SOUTHERN PODIATRY GROUP, P.C.

2718 North Oak Street
Valdosta, Georgia 31602
(229) 242-3668

820 Love Avenue, Suite B
Tifton, Georgia 31794
(229) 382-5599

PATIENT INFORMATION

Today's Date: ______________

Patient's Name: ________________________________ Sex: ( ) M ( ) F Age: ________
Last First Middle

Street Address: ________________________________

Mailing Address: ________________________________

City: ______________ State: ________ Zip: ________ County: ____________

Date of Birth: ____________ Marital Status: ________ Social Security No.: ____________

Race: ____________ Preferred Language: ____________ Ethnicity: ____________

Home Phone No.: ______________ Cell Phone No.: ______________

E-mail Address: ______________ Mobile Carrier: ______________

How would you like to be notified of your next appointment? ☐ Phone ☐ Text ☐ E-mail

Employer's Name: ______________ Work Phone No.: ______________

Address: ______________ City: ____________ State: ________

Your Occupation/Job Title: ________________________________

Emergency Contact: ______________ Phone: ______________

Address: ______________ Relationship to Patient: ____________

City: ______________ State: ________ Zip Code: ________

SPOUSE OR PARENT INFORMATION

Name: ________________________________

Address: ______________ Relationship to Patient: ____________

City: ______________ State: ________ Zip Code: ________

Date of Birth: ______________ Social Security No.: ______________

Home Phone No.: ______________ Work Phone No.: ______________

Employer Name: ______________ Occupation/Job Title: ______________

Address: ______________ City: ____________ State: ________

INSURANCE INFORMATION:

Primary Plan Name: ________________________________

Insured Name: ______________ Social Security No. ______________

Relationship to Patient: ______________ Insurer's D.O.B. ______________

Secondary Plan Name: ________________________________

Insured Name: ______________ Social Security No. ______________

Relationship to Patient: ______________ Insurer's D.O.B. ______________

PLEASE PRESENT INSURANCE CARD/S TO RECEPTIONIST!

(Co-Payments will be collected prior to treatment)

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Patient name: ____________________

My foot problem is: ____________________

Have you been treated for this problem before? ________ Yes ________ No

If yes, then 1) Who was the doctor who treated you. ____________________

2) When did you see him/her? ____________________

3) What treatment was given? ____________________

Name of your family doctor or primary doctor: ____________________

What pharmacy do you use for prescriptions? ____________________

Were you referred to us? If so, who referred you? ____________________

Are you a diabetic? ________ Yes ________ No

Is your diabetes controlled with: (Please circle one) Insulin Pills Insulin and Pills Diet

Name of the doctor treating your diabetes: ____________________

Date diabetic doctor was last seen: ____________________

How did you hear about our office: (Please circle one)

Internet Phone-book Television Newspaper Family Friend

Is this a work-related injury? ________ Yes ________ No

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

AUTHORIZATION OF TREATMENT

I the undersigned hereby authorize the physicians and staff of Southern Podiatry Group to render treatment and/or therapy to myself that they deem medically necessary in order to treat the condition and or conditions I have requested from the physicians and/or staff.

SIGNATURE OF PATIENT/GUARDIAN: ____________________

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: ____________________

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly to Southern Podiatry Group, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 30 days from the date of insurance payment and/or denial. If outside collection attempts are necessary, I will be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

____________________ ____________________

SIGNATURE OF INSURED/GUARDIAN DATE

RELATIONSHIP OF GUARDIAN TO MINOR CHILD: ____________________

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