

**Fisher Foot & Ankle**

1010 North Tennessee St, Ste 114 Cartersville, GA 30120  
phone: 770-386-4111 fax: 770-386-4905 fisherfoot.com

**Patient Registration Form**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

Cell phone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Sex: M\_\_\_ F\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital status: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Family doctor: \_\_\_\_\_ Date of last visit with family doctor: \_\_\_\_\_

Who is responsible for this account? self\_\_\_ parent \_\_\_ guardian \_\_\_ spouse \_\_\_

Date of Birth of responsible party: \_\_\_\_\_

SSN of responsible party: \_\_\_\_\_

**Emergency contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

You may share my information (lab results, appointment info, etc.) with:

_____	_____	(____) _____
Name	relationship	phone number

I understand that payment of all medical care is due at the time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient's account in case of default, including reasonable attorney fees and court costs.

I grant permission to Fisher Foot & Ankle to release any pertinent information to my insurance company upon request, and I authorize payment directly to Fisher Foot & Ankle. A copy of this authorization shall be considered as effective and valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

**Patient Name:** \_\_\_\_\_

Allergies:   \_\_adhesive   \_\_aspirin   \_\_codeine   \_\_iodine   \_\_latex  
\_\_morphine   \_\_novocaine   \_\_penicillin   \_\_sulfa   other: \_\_\_\_\_

**Medications:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical Problems (include those being treated and under control)

<input type="checkbox"/> alzheimer's	<input type="checkbox"/> emphysema	<input type="checkbox"/> neuropathy
<input type="checkbox"/> anemia	<input type="checkbox"/> hearing loss	<input type="checkbox"/> prostate cancer
<input type="checkbox"/> angina (chest pain)	<input type="checkbox"/> hypothyroidism	<input type="checkbox"/> paralysis
<input type="checkbox"/> arthritis	<input type="checkbox"/> headaches	<input type="checkbox"/> rash
<input type="checkbox"/> asthma	<input type="checkbox"/> heart attack	<input type="checkbox"/> reflux (gerd)
<input type="checkbox"/> anxiety	<input type="checkbox"/> foot/leg cramps	<input type="checkbox"/> respiratory problems
<input type="checkbox"/> back pain	<input type="checkbox"/> glaucoma	<input type="checkbox"/> ringing in ears
<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> gout	<input type="checkbox"/> seizures/epilepsy
<input type="checkbox"/> congestive heart failure	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> COPD	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> sciatica
<input type="checkbox"/> constipation	<input type="checkbox"/> impaired vision	<input type="checkbox"/> skin cancer
<input type="checkbox"/> diarrhea	<input type="checkbox"/> kidney stones	<input type="checkbox"/> stroke
<input type="checkbox"/> depression	<input type="checkbox"/> leg pain on walking	<input type="checkbox"/> ulcer
<input type="checkbox"/> diabetes	<input type="checkbox"/> lung cancer	<input type="checkbox"/> varicose veins
<input type="checkbox"/> dialysis	<input type="checkbox"/> multiple sclerosis	<input type="checkbox"/> on aspirin or coumadin

### Family History (please write in who has/had the problem - mom, dad, sister, brother)

diabetes \_\_\_\_\_ high blood pressure \_\_\_\_\_  
cancer \_\_\_\_\_ heart disease \_\_\_\_\_

### Surgical History (check off any surgeries you have had and write in any not on list)

<input type="checkbox"/> appendectomy	<input type="checkbox"/> hip	<input type="checkbox"/> open heart	<input type="checkbox"/> tubal ligation
<input type="checkbox"/> hysterectomy	<input type="checkbox"/> knee	<input type="checkbox"/> gall bladder	<input type="checkbox"/> cancer surgery
<input type="checkbox"/> tonsillectomy	<input type="checkbox"/> hernia	<input type="checkbox"/> cataract	<input type="checkbox"/> cardiac catheterization

**Social History:** \_\_exercise   \_\_drink alcohol   \_\_smoke - how much? \_\_\_\_\_

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### **Patient Financial Policy**

We would like to thank you for choosing Fisher Foot & Ankle to provide care for you and will do our best to assure that you receive competent caring service. Please allow us to explain our office policies. If you have any questions, please ask.

#### **Payment of Fees**

Payment of fees that you are responsible for is required at the time of service unless prior arrangements have been made. We accept cash, checks, mastercard, and visa. There will be a \$20 fee for returned checks. If you have had a check returned for insufficient funds you will be required to pay with cash or credit card in the future.

#### **Insurance Claims**

We file insurance claims as a courtesy to you, if you reassign your benefits to Fisher Foot & Ankle. However, you must pay your portion at the time of service and are responsible for any services not covered by your insurance. We will only bill plans with which we participate with. If you have a plan we do not participate with, you will be required to pay the entire bill at the time of service and the insurer will send the payment directly to you when you send in your claim.

**IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS.**

#### **Appointment Scheduling/No-show Policy**

We ask that you give us at least 24 hours notice before canceling or rescheduling an appointment so that another patient who needs care may be seen. There will be a \$25 charge for patients who do not call ahead of time to cancel or change their appointments.

#### **Authorization to Release Information**

In order to file insurance claims it is necessary to release information to the insurance company regarding examination and treatment.

#### **Signature**

I have read the policy and agree to the release of information as necessary regarding my treatment. I agree to assign benefits to Fisher Foot & Ankle, PC, so that insurance claims may be filed on my behalf. I also acknowledge my financial responsibility for copayments, deductibles, and non-covered services.

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Signature of Responsible Party

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Date

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### Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

\*We are trying to keep trees around, so we do not routinely give patients a copy of the Notice of Privacy Practices. It is posted next to the check-in window, and it does not vary significantly from practice to practice. If you would like a copy please ask and we will happily provide you with one.