Pt#_____ **Welcome To** **Date _____/_____/_____**

Forsyth Foot & Ankle Associates

We are glad you are here. In order to help us provide excellent care, please take a few minutes to complete the following information to the best of your ability. Thank you.

Full Name: _____ Preferred Name:_____

Mailing Address_____City_____ State_____ Zip Code_____

Street Address (If Different) _____ City_____State_____ Zip Code_____

Race: White ___, Black ___, Hispanic ___, Other (list)_____ Ethnicity: _____

SS#_____ Date Of Birth:_____ Age:_____ Sex: Male _____ Female _____

Marital Status: _____ Home Phone:_____ Cell Phone:_____

E-Mail Address:_____ Preferred contact method:_____

Employer:_____ Occupation:_____Work Phone: _____

What Pharmacy Do You Use? _____Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

Spouse's Name:_____ Date Of Birth:_____ Cell Phone:_____

Spouse's Employer _____Work Number:_____ Ext._____

Legal Guardian (If Other Than Patient)

Name:_____ Relationship: _____ Date Of Birth:_____ SS#_____

Address:_____ Home Phone #_____

Employer:_____ Work Phone: _____ Ext.#_____

Emergency Contact:_____Relationship:_____

Home Phone: _____ Cell Phone:_____Work Phone:_____Ext._____

Insurance Information ***WE MUST HAVE A COPY OF YOUR INSURANCE CARD(S).***

Primary:_____Policy #:_____ Group #_____

Policy Holder's Name:_____ SS#_____ Date Of Birth:_____

Secondary:_____Policy #:_____ Group #_____

Policy Holder's Name:_____ SS#_____ Date Of Birth:_____

****Please Continue To The Next Page.****

Patient Name: _____Height:_____Weight:_____Shoe Size:_____

Circle The Area That Is Bothering You: **Foot, Ankle, Leg Or All** **Right, Left Or Both**

What Type Of Problem Are You Having With This Area? _____

How Long Has This Been Bothering You? _____ Days _____ Months _____Years

How Were You Referred To Our Office?_____

Who Is Your Primary Care Physician?_____Phone:_____

Address:_____City:_____ State:_____ Zip:_____

Have you or anyone in your family ever been treated by a physician for any of the following conditions?
Please check all that apply and write in any applicable condition not listed.

	Self	Family (Who?)			Self	Family (Who?)
Arthritis				Hepatitis		
Asthma				High Blood Pressure		
Cancer				High Cholesterol		
Cirrhosis of the Liver				Kidney Disease		
Depression/Anxiety				Poor Circulation		
Diabetes				Sleep Apnea		
Gout				Stroke		
Heart Trouble				Thyroid Trouble		

****If you are diabetic, please list diabetic doctor:_____Date of last visit:_____**

LIST MEDICATIONS you are <u>currently</u> taking:

_____
_____

LIST DRUG ALLERGIES & REACTIONS._____

_____

Have you received the flu vaccination?? ____ YES ___NO If yes, approx. date given:_____
Have you received the pneumonia vaccine?? ____YES ___NO If yes, give approx. date:_____

Social History:

Are you a Smoker? YES ___ , I smoke _____ packs per day for _____ years……..NO ____

I QUIT smoking _____. I did smoke _____ packs per day for _____ years.

Alcohol Use? YES___ NO___ QUIT____ **Drug Use**? YES___ NO___ QUIT____

Are you, or is there a chance that you may be, pregnant? YES___ (If yes, how many months?_____) NO ____

Please list any previous surgeries including approximate year and doctor:

_____
_____

*****Please Continue To The Next Page.*****

Additional patient questions:

Patient Name:_____

1. Are you diabetic? ____ Yes ____ No
    a. If so, please list the doctor that manages your diabetes:_____
    b. Date last saw this doctor: _____
    c. Last eye exam:_____
    d. When was your last hemoglobin A1c drawn? (approx. date):_____
        i. What was the results of the hemoglobin A1c?_____
2. When was your last physical with your primary care physician? _____
    a. Name of PCP:_____
3. Have you ever been diagnosed with hypertension (high blood pressure)? Y or N
    a. If yes, are you currently taking medication for this?_____
    b. When did you last see the physician who manages your hypertension?

        _____
4. When was your last colonoscopy (approx. date)? _____
5. When was your last upper endoscopy (approx. date)?_____
6. If you are a female, list (approx.) the date of your last cervical cancer screening exam:

    _____. Please also provide us the name of the doctor who performed

    this exam:_____.
7. If you are a female over the age of 50, please answer the following. When was your last mammogram??

    Approx date:_____

Forsyth Foot & Ankle Associates
102 Mary Alice Park Rd. Suite 201, Cumming, GA 30040

Financial policy

It is our sincere desire to provide you with the best possible medical care. This involves mutual understanding between the patients, our office staff, and the physicians. We encourage you, our patient, to discuss any questions you may have regarding our payment policy.

Our office requires payment at the time services are rendered. Accepted methods of payment include cash, check, Visa, MasterCard, and Discover. A $30.00 fee will be charged for all returned checks.

Cancelled Or Missed Appointments

If you are unable to keep an appointment, please notify the office immediately. If an appointment is cancelled or missed **without 24-hour notice, you will be billed for a late cancellation or missed appointment. The charge for this is $25.** Please feel free to call and confirm your appointment. Calling on the day of your scheduled appointment to reschedule for another day or time is considered a broken appointment. **Insurance companies do not cover missed appointments.**

Referrals

Should your insurance company require a referral from your primary care physician before you can be seen, it is your responsibility to obtain your referral prior to your appointment. If you are seen without a referral, you must be prepared to pay for all services in full at the time they are rendered.

Insurance Coverage

Patients are expected to pay for all co-payments, deductible amounts, or non-allowed, non-covered services at the time that the service is rendered. Unless we have a contract directly with your insurance company, you are responsible for any difference between our charges and what your insurance company allows.

If you have insurance coverage and have provided our office with all of the necessary information and a copy of your insurance card, our office will file a claim on your behalf. The filing of insurance claims is a courtesy and our office cannot be responsible for negotiating insurance claims for you. We do not guarantee insurance coverage or reimbursement. The maximum time we allow for reimbursement by an insurance company is 45 days. After that time you will be responsible for any unpaid balance.

If you have coverage through more than one insurance company, we must have that information and a copy of the insurance card.

Podiatry benefits frequently require pre-authorization and it is your responsibility to contact your insurance company prior to your first visit. It is your responsibility to notify this office if your insurance changes. You are responsible for payment of services not paid by insurance up until the time we are given the new information.

Signing below certifies you have read this Financial Policy and agree to comply with it. It further certifies you understand that if you do not fulfill your obligation that your account may be referred to an office or agency other than Forsyth Foot and Ankle Associates for collection action. This could be a collection agency, lawyer, or summary claims court and may be reported to the credit bureau. If you choose to neglect this account and allow it to be turned over to a collection agency, a collection fee of up to 40% of the balance due will be added to the account. You may request a copy of this Financial Policy. Signing below also authorizes Forsyth Foot & Ankle Associates/Dr. Michael McGlamry and/or its agents to release to your insurance carrier, or its representative, any information concerning treatment rendered you (or dependent if applicable) necessary to process an insurance claim. Signing below also authorizes and requests payment of insurance/Medicare/Medicaid benefits to be paid directly to Forsyth Foot & Ankle Associates/Dr. Michael McGlamry. This authorization is given voluntarily with understanding and knowledge of purpose.

Signing below certifies and acknowledges that you were provided an opportunity to read the Notice of Privacy Practices and understood the notice. A copy will be given to you if you would like one.

_____ _____

Signature Of Responsible Party Patient Name (Please Print)

_____ _____

Witness (Office Staff) Date

Circle method of payment for today's charge: Cash Check Visa MasterCard American Express Discover

Thank You!

Please Turn In This Form To The Receptionist When Complete.