WELCOME TO OUR OFFICE

The Foot Group, P. C.

WWW.THEFOOTGROUPPC.COM

131 W. DUBLIN DR.
MADISON, AL 35758
(256)772-8566

205 N. MALONE ST.
ATHENS AL 35611
(256)232-2009

For Office Use Only

Office:
- ❑ Athens
- ❑ Madison

Provider:
- ❑ Dr. Blasingame
- ❑ Dr. Griffin

Chart #: _____

Patient ID #2_____

Today's Date: _____/_____/_____

Referred By: _____

ALL INFORMATION IS STRICTLY CONFIDENTIAL

(PLEASE PRINT CLEARLY)

DEMOGRAPHICS

PATIENT'S NAME _____ **BIRTHDATE** _____
(LAST) (FIRST) (MIDDLE) (MONTH, DATE, YEAR)

PATIENT'S SOCIAL SECURITY NUMBER _____ **PATIEMT'S SEX:** ❑MALE ❑FEMALE

PATIENT'S ETHNICITY: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑Declined

PATIENT'S RACE: ❑Amer Ind/Alaska Native ❑Asian ❑Black/African American ❑Native Hawaiian/Other Pacific Islander ❑White ❑Other ❑Declined

ADDRESS _____ **ZIP CODE** _____
(STREET) (CITY) (STATE)

HOME PHONE (**)** _____ **MOBILE PHONE (** **)** _____
AREA CODE AREA CODE

EMAIL: _____

PREFERRED APPT REMINDER METHOD: □ HOME (CALL) □ MOBILE (TEXT) □ EMAIL

EMPLOYER _____ **WORK PHONE (** **)** _____

NAME OF GAURANTOR_____ **ADDRESS** _____

SOCIAL SECURITY NUMBER _____ **BIRTHDATE**_____
(MONTH, DATE, YEAR)

MEDICAL

CHIEF COMPLAINT/REASON FOR VISIT _____

DATE OF LAST GENERAL PHYSICAL EXAM _____
(MONTH-YEAR) (PHYSICIAN)

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING _____

LIST ANY ALLERGIES YOU HAVE (DRUGS, FOOD, HAY FEVER, OTHER) _____

DESCRIBE ANY CONDITIONS WE SHOULD KNOW ABOUT _____ **SHOE SIZE** _____

DO YOU HAVE HIGH BLOOD PRESSURE? _____ **DIABETES?** _____

ARE YOU SEEING THE DOCTOR BECAUSE OF AN ACCIDENT? _____

INSURANCE

PRIMARY INSURANCE COMPANY _____ **POLICY #**_____

INSURED NAME _____ **SOCIAL SECURITY #**_____

RELATIONSHIP TO PATIENT _____ **DATE OF BIRTH**_____/_____/_____
Month Day Year

SECONDARY INSURANCE COMPANY _____ **POLICY #** _____

INSURED NAME _____ **SOCIAL SECURITY #** _____

RELATIONSHIP TO PATIENT _____ **DATE OF BIRTH**_____/_____/_____
Month Day Year

FINANCIAL

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF INSURANCE BENEFITS. I HEREBY AUTHORIZE THE FOOT GROUP, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. IN THE EVENT I DO NOT PAY MY BILL, I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE IN THE EVENT THAT IT IS NECESSARY TO EMPLOY AN ATTORNEY TO ENFORCE ANY PROVISIONS OF THIS CONTRACT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE NAMED PROVIDER FOR PROFESSIONAL SERVICES RENDERED. I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE FOOT GROUP, P.C.

SIGNED _____ **DATE** _____
(PATIENT, OR GUARANTOR IF MINOR)