Easy Walk Foot Clinic, LLC Dr. Azuka Nwaedozie, DPM 5604 Wendy Bagwell Parkway Office: 770-485-3921

 Unit 311 Fax: 770-485-3648

 Hiram, GA 301414

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)***

**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

EASY WALK FOOT CLINIC, LLC

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

EASY WALK FOOT CLINIC, LLC

5604 WENDY BAGWELL PRKWY, UNIT 311

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