

georgia foot & ankle
Institute p.c.

Keith A. Rouse, DPM, FACFAS

Main Office:

310 Eisenhower Drive, Bldg 7A
Savannah, GA 31406
Phone: (912) 355-6503
Fax: (912) 355-9837

Richmond Hill:

10164 Ford Ave, Suite B
Richmond Hill, GA

David A. Valbuena, DPM, FACFAS

Pooler:

119 Canal Street, Suite 106
Pooler, GA

Springfield/Effingham Hospital

459 Hwy 119 S
Springfield, GA

You are scheduled for an appointment at our office on:

_____ @ _____

Welcome to Our Practice

We welcome you to our office and appreciate the opportunity to provide you with medical services. We strive to provide the highest quality of podiatry care to our patients with compassion and integrity.

If you are being seen for treatment of your toenails – it is required that you arrive without any polish on your toe nails. If you arrive at your appointment with polish will applied you will be asked to remove the polish before the provider sees you, or you may have to reschedule.

Fees and Payments

We made every effort to keep down the cost of your medical care. It is our policy to ask for payment at the time of your visit. For your convenience we accept Visa, MasterCard, American Express, Discover and personal checks.

Insurance

Your insurance contract is an agreement between you and your insurance carrier. We participate with most major insurance carriers. As required by most insurance carriers, you are responsible for the payment of deductibles, co-payments, and any non-covered services at the time of your visit. It is your responsibility to get an authorization or referral from your insurance company or primary care physician if one is required, or you will be charged the full amount on the day of your visit.

- | | |
|-----------------------|--|
| HMO Insurance | You must have a current HMO card and a referral sheet from your primary care Physician/insurance carrier. Be prepared to pay your applicable co-payments or deductible. If you do not have a referral, your visit may be rescheduled or you may be held financially responsible for the entire amount of your visit. |
| PPO Insurance | You must have a current PPO card. Your applicable co-payment and/or Deductible is due at the time of service. |
| Medicare | You must have a current Medicare card and be prepared to pay your deductible and/or 20% co-insurance of allowed charges. |
| No Insurance/Self Pay | Payment in full is due at the time of service.
If you have any questions, please call our office at 912-355-6503 |

Insurance and Injury Questionnaire
All patients are required to answer the following questions

Patient Name _____ Date of birth _____

Primary Insurance

Insurance Carrier _____

ID# _____ Group # _____

Policy Holder Information (if other than patient)

Name _____ Date of birth _____

SSN _____ Relationship to Patient _____

Secondary Insurance

Insurance Carrier _____

ID# _____ Group # _____

Policy Holder Information (if other than patient)

Name _____ Date of birth _____

SSN _____ Relationship to Patient _____

Are you receiving Black Lung Benefits? YES NO

Are you receiving Worker's Compensation Benefits? YES NO

Are you receiving treatment for an injury or illness which another party could be held liable or could be cover under no-fault auto insurance? YES NO

Will this claim be filed with any other insurance such as homeowners or business liability, etc?
YES NO

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PATIENT REGISTRATION

Name: _____ DOB ___/___/___ SSN: _____

Please circle all that apply: (these questions are required by the Federal Government. You may decline to answer by circling DECLINE in each column)

Marital Status	Race	Ethnicity	Sex
Married	American Indian	Hispanic/Latino	Male
Single	Asian	Not Hispanic/Latino	Female
Divorced	African American	Declined	
Separated	Hawaiian/Pacific Islander		
Widowed	White		
Domestic Partner	Other _____		
Decline	Declined		

Mailing Address _____ Apt: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Okay to leave a message?
YES NO

Email: _____

Employer: _____

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy Name: _____

Location: _____

If Patient is a minor or dependent, please complete the following information

Responsible Party: _____ DOB: ___/___/___

SSN: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____

Patient Name _____

Emergency Contact (Other than responsible party)

Name: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____

Patient Acknowledgment

I consent to treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring and primary care physicians and to my insurance company if applicable.

I allow fax transmission of my medical records, if necessary.

I acknowledge full financial responsibility for services rendered by Georgia Foot and Ankle Institute.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I further authorize and request that insurance payments be made directly to Georgia Foot and Ankle Institute should they elect to receive such payment.

Patient/Responsible Party Signature _____ Date _____

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**Acknowledgement of the Privacy Act of 2007
Patient Record of Disclosure**

In the general HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home via mail or fax.

I have agreed to let certain individuals participate in discussions and decisions related to my medical care, including but not limited to prescription pick-up and the release of medical records. Therefore, I hereby give permission for Georgia Foot and Ankle Institute to disclose my personal medical information to the following individual(s). I understand that Georgia Foot and Ankle Institute will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers in the treatment of my care. This form can be amended at any time.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

In addition to granting permission to the above named individuals, I have received a copy of the Georgia Foot and Ankle Institutes "Notice of Privacy Practices" which details how my personal health information may be used and disclosed as permitted under Federal and State law. I have read and understand the contents of the notice.

Patients Name

Date

Signature of Patient/Responsible Party

Witness

STAFF ONLY:

If a patient/responsible party refuses to sign this acknowledgment of Receipt, please document why including the date and time.

Presented and Refused Reason

Name/Date/Time

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History and Physical

Patient Name: _____ DOB: ___/___/___

Preferred Pharmacy: _____

Chief Complaint?

How would you describe your problem/reason for your visit?

History of Present Illness

When did your problem start? _____ Is it getting Better / Worse / Same
Have you seen another doctor for this problem YES NO

If yes, which Doctor and when? _____
Have you had any testing for this problem? YES NO

If yes, where? _____ When? _____

Past Medical History

Have you ever been diagnosed or treated for any of the following conditions? Please circle all that apply.

Asthma	Emphysema	Skin Condition
Allergies	Seizures	Thyroid Disease
Alzheimer's	Fibromyalgia	Swelling of Arms/Legs
Aneurysm	Glaucoma	Ear Infections
Arthritis	Headaches	Drug Abuse
Anemia	Heart Disease	Stroke
ADD/ADHD	Hepatitis	Dementia
Anxiety	High Cholesterol	Muscle Conditions
Balance Trouble	High/Low Blood Pressure	Mental Illness
Cancer	HIV Positive	Diabetes
Lung Disease	Kidney Disease	

Allergies:

Patient Name _____

Do you currently wear or have you ever worn orthotics (shoe inserts)? YES NO

If yes, were they prescribed by a physician or health care provider? YES NO

If yes, did they help you to any significant degree? YES NO

Physical Characteristics

Height: _____ Weight: _____ Shoe size _____

Diabetes and Circulation

Are you under active care for diabetes and/or circulation problems? YES / NO

if yes, Doctors Name: _____ Phone #: _____

Date you were last seen by the above doctor: ___/___/_____

Insulin dependent diabetic? YES / NO Diet Controlled? YES / NO

Number of years Diabetic? _____ Average blood sugar range: _____

Previous Hospitalizations/Surgeries

Reason:

Date:

Location:

1. _____
2. _____
3. _____
4. _____
5. _____

Medications: Please list all prescriptions / vitamins/ birth control / over the counter / herbal supplements, their dosage and how many times you take them per day.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Patient Name _____

Drug Allergies: Please include the name of the medication and the reaction

1. _____
2. _____
3. _____
4. _____

Family History

Please mark any major medical conditions that run in your immediate family (Mother, Father, Maternal/Paternal Grandparents, Aunts, Uncles, Brother, Sisters) and indicate your relationship to that person.

Condition	Relative	Condition	Relative
Asthma		Heart Disease	
Arthritis		High/Low Blood Pressure	
Cancer		Mental Illness	
Dementia/Alzheimer's		Muscle Disease	
Diabetes		Stroke	
Epilepsy/Seizures			

Social History

Do you smoke? YES / NO

If yes, amount? _____ How often? _____

Have you smoked/used tobacco products in the past? YES / NO

If yes, amount? _____ How often? _____

Do you drink alcoholic beverages? YES / NO

If yes, amount? _____ How often? _____

Do you use recreational/illegal drugs?

If yes, what type? _____ How often? _____

Do you drink caffeinated beverages?

If yes, what type? _____ How often? _____

Do you exercise regularly? YES / NO

Do you currently practice any diet restrictions? YES / NO

If yes, what type? _____

Patient Name _____

Review of Systems: Circle any symptoms you have experienced in the last month

General:

Altered Taste/Smell
Change in Appetite
Weight Loss/Gain

Eyes:

Cataracts
Glaucoma
Changes in vision
Vision correction(glasses, etc)

Cardiac:

Chest discomfort
Cold hands/feet
Swelling of Extremities
Heart murmurs
High/low blood pressure

Ears/Nose/Throat

Changes in hearing
Recent sinus infection
Snoring
Nose bleeds
Mouth Sores

Gastrointestinal

Abdominal Pain
Constipation
Diarrhea
Hemorrhoids
Heartburn
Nausea
Vomiting

Genital/Urinary

Prostate problems
Sexual Dysfunction
Changes in urinary habits
Kidney stones
Incontinence

Endocrine:

Changes in hair
Excessive hunger/thirst
Change in body odor

Hematologic/Lymphatic

Anemia
Easy bleeding/bruising
Swollen lymph nodes

Respiratory:

Asthma
Shortness of breath
Cough
Pneumonia
Upper respiratory infections
Tuberculosis

Psychiatric:

Personality changes
Depression
Anxiety
Nervousness
Mood swings
Hallucinations
Sleep disturbances

Neurological:

Balance problems
Numbness
Tingling
Burning sensation
Seizures
Falls/Lack of Coordination
Muscle weakness
Headaches

Patient/Responsible Party Signature

Date