New Patient Registration Instructions

Our office hours:

Monday thru Thursday	8:30 AM to 4:30 PM
Friday	8:30 Am to 12:00 Noon
Holidays and Weekends	Closed

Office Info

Phone –	(478) 471-6217
Fax –	(478) 471-8663
Web -	https://nocg.org

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 should 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 require additional information 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. Due to security threats from digital media, our office will not accept CD's or other digital copies of your imaging studies.

Appointment Time:

We only see new patients on Thursdays, between 8:30 AM and 2:00 PM. Please arrive approximately 30 minutes before your scheduled appointment. This will also give us time to enter your information into the computer and put together a "medical chart" for you. *** If you cannot keep your scheduled appointment, PLEASE call us as soon as possible.

Medical Records:

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

Registration Paperwork:

On the following pages, you will find our Registration Form and Medical History Form. Please fill out these forms and bring them with you on your initial office visit. DO NOT modify these forms, else you will be required to fill out these forms again in the office.

Insurance and Identification Cards

Please bring your current insurance identification cards so we can scan them into our medical records system. Without proper ID, you WILL NOT BE SEEN.

Medications:

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

Your Checklist:

_____ Registration Form
_____ Insurance Cards
_____ Your medications
_____ X-rays, CT Scans and MRI Reports
_____ Medical records

DEMOGRAPHIC INFORMATION

Patient Name:

Address:

City:

State: Zip:

Mobile #

Work #

Email :

Date of Birth:

Current Age:

Gender: ◯ Male ◯ Female

Race: ◯ White ◯ Black ◯ Asian ◯ Other:

Ethnicity: ◯ Hispanic ◯ NOT-Hispanic

Primary Language: ◯ English ◯ Other:

Social Security #

Spouse Name:

Spouse Mobile #

REFERRAL INFORMATION

Who referred you to our office?

Main reason for today's office visit?

INSURANCE & BILLING

Primary Insurance:

Secondary Insurance:

EMPLOYER INFORMATION

Employer:

Employer Address:

Work Injury? ◯ YES ◯ NO

Auto Accident? ◯ YES ◯ NO

Date of Injury:

Attorney name & Phone #

How many CHILDREN?	☐ # BOYS _____ ☐ # GIRLS _____
MARITAL STATUS	◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed
SCHOOLING	◯ Finished Grade _____ ◯ High School ◯ 2 yr College ◯ 4 yr College ◯ Masters ◯ Doctorate
WORK STATUS	◯ Working Full-Time ◯ Working Part-Time ◯ Retired ◯ Unemployed ◯ Work-Comp Leave
HAND DOMINANCE	◯ Right Handed ◯ Left Handed ◯ Ambidextrous

HABITS	Currently Use?	If NO, any PAST Use?	Details of Use
Smoking (cigars, cigarettes)	◯ YES ◯ NO	◯ YES ◯ NO	
Alcohol (wine, beer, hard liquor)	◯ YES ◯ NO	◯ YES ◯ NO	
Marijuana, CBD	◯ YES ◯ NO	◯ YES ◯ NO	
Other (cocaine, crack, meth, etc)	◯ YES ◯ NO	◯ YES ◯ NO	

MILITARY SERVICE	YOU	YOUR SPOUSE
Currently ACTIVE DUTY?	◯ YES ◯ NO	◯ YES ◯ NO
Or, are you RETIRED from the Military?	◯ YES ◯ NO	◯ YES ◯ NO
Which BRANCH of the Military did you serve?		
Highest RANK achieved?		
Do you have TRICARE Insurance?	◯ YES ◯ NO	◯ YES ◯ NO
Do you have any OTHER Health 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 _____

MEDICATIONS	STRENGTH	HOW OFTEN DO YOU TAKE IT?

OTHER Medications?

ALLERGIES:

MEDICAL PROBLEMS:

☐ High Blood Pressure	☐ Diabetes	☐ Low Thyroid	☐ GE Reflex
☐ Prior Strokes	☐ Heart Disease	☐ Prior Heart Attacks	☐ COPD
☐ High Cholesterol	☐ CHF (Heart Failure)	☐ Depression	☐ Anxiety

ANY OTHER MEDICAL PROBLEMS:

PAST SURGERIES	Any OTHER Surgery	Date of Surgery
☐ Gall Bladder (date)		
☐ Appendix (date)		
☐ Hysterectomy (date)		
☐ Mastectomy (date)		
☐ Cervical Fusion (date)		
☐ Lumbar Fusion (date)		
☐ Heart Bypass (date)		
☐ Heart Cath (date)		

Patient OR Guardian Signature _____ Date _____

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

Please PRINT THIS FORM and bring a copy to the office during your office visit.