

# GWINNETT PODIATRY ASSOCIATES, L.L.C.

## Patient Information Sheet

---

Patient's Full Name \_\_\_\_\_ Date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex Male / Female  
Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Home Address \_\_\_\_\_ Unit # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer / School \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

---

If the above patient is a child, has a legal guardian, has a spouse, or is not responsible for the bill, please provide the information requested in this section below:

Parent of Child       Legal Guardian       Spouse       Other Party Responsible for Bill

Full Name \_\_\_\_\_ Date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex Male / Female  
Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Home Address \_\_\_\_\_ Unit # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer / School \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

---

Reason for Visit \_\_\_\_\_

Date of Injury \_\_\_\_\_ If Accidental Injury, Please Briefly Describe the Circumstances ( Necessary for Insurance Benefits to Be Paid ):

Did This Injury Occur At Work? Yes / No      If Yes, has a Georgia Worker's Compensation claim been officially filed? Yes / No

Contact Person at Work \_\_\_\_\_ Phone # of Contact \_\_\_\_\_

Did This Injury Occur From a Car Accident? Yes / No      If Yes, provide Auto Insurance Information: \_\_\_\_\_

---

Do You Have Health Insurance Coverage? Yes / No      If Yes, Please Provide Information Below, and Give Card to Office Staff:

Name of Insured Person \_\_\_\_\_

Social Security # of Insured Person \_\_\_\_\_ Date of Birth of Insured Person \_\_\_\_\_

Full Name of Primary Insurance \_\_\_\_\_

Policy and Other ID #'s \_\_\_\_\_

Full Name of Secondary Insurance \_\_\_\_\_

Policy and Other ID #'s \_\_\_\_\_

---

How Did You Hear About Our Practice? \_\_\_\_\_

If You Were Referred by Another Doctor or Doctor's office, Please Provide Name, Address, and Phone Number: \_\_\_\_\_

---

Patient or Guardian Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

# GWINNETT PODIATRY ASSOCIATES, L.L.C.

## Medical Health History Form – PMFSH and ROS

**PLEASE COMPLETE BOTH PAGES AND SIGN THE FORM AT THE BOTTOM, IT IS VERY IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL OF THE QUESTIONS**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male / Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Please list regular Family or Medical Doctor, (Name, Address, and Phone #): \_\_\_\_\_

**PAST MEDICAL AND SURGICAL HISTORY:** Please circle if you have, or have ever had, any of the following conditions –

- |                                    |              |                  |                   |  |                     |
|------------------------------------|--------------|------------------|-------------------|--|---------------------|
| high blood pressure                | sleep apnea  | seizure disorder | stomach problems  | rheumatoid arthritis                                 | bleeding disorder   |
| irregular heart beat               | emphysema    | depression       | esophageal reflux | osteoarthritis                                       | blood clots         |
| heart disease                      | lung disease | anxiety          | ulcer disease     | hypothyroid (low)                                    | hyperthyroid (high) |
| heart attack                       | pneumonia    | stroke           | liver disease     | cancer – if yes, what type _____                     |                     |
| heart failure                      | asthma       | mental illness   | hepatitis         | adult diabetes – if yes, do you use insulin Yes / No |                     |
| any prior problems with anesthesia |              | HIV/AIDS         | kidney disease    | childhood diabetes – if yes, do you insulin Yes / No |                     |

**List any other medical conditions not listed above:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** Please list ALL medications you currently take, please include the frequency and dosage –

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** Please list any allergies to medications that you have, with the type of reaction caused by the medication –

\_\_\_\_\_  
\_\_\_\_\_

**EMPLOYMENT:** Occupation: \_\_\_\_\_

Date last worked if out of work: \_\_\_\_\_

Physical Job Duties: \_\_\_\_\_

**Please list ALL surgeries you have had with year and details:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:** Marital Status: \_\_\_\_\_

Education (years/degree): \_\_\_\_\_

Alcohol Use (type, amount): \_\_\_\_\_

Tobacco Use (amount, years used): \_\_\_\_\_

**FAMILY HISTORY:** Please list age and health of parents, (if deceased, how), and any medical problems in your family –

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Other Family Members such as Grandparents and Siblings:

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE COMPLETE THIS SECOND PAGE AND SIGN THE FORM AT THE BOTTOM, IT IS VERY IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL OF THE QUESTIONS**

**REVIEW OF SYSTEMS:** Please circle if you have any of the following symptoms – please also give a brief description -

**Constitutional:** fever, recent weight gain/loss, appetite problems \_\_\_\_\_

**Eyes:** double vision, blurring, difficulty seeing \_\_\_\_\_

**Ears, Nose, Mouth, Throat:** deafness, sinusitis, hoarseness, dizziness \_\_\_\_\_

**Cardiovascular:** chest pain, palpitations, murmur, extra beats \_\_\_\_\_

**Respiratory:** shortness of breath, wheezing, cough, bloody cough \_\_\_\_\_

**Gastrointestinal:** abdominal pain, constipation, diarrhea, rectal bleeding \_\_\_\_\_

**Urologic:** pain with urinating, hesitant urination, bleeding, incontinence \_\_\_\_\_

**Gynecologic:** breast masses, pain, discharge \_\_\_\_\_

Are you sexually active? **Yes / No** Birth control used if any? \_\_\_\_\_

Is there any chance you could be pregnant now? **Yes / No** If no, why not? \_\_\_\_\_

**Skin:** persistent rashes or lesions, changes in moles \_\_\_\_\_

**Neurologic:** seizures, loss of balance/coordination, weakness, memory loss \_\_\_\_\_

**Psychiatric:** depression, anxiety, hallucinations, sleep disturbances \_\_\_\_\_

**Endocrine:** excessive thirst, excessive urination, heat/cold intolerance \_\_\_\_\_

**Blood and Lymphatic:** anemia, bleeding tendencies, swollen nodes \_\_\_\_\_

**Allergic and Immunologic:** hives, eczema, persistent itching \_\_\_\_\_

**Musculoskeletal:** stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arms or legs, numbness/tingling \_\_\_\_\_

**Other** problems not covered above: \_\_\_\_\_

**PATIENTS PLEASE SIGN FORM HERE:** Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR PRACTITIONER USE ONLY - I have reviewed and updated the above past medical, family and social history with the patient:**

Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_ Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_ Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_ Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_ Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_ Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_ Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

# GWINNETT PODIATRY ASSOCIATES, L.L.C.

Lawrenceville Office • 545 Old Norcross Road • Suite 300 • Lawrenceville, GA 30045 • Ph 770.963.6300  
Hamilton Mill Office • 2108 Teron Trace • Suite 100 • Dacula, GA 30019 • Ph 678.318.8020

## Office and Financial Policy Notification

### FINANCIAL RESPONSIBILITY STATEMENT

All patients are responsible for any bills they incur for services and products utilized while being treated by our practice. Insurance is an agreement between you and your insurance company to help pay for medical costs incurred. Having insurance is not a substitute for payment. All insurers have rules and guidelines regarding what costs they will cover based on your contract with them. It is always your responsibility to pay any deductibles, any co-insurance, all co-pay amounts, and any other balances not paid to us by your insurance. Any office visit co-payments not paid at the time of service will have a \$25.00 additional collection fee added. We will file for payment directly from your insurance company in most cases if you have confirmed and recognized insurance coverage. We do this as a convenience and service for our patients. Still, you are ultimately responsible for your full bill.

Patients without insurance must make a deposit before services are rendered. All fees incurred during the visit will be deducted from this deposit. After services are rendered, all uninsured patients must pay in full at time of service, or immediately arrange a payment plan that is acceptable to our financial staff. Payments must then be made on a regular basis as agreed, or collection action will be taken.

### SERVICES NOT COVERED BY INSURANCE

We provide a variety of services and products at our practice strictly for the convenience of our patients. Many of these products and services may not be covered by your health insurance provider. Unfortunately the increasing complexity of the health care benefits system has made it impossible for us to know in advance exactly what your insurer may or may not pay for.

If you elect to utilize these products or services, you will be responsible for all fees incurred. We will attempt to indicate to you if we have recommended a product or service which may not be covered by insurance. As a courtesy, we will usually submit a bill directly to your insurer for you. If we are not reimbursed in full by your insurer, we reserve the right to bill you for the remaining costs of the services. Even if the insurer provides coverage, they often expect the patient to contribute a portion of the fees.

These are examples of services and supplies often not covered by health insurances such as HMO's or medicare/medicaid:

*Medical supplies such as crutches, braces, and slings*

*Medications given by injection*

*Materials used to apply casts and splints*

*Fees for forms filled out for other parties*

### RELEASE OF MEDICAL INFORMATION

Many insurance companies will contact our office to request information they need to process your claims. By signing the form below you authorize our practice to release any medical information necessary to help with reimbursement.

### AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS

I authorize direct payment to Gwinnett Podiatry Associates, LLC., of all medical benefits otherwise payable to me for any and all services rendered. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE BILL AT THE TIME OF SERVICE unless another payer assignment, such as insurance, has been accepted. WE CAN ACCEPT CASH, ELECTRONICALLY VERIFIED PERSONAL CHECKS, MASTERCARD, VISA, DISCOVER, AND AMERICAN EXPRESS.

**THIS FORM MUST BE SIGNED BELOW I have read and agree to the above:**

PLEASE PRINT FULL NAME \_\_\_\_\_

SIGNATURE OF PATIENT (OR GUARDIAN) \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

# **GWINNETT PODIATRY ASSOCIATES, L.L.C.**

Lawrenceville Office • 545 Old Norcross Road • Suite 300 • Lawrenceville, GA 30045 • Ph 770.963.6300  
Hamilton Mill Office • 2108 Teron Trace • Suite 100 • Dacula, GA 30019 • Ph 678.318.8020

## **Patient Consent for Use and Disclosure of Protected Health Information**

*This form is necessitated by HIPAA Federal Privacy Regulations. We apologize for the cost, time spent, and inconvenience caused by the administration of all HIPAA rules.*

I hereby give my consent for Gwinnett Podiatry Associates, LLC, to use and disclose protected health information (P.H.I.) about me to carry out treatment, and obtain payment, and perform healthcare operations (T.P.O.).

The Gwinnett Podiatry Associates, LLC, Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Gwinnett Podiatry Associates, LLC, reserves the right to revise its Notice of Privacy Practices at any time. A revised and current Notice of Privacy Practices may be obtained by forwarding a written request to:

Gwinnett Podiatry Associates, LLC, Privacy Officer  
545 Old Norcross Road, Suite 300  
Lawrenceville, GA 30045

With this consent, Gwinnett Podiatry Associates, LLC., may call my home or alternate locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out T.P.O., such as appointment reminders, insurance inquiries, and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Gwinnett Podiatry Associates, LLC, may mail to my home or alternate locations any items that assist the practice in carrying out T.P.O., such as appointment reminders and financial statements.

I have the right to request, in writing, that Gwinnett Podiatry Associates, LLC, restrict how it uses my P.H.I. to carry out T.P.O. However, the practice is not required to agree to my requested restrictions, but if it does agree, it is bound by this agreement.

By signing this agreement, I am consenting to Gwinnett podiatry Associates, LLC., the use and disclosure of my P.H.I. to carry out T.P.O.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Gwinnett Podiatry Associates, LLC., may decline to provide treatment to me.

**THIS FORM MUST BE SIGNED BELOW** I have read and agree to the above:

PLEASE PRINT FULL NAME \_\_\_\_\_

**SIGNATURE OF PATIENT (OR GUARDIAN)** \_\_\_\_\_ **DATE SIGNED** \_\_\_\_\_