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 OF VISIT: ____________________ **Date of Birth**_______________ **Gender**: M☐ F☐

PATIENT FULL NAME: ____

Address____[Apt. # _______]

City ________________________________ State__________ Zip____________________

Email address: ____

Preferred Phone: _____________________ Secondary Phone: ______________________

Social Security Number:___________________________________

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Spouse/Partner's full name if applicable: __________________________

Employer _______________________________________ Phone_______________________

Pharmacy Name ________________ Pharmacy Address and City___________________________

Pharmacy Phone Number_______________

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**__________

Preferred Phone#_________________ Secondary Phone#________________

Whom may we thank for referring you to the practice? ________________Phone#_______________

PRIMARY CARE PHYSICIAN: ___________________________________ Phone#_____________

First name Last name

Date last seen in physician's office: _____________(please give a specific date if possible)

Primary care physician's office address/location: _________________________

_______________________________________ ________________________

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:______ Shoe size:__________
Race: _______________ Ethnicity: Hispanic ☐ Non-Hispanic ☐
Preferred Language: English / Other ____________What type of shoes do you wear? _______

What is the reason for your visit today? ____
Where on your foot/ankle/leg 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 pain level? _____ If you have pain, what quality? Sharp, stabbing, dull ache, throbbing, burning, etc. ____
Was this a work-related accident? ____________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 circle if you have, or have ever had, any of the following conditions

High blood pressure	Hypothyroid (low)	Intestinal disease
Heart attack / MI/ CAD	Hormone/gland problems	Cancer (type?)
Heart disease / Pacemaker	Hepatitis (what type?)	Anemia (type?)
Angina	Liver disease: cirrhosis	Bleeding problems
Heart failure	Liver jaundice	High cholesterol
Bypass (heart or legs?)	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 disease: CKD	Psoriasis
Neurologic disorders	failure / insufficiency	Skin disorder (type?)
Tuberculosis	Urinary/Bladder infection	Immune disorder
Asthma/Bronchitis/ COPD	Prostate disease	AIDS or HIV+
Pneumonia	Gynecological disorders	Joint pain / stiffness
Emphysema	Stomach ulcers	Stroke
Sleep Apnea CPAP use?	Stomach bleeds	Psychiatric disorders
Diabetes (type 1 or 2, # of	Hiatal hernia	(type?)
years diagnosed ____)	Gastro-esophageal reflux	Depression or Anxiety
Hyperthyroid (high)	Colon cancer	Problems with anesthesia

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List any other medical conditions not included above: ______________________________

____

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 - (e.g.: Penicillin, Sulfa, Latex, Nickel, Shellfish, Iodine, Adhesive tape) ____________________

____

____

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**?______ How many **packs/cigars** a day?_______ For how many years?________
Are you a current non-smoker, but used tobacco in the past? ____How long ago did you quit? __________
Do you take any illicit or recreational drugs? ____________________________________
Occupation:___________________________ At your job you mostly: ☐ Sit ☐ Stand ☐ Walk
Women only: Is there any chance you could be pregnant? _____

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, leg, 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 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 check):

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 procedures, supplies, durable medical goods, 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 or perform 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, non-covered services, procedures, supplies, 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 60 days past the date of service.

DELINQUENT ACCOUNTS: If your account continues to be delinquent after 90 days, your account will be turned over to a collection agency for pursuit of payment. Collection status and legal action could seriously impact your credit rating. <u>If your account has previously been in a collection status, then a Prepayment for the first returning visit will be $100.00. Each visit thereafter, will require a $50.00 Prepayment fee.</u>

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% collection fee 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 ____________________________