape
( ) Seafood/Any food
( ) Other _____

Please List all Medications:

_____
_____
_____
_____

Personal History:

A. **List all surgeries.**

_____
_____
_____

B. **Females Only: Are you pregnant at this time: ( ) Yes ( ) No Are you nursing: ( ) Yes ( ) No**

C. **Do you smoke? Yes_____ No____ If yes, how often? _____**
D. **Do you consume alcohol? Yes____ No____ If yes, how often? _____**
E. **If diabetic, what type? _____**
   Insulin dependent? _____ or Diet controlled? _____
   How long have you been diabetic? _____ Average blood sugar: _____
F. **Have you ever been under Hospice Care? Yes___ No___ . If yes, when? Month_____ Year_____**
G. **Have you even been incarcerated? If yes, when? Month_____ Year_____**

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Signature of Responsible Party _____Date_____

Work related: ___yes ___no Vehicle Accident: ___ yes ___no Sports Related: ____yes ____no

What have you done for your foot or ankle problem ?_____

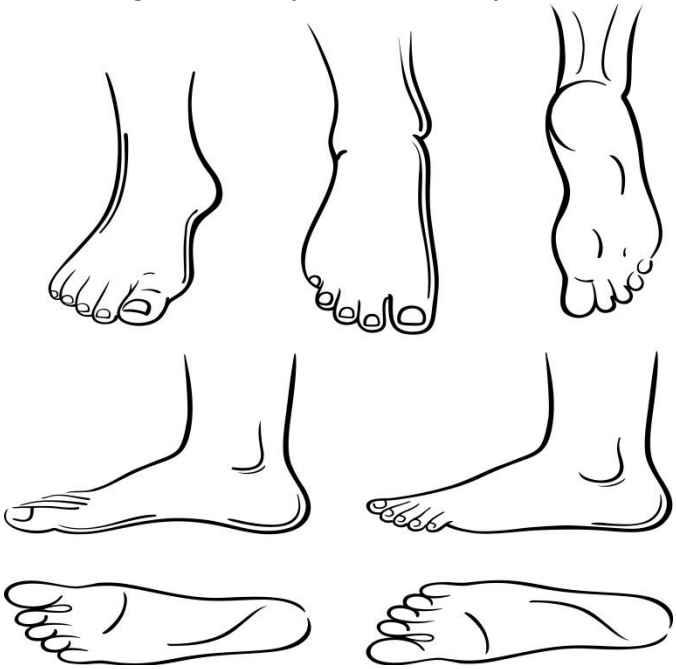
_____

Have you seen another doctor for your foot or ankle problem? ___yes ___no

Doctor's Name;_____ Is Doctor a Podiatrist___yes ___no

Doctor's telephone #:_____Do you have X-Rays? ___yes ___no

On the diagram below, please mark the place(s) where you have pain in your feet or ankles.



Tell us on a scale of 1 – 10 (10 being the worse) your level of pain? _____

What type of pain are you experiencing?

Throbbing ___ Burning ___ Aching ____ Other (please describe)_____

Do you or have you ever worn orthotics (inserts)? Yes_____ No_____

Do you buy them over the counter or were they prescribed by a physician? Counter_____ Physician____

Did the orthotics or inserts help your feet? Yes_____ No____

Do you play sports or do you walk or run? If so tell us the sport that you play?_____

If you walk or run, which one and how often?_____

Does your employer require you to wear a certain type of shoe. If yes, tell us the type of shoe that you are required to wear. _____

Antioch Medical Associates
The Foot and Ankle Group
Dba Antioch Foot and Ankle Group
Acknowledgment & Authorization

PLEASE READ CAREFULLY: All charges or co-payments, if applicable, are due at the time of services. The patient is responsible for all fees, regardless of insurance coverage. I understand that I need to provide, where needed, referrals from my Primary Care Physician. Furthermore, I understand that I need to notify Antioch Medical Associates of tests, labs, or other treatments that may not be covered by my insurance policy. I realize that I am responsible for fees that are not covered by my insurance carrier.

Preferred Laboratory: Labcorp ____ Quest _____ SE Pathology____ St. Joseph/Candler ____

ASSIGNMENT OF BENEFITS: I hereby assign payment of medical benefits, as may be payable to me, to Antioch Medical Associates for any benefits due to me for medical or surgical care, by reason of such treatment rendered to me or the patient/insured.

HIPAA COMPLIANCE NOTICE: I hereby acknowledge that I have read the Antioch Medical Associates NOTICE OF PRIVACY POLICIES that describes how information about me may be used and disclosed and how I may obtain access to this information. Furthermore, I acknowledge that I understand these policies and have received a personal copy of this information for my records. Antioch Medical Associates will abide by all HIPAA regulations regarding privacy and confidentiality as outlined in our NOTICE OF PRIVACY POLICIES.

AUTHORIZATION TO RELEASE LAB AND DIAGNOSTIC TEST RESULTS: I understand that Antioch Medical Associates policy is to notify patients of any abnormal labs or diagnostic test results. We will notify you as soon as possible. I indicated below which results may be released and to whom that information may be released. (You may choose more than one option).

____Give my results to me personally. My daytime phone number is (_____) _____-_____.
(If you are not available to speak to us, we will leave a message to call our office).

____ If you cannot reach me personally, I authorize Antioch Medical Associates to release my results to another person, specifically:

Name: _____ Relationship: _____

Daytime Telephone Number: _____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I authorize Antioch Medical Associates to release/obtain all information necessary to secure payments, transmit and process claims electronically or though any other reasonable and customary means, including, but not limited to Medicare.

CONSENT FOR TREATMENT: I voluntarily consent to my treatment at this office and authorize such treatment, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physician. I have read this consent, and I am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND VOLUNTARILY AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Patient's Signature _____ Date _____

Antioch Medical Associates, The Foot and Ankle Group
Dba Antioch Foot and Ankle Group
9104 Middleground Road, Suite 2, Savannah, Georgia 31406

This notice describes how medical information about you may be disclosed and how you can get access to this information.

Please read it carefully.

You may be worried about keeping your health and medical information private, we understand. There are laws and ways health care providers can use and share medical information about patients. The law says that we need your permission (authorization) for certain uses, but not others.

Your personal medical information is called Protected Health Information or "PHI". The law allows us to use your PHI without your permission for the purpose of medical Treatment, Insurance payment or for business Operations (TPO). Examples are the following:

- **Treatment: Any medical staff involved in treating you can use your PHI. They can also share it with others involved in your care. For example if our office refers you to a specialist we may share your PHI with that office.**
- **Payment: We may use and share your PHI to collect payment for services. For example, we may give your PHI to your insurance company as requested for payment for services.**
- **Operations: We are continually striving to provide the highest level of service to our patients and in doing so we may from time to time use your PHI for business purposes such as, to manage our budget or evaluate the quality of our care.**

As well, there are other cases where we can share your PHI without permission. Examples are the following:

- **To Follow the Law: We may share PHI to follow the law, to report or solve crimes or to help law enforcement.**
- **To Protect Public Health: We can give PHI to people who work to stop the spread of diseases, and we must report abuse and neglect.**
- **To Help Coroners of Medical Examiners: We may need to give PHI to help identify a body or the cause of death.**
- **For Organ or Tissue Donation: We may give PHI to help agencies that match organ donors with people on waiting lists.**
- **To Avoid a Serious Threat to Others: We can give PHI to people working to prevent a threat to the health or safety of other people.**
- **Special Government Functions: We may share PHI with federal officials for national security reasons.**
- **Workers' Compensation: We can release PHI to comply with laws that protect you if you are hurt or get sick on the job.**
- **Appointment Reminders and Other Items of Interest: We can use your PHI to contact you about an appointment. We can also contact you about other treatments, services, and programs that may interest you.**
- **Your Access to Your Own PHI: We may share PHI with you or someone you choose to represent you.**
- **Government Offices: We must give your PHI to certain federal workers when you are checking on how we follow the privacy laws.**

We must have your written authorization to use your PHI for any other reasons than listed above. This notice tells you our rules for using PHI. We have to follow what we say in this notice. You may revoke this authorization to release your information, with some limitations, at any time in writing.

The law says we must keep your PHI private. It also says that we must tell you in writing:

- **What the law says we can and cannot do with your PHI**
- **Our privacy policies regarding PHI**

We have the right to change information and policies contained in this notice. A new notice must be given to you and posted in our office when changes are made.

You have certain rights under the privacy laws:

- **You can ask us not to share your PHI with a person or group. Keep in mind we do not have to honor this request; we must only honor what we have set forth in this notice. No matter what, we can always share your PHI in an emergency.**
- **You can ask that we not contact you in certain ways or a certain places, such as work or home.**
- **You may ask that we fix mistakes or add new facts to your PHI. We will not honor these requests if: it wasn't written by us, contained in other physicians records released to our office, is not something you are allowed to see, or is not correct and complete.**
- **You may ask for a list of the people and groups who have seen your PHI within the past (6) years. The list will not include times when you gave your written permission to release your PHI.**

You must make the above requests in writing. Your request should be sent to: Antioch Medial Associates c/o Compliance Officer: Mrs. Plummer 9104 Middlegroud Road, Suite 2 Savannah, GA 31406. We must reply to you within (30) days after receipt of your request. We will respond in writing with your determination.

You may request copies of this notice by contacting our office at (912) 927-8011. Copies are also posted within our office.

You may complain to us if you believe your privacy rights have been violated. You may contact our privacy officer Mrs. Plummer at our office. You also have the right to complain to the Secretary of the Department of Health and Human Services.