New Patient Registration Packet

Our Office Hours and Contact Information

Monday thru Thursday 8:30 AM to 4:30 PM ..... Friday 8:30 Am to 12:00 Noon ..... Holidays and Weekends Closed
Phone – (478) 471-6217 ..... Fax – (478) 471-8663

How to schedule a new evaluation or consultation:

We will schedule a new patient appointment on a "Referral Only" basis. If we are seeing you thru Medicare or private commercial insurance, your Primary Care Physician must refer you to us. If we are seeing you as a Work Injury or for an IME, then your insurance company, or an Attorney, or a Nurse Case Manager can refer you to us.

If this evaluation involves an "Auto Accident"

If you are being seen for injuries sustained in a non-Work Comp auto accident, PLEASE contact our office BEFORE your office visit. We will need to discuss financial issues with you prior to your office visit.

X-rays, CT scans, and MRI scans:

If you have had any x-rays, CT scans, or MRI scans, you must make sure those reports are forwarded to our office before your office visit. You must also bring the actual films with you on your visit, so Dr. Athni will have the option of reviewing the films. Please DO NOT drop off the films before your visit, as this will increase the chances of our office losing your films.

Appointment Time

We only see new patients between 8:15 AM and 2:00 PM, Monday thru Thursday's. Please arrive approximately 15 minutes before your scheduled appointment. This will also give us time to enter your information into the computer and put together a "medical chart" in your name. *** If you cannot keep your scheduled appointment, PLEASE call us as soon as possible. ***

Validate Your Identity

Per federal law, we must verify your identity prior to being seen. PLEASE bring a Driver's License or an official State ID to validate your identity. We will make a copy of your ID for our records.

Insurance Coverage

You must bring a copy of your current Insurance Card or Medicare Card. Without proof of current insurance coverage, we may not be able to see you as a patient.

Medical Records:

We must have ALL your recent and relevant medical records BEFORE an appointment can be made.

Medications

Please bring ALL your actual medications (NOT just a list), so Dr. Athni will have the option to review them with you.

Registration paperwork

On the following pages, you will find our 3 page Registration Form / Medical History Form. Please fill out these forms and bring them with you on your office visit.

--- DO NOT modify these forms, else you will be required to fill out these forms again in the office.
--- PLEASE use your own handwriting (not typed) to fill out these forms
--- PLEASE use BLACK ink, not blue ink when filling out these forms.
--- PLEASE do NOT write on the back side of these pages.
--- PLEASE do NOT print these pages "back to back".

Your Checklist

_____ Registration Form (Page 1 of registration packet)
_____ Medical History Form (Page 2 of registration packet)
_____ Other Personal Information Form (Page 3 of registration packet)

*** make sure you complete these forms properly according to the instructions stated

_____ Driver's License or Official State ID with picture
_____ Your current Insurance Card

_____ Your actual medications (not just a list)
_____ X-rays, CT Scans and MRI - actual films
_____ X-rays, CT Scans and MRI – official Radiology reports
_____ Medical records – any relevant medical records pertaining to current medical problem

Patient Registration - Please Print Clearly

Please give us your Insurance Cards Drivers License so we can keep a copy in our files

Name:

Address:

City: State: Zip:

Date of Birth:

Social Security #

Gender M F

Marital Status S M W D Sep

Employer:

Employer Address:

(spouse information is needed for insurance billing)

Name of Spouse :

Spouse Date of Birth :

Name of Physician who referred you to our office?

Main reason for today's office visit?

INSURANCE & BILLING

Primary Insurance Company :

Secondary Insurance Company :

Contact Information	**Can We Use This Number To Contact You ?**
Home Phone ( ) -	YES NO
Work Phone ( ) -	YES NO
Mobile or Cell Phone ( ) -	YES NO
Another Main Contact Phone ( ) -	YES NO
Fax ( ) -	YES NO
Pager ( ) -	YES NO
Other Phone ( ) -	YES NO

Patient OR Guardian Signature_____ Date_____

If Responsible Person is a Parent/Guardian, Please Print Your Name _____

Other Personal Information - Please Print Clearly

Your AGE : _____ years old GENDER ? Male Female

Do you consider yourself: Right Handed Left Handed Ambidextrous

What is your RACE ? Caucasian African-Am. Hispanic Asian Indian Mixed Other

MARITAL STATUS Single Married Separated Divorced Widowed

How many CHILDREN do you have? # BOYS _____ # GIRLS _____

Your HEIGHT : _____ Your WEIGHT : _____ lbs

SCHOOLING - Finished _____ Grade High School College Degree Masters Doctorate

WHERE do YOU work ?

WHERE does your SPOUSE work ?

☞ MILITARY SERVICE	YOU	YOUR SPOUSE
Currently Active Duty?	YES NO	YES NO
Are you RETIRED from the military?	YES NO	YES NO
Which branch of Military?	Army Navy AF Marine	Army Navy AF Marine
What is your Rank ?	_____	_____
Do you have TRICARE Insurance?	YES NO	YES NO
Do you have any OTHER Insurance?	YES NO	YES NO

Name of OTHER health insurance?

☞

HABITS	Currently use ?	If NO, Use in Past	Specify Type and Quantity
Smoke cigars or cigarettes	YES NO	YES NO	
Alcohol (Wine, Beer, Hard Liquor, etc)	YES NO	YES NO	
Marijuana	YES NO	YES NO	
Illegal Drugs (Cocaine, Crack, etc.)	YES NO	YES NO	

☞ **WORK or AUTO INJURY**

Is your current medical condition related to…..	Date Of Injury	Case Settled ?	Attorney Name & Phone Number
WORK INJURY…..... YES NO		YES NO	
AUTO ACCIDENT….. YES NO		YES NO	

☞ Patient OR Guardian Signature_____ Date_____

If Responsible Person is a Parent/Guardian, Please Print Your Name _____

Health Information - Please Print Clearly

☞ Please CIRCLE or LIST all Medical problems YOU have had in your life

High Blood Pressure	Diabetes	Low Thyroid	Prior Strokes	Prior Heart Attacks
High Cholesterol	COPD	GE Reflux	Heart Disease	Congestive Heart Failure

List Any Medical Problems Not Already Circled or Listed

☞ Please CIRCLE or LIST all Surgeries YOU have had in your life – with DATE of surgery

Gall Bladder _____ (date)
Appendix _____ (date)
Hysterectomy _____ (date)
Mastectomy _____ (date)
Cervical Fusion _____ (date)
Lumbar Fusion _____ (date)
Heart Bypass _____ (date)
Heart Cath _____ (date)

List Any Surgery Not Already Listed	Date of Surgery

☞ Please list all your current Medications

Medication – with Dosage Strength	How often do take this med?

☞ What Medications are you ALLERGIC to?

☞ Patient OR Guardian Signature_____ Date_____

If Responsible Person is a Parent/Guardian, Please Print Your Name _____