LANIER
FOOT AND ANKLE

New Patient Registration Form

Copay $ _____

General Information (please print)

Name: _____ DOB: _____ Sex: ☐M ☐F

Social sec #: _____ Marital status: ☐Single ☐Married ☐Divorced ☐Widowed

Primary address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ E-mail: _____

Do you wish to enroll in the Patient Portal (using your email address above): ☐ Yes ☐ No

Emergency contact: _____ Relationship: _____ Phone: _____

Pharmacy name: _____ Phone: _____ Fax: _____

Employment status: ☐ Employed ☐ Not employed ☐ Retired ☐ Student

Employer: _____ Occupation: _____

Communication Authorization

Please select your preferred contact method:

Phone ☐ Text ☐ Email ☐

Sharing of Medical Information

I give the physician and office staff of Lanier Foot and Ankle permission to discuss my medical condition with the following individuals:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Doctor Information

Referring Physician: _____ Specialty: _____

Primary Care Physician: _____ Phone: _____

Primary Insurance

Insurance name: _____ Subscriber's name: _____

Insurance ID#: _____

Social Sec #: _____ DOB: _____ Relationship to insured: _____

Secondary Insurance

Insurance name: _____ Subscriber's name: _____

Insurance ID#: _____

Social Sec #: _____ DOB: _____ Relationship to insured: _____

Patient Authorization for ePRESCRIBE

ePrecribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of Lanier Foot and Ankle to enroll me in the ePrescribe Program.

Patient signature _____ Date _____

Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of Lanier Foot and Ankle to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

Patient signature _____ Date _____

Patient Authorization for PPO and HMO PATIENTS

I authorize the physician/staff of Lanier Foot and Ankle to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above-named insurance company to pay directly to Lanier Foot and Ankle the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature _____ Date _____

Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify Lanier Foot and Ankle of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Lanier Foot and Ankle is the patient's responsibilities.

Patient signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish***. I acknowledge that I have received a copy of the Lanier Foot and Ankle's Notice of Privacy Practices.***

_____	_____	_____
Printed name	Signature	Date signed

LANIER
FOOT AND ANKLE
Gregory T. Sutton, DPM
Ana G. Recendiz, DPM
447 E.E. Butler Parkway, Floor 1 Gainesville, GA 30501
Telephone # (770) 796-0005

Financial Policy and Signature on File

I understand that I am financially responsible for all services rendered and for the following reasons:

If: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company *(This applies to present and future visits).*

Payment is required for all services at the time they are rendered. Self-Pay patients must be prepared to pay $50.00 at time of service.

Co-payments must be paid at the time of service. Co-payments for office services/visits are required when you check-in.

Any outstanding balances are required to be paid prior to your next visit.

If your account balance is more than 180 days past due, you are in jeopardy of being discharged from the practice and your account may be turned over to a collections agency.

In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account.

Refunds from services charged on a credit card will be returned to the same credit card.

An appointment which is not cancelled 24 hours in advance and is missed will be considered a “no show” and will be subject to a $25.00 fee.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Patient or Responsible Party

Name (*Print*)_____

Signature_____Date_____

NAME: _____

Reason for today's visit:

_____

_____

Please rate your pain on an average day due to this condition by circling a number below:

1 2 3 4 5 6 7 8 9 10

Duration of Current Condition: (# Weeks/Months/Years)

_____

List any CURRENT medical problems:

_____

_____

_____

Please list past surgeries and hospitalizations (if any):

Surgery/Hospitalization	Date (Approximate)	Complications (if any)

Do you currently smoke? ☐ **YES** ☐ **NO** **Years smoked: _____ Packs/Day: _____**

Did you smoke previously? ☐ **YES** ☐ **NO** **Years smoked: ___ Packs/Day: ___ Year quit: _____**

Other Tobacco Products? ☐ **YES** ☐ **NO** **Description and Amount: _____**

Consume Alcohol? ☐ **YES** ☐ **NO** **How Often? _____**

Illicit Drug Use? ☐ **YES** ☐ **NO** **Description: _____**

Female Patients Only:

Currently Breastfeeding? ☐ **YES** ☐ **NO**

Currently Pregnant? ☐ **YES** ☐ **NO**

NAME: _____

Please list any Allergies to any medications or substances you may have:

☐ **No drug allergies | No other allergies**

Allergy	Reaction

Please list ALL current medications including any over the counter medications, herbs, supplements, vitamins including the dose amount and how many times per day:

_____

_____

_____

_____

_____

_____

Please list any major illnesses/medical conditions of direct family members:

Relative	Condition	Currently Living?	Age