# 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 AT LEAST 30 minutes before your scheduled appointment. This will allow 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 -- DO NOT USE blue ink when filling out these forms.
--- PLEASE do NOT write on the back side of these pages.
--- PLEASE print these pages on separate sheets of paper (NOT front-back printing)

# Your Checklist

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

Mobile #

Work #

Email :

Social Security #

Date of Birth:

Gender: Male Female

Race: White Black Asian Other

Ethnicity: Hispanic NOT-Hispanic

Primary Language: English Spanish

Marital Status S M W D Sep

Employer:

Employer Address:

Name of Physician who referred you to our office?

Main reason for today's office visit?

*INSURANCE & BILLING*

Primary Insurance Company :

Secondary Insurance Company :

*(spouse information is needed for insurance billing)*

Name of Spouse :

Spouse Date of Birth :

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

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

MARITAL STATUS Single Married Separated Divorced Widowed

SCHOOLING - Finished ______ Grade High School College Degree Masters Doctorate

WORK STATUS: Full-Time Part-Time Work-Comp Leave Retired NOT Working

Do you consider yourself: Right Handed Left Handed Ambidextrous

Your HEIGHT : _______________ Your WEIGHT : _______________ lbs

| **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 | |

| **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? | | |

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 |
|---|---|
| | |
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| | |
| | |

**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 ________________________________________