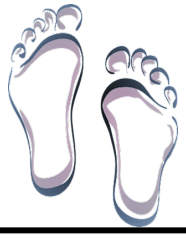
Moore Foot and Ankle Solutions

109 Osigian Blvd. Ste 300
Warner Robins, GA 31088
Office #: 478-333-2430



4116 Arkwright Rd. Ste 1
Macon, GA 31210
Fax #: 478-333-2173

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Social Security No: _____

Gender: ☐ Male ☐ Female | Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Race: ☐ Asian ☐ Caucasian ☐ African American ☐ Other | Primary Language: _____

Address: _____ Apt #: ____ State: ____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ | Preferred: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Employment Status: ☐ Employed ☐ Part-time student ☐ Full-time student ☐ Disabled ☐ Unemployed ☐ Retired

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Responsible Party: **Patients under the age of 18 must provide contact information for a responsible party.**

Responsible Party Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: **All clients must provide the nearest relative that is NOT living with you.**

Emergency Contact Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

Physicians:

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Cardiologist: _____ Phone #: _____

Patient Information

Insurance Information:

Primary Insurance Name: _____ Policy ID:_____

Policy Holder Name:_____ Policy Holder D.O.B: _____

Policy Holder Social Security No: _____

Relationship to Policy Holder: _____

Secondary Insurance Name:_____ Policy ID: _____

Policy Holder Name:_____ Policy Holder D.O.B:_____

Policy Holder Social Security No: _____

Relationship to Policy Holder:_____

Please read the following authorization statement and sign below to accept the terms of our services.

I authorize the release of any health information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including private insurance and other health plans to Moore Foot and Ankle Solutions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize the practice to appeal any incorrect insurance payment.

_____ _____

Signature of Client/Responsible Party Date

History of Present Illness

Location of pain: _____

Type of pain: ☐ Aching ☐ Burning ☐ Cramping ☐ Itching ☐ Stabbing ☐ Tingling

Duration of pain: ☐ Hours ☐ Days ☐ Weeks ☐ Years

Severity of pain: _____ (Scale from one to ten)

Location of swelling: _____

Duration of swelling: _____ Severity of swelling: _____ (Mild, moderate, severe)

What helps? ☐ None ☐ Rest/Elevation ☐ Walking ☐ Hose ☐ OTC Medications ☐ Other: _____

Causes? ☐ None ☐ Prolonged sitting ☐ Standing ☐ Walking ☐ Other: _____

What medication(s) help? _____

Have you ever worn a support hose? ☐ Yes ☐ No | If yes, how long? ☐ Weeks ☐ Months ☐ Years

Do you have any of these symptoms listed currently?

☐ Dizziness ☐ Slurred speech ☐ Loss of balance ☐ Headaches

☐ Weakness on one side of the body ☐ Loss of vision ☐ Facial drooping

Do you smoke? ☐ Yes ☐ No | If yes, how often? _____

Have you ever smoked tobacco? ☐ Yes ☐ No | If yes, how often? _____

Dialysis Patients Only

Are you on dialysis currently? ☐ Yes ☐ No | When did you last dialyze? _____

Do you currently have a Fistula or Graft? ☐ Yes ☐ No | If yes? ☐ Right ☐ Left

History of Present Illness

Current Medications

Do you have any drug allergies? ☐ Yes ☐ No Known Allergies | If yes, please list here:_____

_____

_____

Medication Name	Dosage	Number of times per day

Medical History

Please mark the year you were diagnosed in the box provided.

Condition	Year	Condition	Year
Cardiovascular		**Pulmonary**	
Abdominal Aortic Aneurysm		Asthma	
Aneurysm, other		Chronic Bronchitis	
Angina		COPD	
Arrhythmia		COVID	
Arterial Thrombosis		Cystic Fibrosis	
Carotid Artery Stenosis		Emphysema	
Congestive Heart Failure		Lung Infection	
Coronary Artery Disease		Pneumonia	
Deep Vein Thrombosis		Pulmonary Embolism	
Heart Disease		Pulmonary Hypertension	
High Blood Pressure		Sleep Apnea	
High Cholesterol		Tuberculosis	
Heart Attack		Other:	
Heart Murmur			
Irregular Heartbeat		**Musculoskeletal**	
PAD/Atherosclerosis		Arthritis	
Superficial Phlebitis		Chronic Pain	
Varicose Veins		Fibromyalgia	
Venous Insufficiency		Fracture	
Lymphedema		Gout	
Other:		Osteoarthritis	
		Osteoporosis	
Renal/Genitourinary		Rheumatoid Arthritis	
Acute renal failure		Lupus	
Bladder infection		Other:	
Chronic renal failure			
Dialysis		**Endocrine**	
Enlarged prostate		Addison's disease	
Erectile dysfunction		Diabetes Insulin Dependent	
Kidney infection		Diabetes Non-Insulin Dependent	
Kidney stones		Enlarged thyroid	
Urinary incontinence		Hepatitis	
Urinary tract infection		Hyperthyroidism	
Other:		Jaundice	
		Other:	

Medical History

Condition	Year	Condition	Year
Gastrointestinal		**Cancer**	
Cirrhosis of Liver		Bone cancer	
Colitis		Brain tumor	
Colon polyps		Breast cancer	
Diverticulitis		Colon cancer	
Hepatitis		Hepatic carcinoma	
Indigestion/Heartburn		Leukemia	
Irritable Bowel Syndrome		Lung cancer	
Pancreatitis		Lymphoma	
Reflux		Melanoma	
Stomach Ulcer Disease		Pancreatic cancer	
Other:		Prostate cancer	
		Renal cancer	
Hematology		Skin cancer	
Bleeding disorder/clotting		Testicular cancer	
Hemolytic anemia		Thyroid cancer	
Iron deficiency anemia		Other:	
Blood transfusion			
HIV positive/Hepatitis C		**Neurological**	
Pernicious anemia		Alzheimer's	
_____ anemia		Anxiety	
Other:		Cerebral Palsy	
		Dementia	
Other		Depression	
Allergies		Down syndrome	
Chicken pox		Headaches/Migraines	
Measles		Meningitis	
Mumps		Mental retardation	
Immunodeficiency		Multiple Sclerosis	
Infectious disease		Muscular Dystrophy	
Cataracts		Myasthenia Gravis	
Glaucoma		Parkinson's Disease	
Medication noncompliance		Peripheral Sensory Neuropathy	
Obesity		Seizure disorder	
Ovarian cysts		Stress	
Pregnancy (How many?)		Stroke	
Other:		Transient Ischemic Attack (TIA)	

Surgical History

Please mark the year you received surgery in the box provided.

Surgery	Year	Surgery	Year
Breast surgery		Fistulagram	
Cataract removal		Angioplasy	
Appendectomy		Arteriogram	
Cosmetic surgery		Bypass graft	
Hysterectomy		Carotid surgery	
Injury related		Abdominal aneurysm	
Hemorrhoidectomy		Embolectomy	
Tonsils/Adenoids		Stent placement (renal)	
Tubal ligation		Stent placement (legs)	
Gall bladder removal		Other:	
Other:			
		Foot	
Amputation		Bunion	
Heart Catheter		Hammertoe	
Heart Bypass surgery		Excision Neuroma	
Heart stent		Ankle	
Pacemaker		Spine Surgery	
Defibrillator		Other:	
Knee surgery			
Hip surgery			
Dialysis graft/fistula			
Spider vein treatment			
Varicose vein surgery			
De-clotting procedure			
Other:			

Family Medical History

Please mark in the appropriate block which family member has/had the following medical conditions with the abbreviations listed below.

Mother (M)	Aunt (A)
Father (F)	Uncle (U)
Brother (B)	Sister (S)
Paternal Grandmother (Pat-M)	Maternal Grandmother (Mat-M)
Maternal Grandfather (Mat-F)	Paternal Grandfather (Pat-F)

Condition	Family Member(s)	Comments
Alzheimer's		
Aneurysm		
Bleeding Disorder		
Blood Clot		
Cancer		
Carotid Stenosis		
COPD		
Diabetes		
Heart Disease		
Hepatitis B/C		
High Blood Pressure		
High Cholesterol		
Hyperthyroidism		
Hypothyroidism		
Lung Problems		
Multiple Sclerosis		
Other		
Parkinson's Disease		
PVD		
Renal Failure		
Stroke/TIA		
Varicose/Spider Veins		
Venous Disease		

Social History

Information obtained from:

☐ Patient ☐ Parent ☐ Spouse ☐ Significant Other
☐ Sibling ☐ Child ☐ Caretaker ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Living Arrangements: ☐ House ☐ Apartment ☐ Assisted Living ☐ Nursing Home
☐ Other: _____

Do you exercise? ☐ Yes ☐ No

Caffeine use? ☐ Yes ☐ No

Alcohol use? ☐ Denies usage ☐ Yes – socially ☐ Yes – daily: How much? _____
How long? _____

Tobacco use? ☐ Never ☐ Previously but not currently ☐ Yes: How much? _____
How long? _____

Substance use? ☐ Never ☐ Yes: Type: _____ Frequency: _____

Current Symptoms:

General/Constitutional
☐ Weight gain
☐ Weight loss
☐ Chills
☐ Fever
☐ Fatigue
☐ Loss of appetite
☐ Night sweats
☐ None apply

Gastrointestinal
☐ Abdominal pain/swelling
☐ Appetite changes
☐ Bloody/Black stools
☐ Constipation
☐ Diarrhea
☐ Acid Reflux
☐ Heartburn/Indigestion
☐ Nausea
☐ Vomiting
☐ Rectal swelling/bleeding
☐ Trouble swallowing
☐ Vomiting blood
☐ None apply

Extremities
☐ Amputations
☐ Bone/joint pain or swelling
☐ Burning sensations in feet/legs
☐ Cold sensations in feet
☐ Difficulty walking
☐ Numbness in arms
☐ Numbness in legs
☐ Pain in leg/calf when walking
☐ Swelling of legs/feet
☐ Ulcers of arms/hands
☐ Ulcers of legs/feet
☐ Varicose veins
☐ Spider veins
☐ Weakness in arms/legs
☐ None apply

Social History

Eyes
- ☐ Pain
- ☐ Cataracts
- ☐ Glasses/contacts
- ☐ Impaired vision
- ☐ Redness
- ☐ Vision changes
- ☐ Double vision
- ☐ Discharge
- ☐ Light sensitivity
- ☐ Blurred vision
- ☐ None apply

Cardiorespiratory
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Swelling of feet/ankles
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Calf pain
- ☐ Leg pain
- ☐ Wheeze pain
- ☐ Bloody sputum
- ☐ None apply

Neurological
- ☐ Fainting/loss of consciousness
- ☐ Temporary loss of vision
- ☐ Weakness in arms/legs
- ☐ Speech problems
- ☐ Numbness
- ☐ Dizziness
- ☐ Headaches
- ☐ Unsteadiness
- ☐ Tremors
- ☐ Confusion
- ☐ Memory loss
- ☐ Seizure
- ☐ None apply

Ears/Nose/Throat
- ☐ Hoarseness
- ☐ Ringing in ears
- ☐ Hearing impairment/loss
- ☐ Mouth sores
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Sore throat
- ☐ None apply

Skin
- ☐ Scars
- ☐ Open wounds
- ☐ Discoloration
- ☐ Dry skin
- ☐ Drainage
- ☐ Hair/nail changes
- ☐ Fungal nail infection
- ☐ Mole changes
- ☐ Rashes
- ☐ Sores
- ☐ Redness
- ☐ Lumps
- ☐ Breast discharge
- ☐ None apply

Musculoskeletal
- ☐ Back pain
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Thick toenails
- ☐ Arthritis
- ☐ Hip pain
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Poor balance
- ☐ None apply

Genitourinary
- ☐ Burning
- ☐ Sexual impotence
- ☐ Incontinence
- ☐ Urgency
- ☐ Blood in urine (Hematuria)
- ☐ Renal failure
- ☐ Frequency issues
- ☐ Flank pain
- ☐ None apply

Allergic/Immunity
- ☐ Allergic reaction
- ☐ Seasonal allergies
- ☐ Sinus allergy symptoms
- ☐ Frequent illness
- ☐ None apply

Lymphatic
- ☐ History of blood transfusions
- ☐ Slow healing
- ☐ Enlarged glands
- ☐ Anemia
- ☐ Excessive bleeding
- ☐ Easy bruising
- ☐ None apply

Social History

Psychiatric

- ☐ Depression
- ☐ Memory changes
- ☐ Anxiety
- ☐ Stress
- ☐ None apply

Endocrine/Neck

- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Enlarged thyroid
- ☐ Enlarged glands
- ☐ Excessive thirst
- ☐ Hot flashes
- ☐ Intolerance to hot/cold temperatures
- ☐ Hair loss
- ☐ Excessive sweating
- ☐ Excessive heat
- ☐ Excessive cold
- ☐ None apply

Consent & Understanding

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice:

_____ (Initials): I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the office by phone or in writing. I understand I have the right to request how my information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

_____ (Initials): I authorize Moore Foot & Ankle Solutions and medical staff to discuss my healthcare information (which may include history, diagnoses, labs, test results, treatment, and other health information).

Consent for care:

_____ (Initials): I, with my initials, authorize Moore Foot & Ankle Solutions, and an employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment, or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment. With this consent, Moore Foot & Ankle Solutions may call, mail, or e-mail my home or other alternative location and leave a message on voice mail or in person in reference to any items that assists the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

Consent Related to Privacy Notice:

_____ (Initials): I also authorize this practice to furnish information to the identified insurance carrier(s) for all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Consent & Understanding

Financial Policy:

_____ (Initials): We appreciate you choosing us for your healthcare. We will adhere to the following financial policy to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan ad state regulations.
- I understand that if I have an insurance co-payment, all payments are expected to be paid upon arrival before you can be seen.
- I understand that my contract with my insurance may or may not cover some services. All insurance policies are not the same. They vary by employer group. Moore Foot & Ankle Solutions is not responsible or able to know every policy available. It is my responsibility to verify, applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

24-Hour Cancellation & "No Show" Fee Policy:

_____ (Initials): Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Moore Foot & Ankle Solutions reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which absent a compelling reason, are not cancelled with a 24-hour advance notice.
"No show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.
Moore Foot & Ankle Solutions is a physician owned and operated facility.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents, 24-hour cancellation and No-show fee policies stated above, and I agree to accept full responsibility as described above:

_____ _____

Patient/Responsible Party Signature Date

_____

Patient Name (Print)

ePrescribing Consent

ePrescribing Information:

ePrescribing is a software that sends prescription over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information. The software allows your doctor to see important health information. For example, drug interactions, prescription history, and more.

Benefits:

- No more confusion over handwritten prescriptions
- Reduction of medical errors
- Reduced chances of adverse drug reactions
- Fewer trips to the pharmacy
- A quicker way to get prescriptions filled (note: refill requests should be made directly to your pharmacy)

Pharmacy Information:

Name of Preferred Pharmacy: _____

Address: _____

Zip Code:_____ Phone:_____ Fax: _____

Patient Consent:

Moore Foot & Ankle Solutions may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefits payors for treatment purposes.

Note: Please notify us if your pharmacy information should change.

_____

Patient Name/Responsible Party Signature

Narcotic Prescribing Policy

Thank you for choosing Moore Foot & Ankle Solutions for your health care needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain our good health.

It is important that you must read this Narcotic Prescribing Policy. To be treated by Moore Foot and Ankle Solutions, you must understand, agree to, and initial the provisions set forth below post-surgical or chronic:

_____ 1. (Initials) The prescribing of narcotics for chronic pain is a challenge under the best of circumstances due to issues of substance abuse, addiction, legal requirements, the historical percentage of drug abusers intermingled with the chronic pain population and many other factors. The goal of our medical practice is to provide narcotics when deemed appropriate utilizing the guidelines of the Federal of State Medical Bords. To continue prescribing to patients, it is necessary to have tight controls and rigid rules established to eliminate those who procure narcotics for illegal purposes or for substance abuse, to protect privileges of our practice to prescribe, maintain the health and welfare of the patients and to obey the laws under which we operate, both federal and state.

_____ 2. (Initials) Narcotics are but one avenue of pain therapy and never represent the sole method of pain control. Narcotics have potential for addiction and substance abuse, are diverted by some for sale of or improper routes of administration or are shared with others. Narcotics may produce dependence, tolerance, and addiction. Side effects of narcotics include sedation, respiratory depression, swelling in the feet, dental decay acceleration, hives, itching, slurred speech, impaired thinking, and function to the point a person may be dangerous when driving or operating machinery when taking narcotics, ICU admission, coma, and death. For these reasons, we reserve the right to change to a non-narcotic therapy at any time it is medically indicated. We also reserve the right to insist on patient treatment for narcotic dependence. There is no implied or expressed patient right to narcotic therapy in our physician's office.

3. Expectations of appropriated patient behavior and responsibility:

_____ 3a. (Initials) One pharmacy must be used for scripts. If that pharmacy does not have the prescription, then we will expect patients to go to another pharmacy rather than receive a partial refill on the narcotic. We will not write additional scripts to cover the balance of a shortfall from a pharmacy with insufficient supplies. Therefore, in advance, ask the pharmacist not to fill the prescription with a partial refill if the pharmacy lacks sufficient stocks to carry out the prescription filling. If a second pharmacy must be used to fill a script of narcotics, then notify our practice at that time regarding the situation.

_____ 3b. (Initials) Refills of a script for narcotics are only performed during scheduled office visits. We will not call-in narcotic prescriptions during non-office hours.

_____ 3c. (Initials) There are no early refills. The patient is expected to make the prescription quantity last until the next office visit. We do not fill prescriptions that were lost, stolen, spilled, flushed, eaten by cat/dog, etc. The responsibility for safekeeping of these medications lies solely with the patient. Therefore, each patient is expected to keep a lock box or location for safekeeping for the main supply of the narcotic medication instead of carrying around the entire month's supply.

_____ 3d. (Initials) It is the policy of our practice that driving or operating machinery while taking narcotics may have untoward consequences, and if the patient elects to operative machinery or equipment, they do so at their own risk or injury death.

_____ 3e. (Initials) Sudden cessation of narcotics causes injury to the patient only in very rare circumstances. However, sudden cessation of high dose narcotics will result in severe abdominal cramping, severe anxiety, rapid heart rate, elevated blood pressure, nausea, etc. Therefore, it is prudent to sue the narcotics as prescribed rather than running out early or violation of our policies which will result in sudden cessation of narcotic prescribing.

_____ 4. (Initials) Reasons narcotics may be immediately discontinued.
Reasons of which narcotics will be stopped immediately and without any withdrawal medications include, but are not limited to: evidence of prescription alternation or fraud or solid evidence presented to our clinic that the patient has been selling narcotics, sharing narcotics with others, injection of oral or trans dermal narcotics, threats of legal action or violence made against any of our staff in order to obtain narcotics, etc.

_____ 5. (Initials) Reasons narcotic therapy may be modified or reduced
Reasons for which narcotic therapy will be modified or discontinued with the possibility of a drug taper or non-narcotic withdrawal medication administration; lost or stolen scripts, overuse of medications, failure of escalation doses of narcotics to provide relief in the absence of any demonstrable worsening findings on clinical examinations including x-rays/MRIs, excessively frequent calls to our clinic regarding chronic pain issues, prevarication regarding prior treatment and substance abuse, cancelling appointments for procedures but showing up for office visits or failure to participate in the integrated therapies of our practice.

_____ 6. (Initials) Chronic pain is just that: it is a long-standing problem which has been present for months or years. It is important that patients keep a long-term perspective on the treatment of this condition. Frequent calls to our clinic for non-urgent issues or free changes outside of appointment times may make patients non-candidates for continued therapy in our center. Calls for non-emergent issue or issues which should be handled during office hours will jeopardize continued treatment in our practice.

_____ 7. (Initials) For questions regarding our narcotic policy, call our office and ask for the Practice Manger.

I, _____, have read and understand the prescribing policies above.

_____ _____
Patient/Responsible Party Name (Please print) Date

_____ _____
Patient/Responsible Party Signature Witness Initials

Risk Management Policy

Patient noncompliance of physician orders may often delay, hinder, or change expected positive outcomes for treatment of any kind of diagnoses. The following list are examples of patient noncompliance which includes but is not limited to:

- Failure to attend appointments as scheduled
- Failure to have diagnostic testing or consultation as recommended
- Failure to comply with medication therapy
- Failure to comply with physician's plan of care

For proper risk management purposes, please sign this form in the appropriate area to signify your understanding that Moore Foot & Ankle Solutions is not subject to any liability arising from any injury to person or property because of any form of patient noncompliance.

_____ _____

Patient Signature Date

Thank You

We appreciate your trust in us and thank you for the opportunity to serve your health care needs. If you have any questions or concerns about our Narcotic Prescribing Policy, please speak with a Moore Foot & Ankle Solutions Specialist.

In Good Health,
Moore Foot & Ankle Solutions