Podiatry Group of Georgia

Patient Information

First Name:	M.I.:	Last Name:
Preferred Name:	DOB:	Sex: ☐ Male ☐ Female
Race:	Marital Status:	Shoe size:
Address:	City:	Zip:
Home #:	Cell #:	
Employer:	Work #:	
Email Address:		
☐ Please check to receive appointment reminders / e-newsletter		

Policy Holder Information

☐ Check if same as Patient Information		
First Name:	M.I.:	Last Name:
DOB:	Home #:	Cell #:
Address:	City:	Zip:
Employer:	Work #:	
Emergency Contact Name:		

Podiatry Group of Georgia
2864 Johnson Ferry Road, Suite 100, Marietta, GA 30062
Phone: (404) 806-3731 | Fax: (770) 321-0001
www.podiatrygroupofgeorgia.com

Relationship to patient:	Emergency Contact Phone:

How did you hear about Podiatry Group of Georgia?

☐ Primary Care Physician ☐ Other Physician (name) _____

☐ Patient/Friend/Family ☐ Insurance Provider ☐ Internet ☐ Other

Primary Care Physician

Full Name:

Phone:	Address:

Pharmacy Information

Pharmacy Name:		Phone #:
Address:	City:	Zip:

Insurance Information

Primary Insurance Company Name:		
Policy/Contract No:	Group No:	Effective Date:
Group Name:	Insurance Phone Number:	
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Secondary Insurance Company Name:		
Policy/Contract No:	Group No:	Effective Date: 10/10/2007
Group Name:	Insurance Phone Number:	
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:		

Assignment of Benefits & Authorization to Release Information

If I am entitled to benefits under the Medicare, the Medicaid, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Podiatry Group of Georgia, I assign, transfer and convey the benefits payable under such program, policy or plan for services rendered to me. I authorize payment of benefits directly to Podiatry Group of Georgia, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts, deductibles, Durable Medical Equipment and any charges for services deemed to be non-covered, not pre-certified or not preauthorized by my insurance plan.** _____ ***(initial)***. I give my consent for examination and treatment by Dr Neha Delvadia _____ ***(initial)***. I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understood the Notice. _____ ***(initial)***. I acknowledge that I have received and read the Financial Policy of Podiatry Group of Georgia.

Party Signature: _____ Relationship: _____

Date: _____

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Medical History

Please list any specific problems you want to discuss with the doctor. How long have you had this issue for? What seems to make the condition worse? Does anything make the condition better?

_____

What is the nature of your pain?

☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Radiating ☐ Itching ☐ Stabbing

Is there a history of injury? ☐ Yes ☐ No Date of injury: _____

Is this a work-related injury? ☐ Yes ☐ No Date of injury: _____

Have you seen any other physician for this problem? Have you had any treatments for this issue?

_____

Has this condition affected your ability to work, exercise or perform daily activities? ☐ Yes ☐ No

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Past Medical History

(Please check all that applies)

❑ High blood pressure	❑ Sickle cell	❑ Leukemia/Lymphoma	❑ Crohn's disease
❑ Stroke/TIA	❑ Thalassemia	❑ Colitis	❑ Ulcerative colitis
❑ Angina/heart attack	❑ Diabetes	❑ Multiple sclerosis	❑ Lyme disease
❑ Heart rhythm disorder	❑ Eye disease	❑ Cerebral palsy	❑ HIV/AIDS
❑ Heart valve problem	❑ Kidney disease/dialysis	❑ Polio	❑ Syphilis
❑ Heart failure	❑ Neuropathy	❑ Seizure/Epilepsy	❑ Liver disease/Hepatitis B or C
❑ Asthma/COPD	❑ Thyroid disorder	❑ Muscular dystrophy	❑ Tuberculosis
❑ Blood clot in vein	❑ High cholesterol	❑ Panic/anxiety disorder	❑ Rheumatic fever
❑ Pulmonary embolus	❑ Osteoarthritis	❑ Bipolar illness/depression	❑ Sleep apnea
❑ Chronic bronchitis	❑ Lupus/SLE	❑ Psychiatric illness	❑ Back trouble/Sciatica
❑ Sarcoidosis	❑ Rheumatoid arthritis	❑ Dementia/Alzheimer's	❑ Skin disorder
❑ Raynaud's	❑ Psoriasis	❑ Stomach ulcers	❑ Use of steroids in the past 6 months
❑ Anemia	❑ Gout	❑ Reflux/GERD	❑ Other medical problems:
❑ Blood transfusion	❑ Cancer	❑ Spinal cord injury	
❑ Bleeding tendency	Type:	Level:	

Please list all previous surgeries and hospitalizations:

❑ Tonsils / adenoids	❑ Amputation	❑ Other vascular bypass
❑ Appendix	❑ Gallbladder	❑ Other:
❑ Hysterectomy	❑ Hernia	
❑ Angioplasty (balloon/stent)	❑ Coronary (heart) bypass	

Have you ever had difficulty with anesthesia? ❑ Y ❑ N Bleeding problems after surgery? ❑ Y ❑ N

Please check pertinent issues you have had recently or frequently:

❑ Fever, chills	❑ Pain with breathing	❑ Kidney stones	❑ Dizziness
❑ Weight change	❑ Difficulty breathing	❑ Pelvic pain	❑ Dry skin/itching/rash
❑ Heat/cold intolerance	when lying down	❑ Thick scar/keloid	❑ Hives/urticaria
❑ Night sweats	❑ Pain/bleeding/difficulty	❑ Constipation	❑ Enlarged lymph nodes
❑ Headaches/Migraine	with urination	❑ Eating disorder	❑ Depression
❑ Nasal congestion	❑ Nausea/vomiting	❑ Abdominal pain	❑ Claustrophobia
❑ Nasal bleeding	❑ Vision blurring	❑ Loss of sensation	❑ Sleep disorder
❑ Sinus problems	❑ Osteomyelitis	❑ Diarrhea	❑ Leg pain with exertion or at night
❑ Sore throat	❑ MRSA	❑ Rectal bleeding	❑ Poor balance
❑ Easy bruising	❑ Previous foot/leg wound	❑ Chest pain with exertion	❑ Numbness/tingling/burning of feet
❑ Difficulty swallowing	❑ Leg swelling	❑ Varicose veins	❑ Sexually transmitted disease
❑ Heartburn	❑ Previous pressure ulcer	❑ Palpitations	❑ Hearing loss
❑ Shortness of breath	❑ Muscle weakness	❑ Cardiac arrest	❑ Tinnitus (ringing in ears)
❑ Wheezing	❑ Joint pain/swelling	❑ Pacemaker/defibrillator	❑ Language, cultural, or religious concerns
❑ Pain with cough	❑ Fatigue	❑ Immune disorder	

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List or attach a complete list of all current Medications:

Last tetanus immunization: Date: _____ ☐ Unknown ☐ <5 years ☐ <10 years

Allergies:

☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Contrast ☐ Latex ☐ Iodine ☐ Shellfish

☐ Other: _____

Social History:

Have you ever used illicit drugs? ☐ Yes ☐ No
Abused prescription medications, drug or alcohol? ☐ Yes ☐ No
Do you ever drink alcohol? ☐ Yes ☐ No How often? _____ How much? _____
Have you ever used tobacco? ☐ Yes ☐ No Amount per day_____ Age began_____ Quit at Age_____
What is your occupation? _____ Are you retired? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No
Currently using hormones or oral contraceptives? ☐ Yes ☐ No ☐ N/A
Women Are you Breastfeeding? ☐ Yes ☐ No Could you be pregnant now? ☐ Yes ☐ No

Are there any diseases / illnesses that seem common or run in your family?

_____

To the best of my knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status.

Print Name: (Yourself, Parent or Guardian): _____

Signature: _____

Date: _____

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24 HOUR CANCELLATION & "NO SHOW' FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Podiatry Group of Georgia reserves the right to charge a fee of $50.00 for all missed appointments (no show) and appointments which, absent a compelling reason, are not cancelled within 24hr advance notice.

"No Show" fee will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

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