Easy Walk Foot Clinic, LLC
5604 Wendy Bagwell Parkway
Unit 311
Hiram, GA 301414

Dr. Azuka Nwaedozie, DPM
Office: 770-485-3921
Fax: 770-485-3648

Thank you for trusting our office with your health care needs. We promise to do our best to provide you with the finest care available. If you have any additional questions, please do not hesitate to ask.

DATE: _____20____

Patient Information (Please PRINT clearly)

Name: _____ *Preferred Name*: _____
Last First MI

DOB: _____/_____/_____ Sex: __Female __Male SSN: _____-_____-_____

Preferred Language: _____ Race: _____ Ethnicity: __Hispanic __Non-Hispanic

Do you have an Advanced Directive? __Yes __No (If no, would you like one? _____)

Contact Information:

Address: _____ Apartment#: _____
City: _____ State: _____ Zip: _____
Home#: _____-_____-_____Cell#: _____-_____-_____ Preferred Number: _____
Email_____@_____.com

Emergency Contact: _____ Phone: _____- _____-_____

Primary Doctor: _____ Phone: _____-_____-_____

Social History
Do you smoke? ___ Yes ___ No ___Former Packs Per Day: _____ Years: _____
Have you quit? _____ If yes, how long? _____
Smokeless Tobacco Use? ___ Yes ___No ___Former Recreational Drug Use? ___Yes ___No ___Former

Alcohol Use: __Never __Occasional __Moderate __Excessive __Former Use

Employment (Responsible Party)
Employer: _____ Phone: _____-_____-_____
Address: _____ Dept: _____
City: _____ State: _____ Zip: _____

Please present I.D. and insurance card(s)

Medical History (Please complete in FULL)

TURN PAGE OVER TO COMPLETE HISTORY

Reason for Today's Visit: _____

Have you had any lab work in the last 30 days? _____

Height: _____Weight:_____ Shoe Size: _____ Last A1C (Diabetic pts.)_____

(Women) Are you Pregnant: __Yes __No Nursing: __Yes __No Birth Control: __Yes __No

*Check **ALL** that apply if you are under **current treatment for or have had in last 10 years**:*

__ Anemia	__Congenital Heart Lesions	__Hernia Repair	__Scarlet Fever
__Arthritis	__Cortisone Treatment	__High Cholesterol	__Shortness of Breath
__ Artificial Valve	__Cough, Persistent	__High Blood Pressure	__Rash
__Asthma	__Cough with blood	__HIV/Aids	__Jaw Pain
__ Abnormal Bleeding	__Back Problems	__Diabetes	__ Cancer
__Circulation	__COPD	__ Kidney Disease	__ Hepatitis
__ Thyroid Disease	__Headaches/Migraines	__ MVP	__ Pacemaker
__TB	__Seizures	__Swelling of ankle and feet	
__Stroke	__Venereal Disease	__Artificial joints	__Other_____

Surgeries: _____
_____

Family Medical History: ____Diabetes ____Heart disease _____Stroke ____Poor circulation ___Kidney Disease

Current Medication: (We will accept current list for copying)

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: YES ___ NO___ (If YES please list)

_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy & Phone#: _____(_____)_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if there is a change in my, or my minor child(s) health.

_____ _____
Signature of Patient, parent or guardian Date

_____ _____
Printed Name Relation to patient

5604 WENDY BAGWELL PKYWY UNIT 311
HIRAM, GA 30141

CONSENT TO TREATMENT

I hereby authorize Easy Walk Foot Clinic and any of its physicians and assistants to provide and render such medical care and treatment to the below named patient as is necessary under the circumstances including, without limiting the generality of any of the following: physical exam, x-rays and office procedures.
_____ (Initials)

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby irrevocably transfer and assign Easy Walk Foot Clinic all insurance benefits otherwise payable to me but not to exceed Easy Walk Foot Clinic's charges for the services rendered to me, and authorize my insurance carrier to pay such benefits directly to Easy Walk Foot Clinic on my behalf. I understand that I may be financially responsible to Easy Walk Foot Clinic for charges not paid under this assignment. I further authorize Easy Walk Foot Clinic and any holder of medical information or records concerning me to release such information or records to any pharmacist who provides medication to me, to my insurance carrier or to any other insurance carrier I have made, or will make, a claim.
_____ (Initials)

MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

If applicable, I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize Easy Walk Foot Clinic to release to the Center for Medicare Services or its intermediaries or carriers any information needed for this or related Medicare claim; I request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment for me.
_____ (Initials)

PERSONAL RESPONSIBILTY FOR PAYMENT OF CHARGES

I understand that though I am a participant in a managed care organization or plan, which may limit my liability, I am personally responsible for the payment of all charges that occur as a result of my medical treatment. The ***charges associated with treatment, are but not limited to copay, deductible and non-covered services.***
_____ (Initials)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

My signature below indicates that I have read and understand all the above information, and that I have ___received ___declined a copy of the Notice of Privacy Practices of Easy Walk Foot Clinic, LLC.

If notice is declined, please check reason: ___ Patient already has copy
___ Patient refuses copy
___ Patient is minor

_____ _____ _____
Printed Name Signature Date

HIRAM, GA 30141

PATIENT CONTACT INFORMATION

In the event we are unable to reach you directly at the phone number you provided to us, may we leave a message on your voice mail? __Yes __ No
OR
May we leave a message with someone? __Yes __No, If "yes", who? _____
(We will ***NOT*** leave medical information on your voice mail or discuss with anyone *NOT* listed)

I hereby authorize Easy Walk Foot Clinic or associates to contact me by the use of automatic dialing system, by pre-recorded forms of voice/messages system, by electronic mail owned or used by guarantor/responsible party, by text and/or telephone/cell phone for reasons related to appointments and/or services I received at Easy Walk Foot Clinic. _____ (Initials)

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH OTHERS

List anyone whom we may speak to on your behalf.
Please note, if you do not list your spouse, we *will not* be able to discuss any information with them. Also, if you are the legal guardian (non-parental) of a minor or disabled person, please list yourself.

Please be aware that you may add or delete names at any time with written notice to this office.

Name: _____ Phone#: _____
Relationship to patient: _____

Name: _____ Phone#: _____
Relationship to patient: _____

_____ _____ OR _____ _____
Signature of patient Date Signature of person acting on behalf of patient Date

STATEMENT OF PERSON ACTING FOR PATIENT

I have executed the above information for the Patient. My relationship to the patient is that of (check line that is appropriate).

____ It is impractical for the patient to execute this document because the patient's mental or physical condition is such that the patient should not be asked to transact business.

____ The Patient is a minor.

_____ _____
Signature of Person Acting for Patient Date

_____
Office Staff