WELCOME TO OUR OFFICE

PODIATRIC CARE OF NORTHERN VIRGINIA
224 D Cornwall St. NW Suite 203
Leesburg, VA 20176 703-777-5830 ph 703-777-5155 fax

PATIENT NAME:____ DATE:_____________________

RESPONSIBLE PARTY'S NAME:____

YOUR SHOE SIZE:__________CELLPHONE:_______________TELEPHONE:_________________

ADDRESS:____

CITY:____________________________STATE:___________________ZIP:_____________________

DATE OF BIRTH:__________________AGE:_____________________SEX:_____________________

SOCIAL SECURITY #:____________________________MARITAL STATUS:__S__M__D__W__SEP

RACE__________________ HISPANIC (Y/N) _____ PRIMARY LANGUAGE__________________

EMPLOYER:______________________________OCCUPATION:______________________________

EMPLOYMENT ADDRESS:_____________________________WORK PHONE:_________________

NAME OF SPOUSE (OR PARENT OR GUARDIAN):____

OCCUPATION:__________________________EMPLOYER (SPOUSE):_________________________

EMPLOYMENT ADDRESS:_____________________________WORK PHONE:_________________

HOW WERE YOU REFERRED TO THE OFFICE?___________________________________

MAY WE LEAVE HEALTH INFORMATION AT THE ABOVE TELEPHONE NUMBERS?
YES___ NO___

MEDICAL INSURANCE: Yes___ No___ Subscriber Name_____________________________________

INSURANCE COMPANY NAME____

D.O.B. OF SUBSCRIBER:_____________INSURANCE ADDRESS:___________________________

GROUP NAME:________________GROUP #:_______________ID#:___________________________

HMO: YES__NO__REFERRAL NEEDED: YES__NO__DEDUCTIBLE AMOUNT $______________

CO-PAYMENT $______MEDICARE #:___________________MEDICAID#:_____________________

PLEASE PROVIDE US WITH ANY UPDATED INSURANCE INFORMATION IF YOUR STATUS SHOULD CHANGE. THIS IS NECESSARY FOR US TO PROPERLY FILE YOUR INSURANCE CLAIMS. THANK YOU.

Due to the rising costs of billing, payment for professional services rendered is due and payable upon completion of each visit. We will submit to your insurance company, but we would like you to realize that payment from insurance companies varies. There may be some services that are not covered by your insurance company. You may be responsible for those non-covered services as well as any co-insurance due and deductible due. We are providers for many carriers and will accept assignment for them. However, you will still be responsible for any outstanding co-insurance, deductible not met, or any non-covered services. $25.00 CHARGE FOR APPOINTMENTS NOT CANCELED WITH 24 HOUR NOTICE TO OFFICE.

We invite you to discuss any questions you may have regarding our services or fees. We care and value you as our patient.

I authorize payment of medical benefits including Medicare to Podiatric Care of Northern Virginia. I promise to pay any outstanding balance to Podiatric Care of Northern Virginia in scheduled monthly payments, if needed, as established by the office manager. I have read all of the above.

DATE:_________________SIGNATURE____

WHAT IS YOUR PRESENT FOOT PROBLEM? ____

____HOW LONG:___________________________

TREATMENT IF ANY____

FAMILY DOCTOR:________________________________TELEPHONE #:________________________

ADDRESS (CITY, STATE, ZIP)____

ARE YOU NOW OR HAVE BEEN UNDER A DOCTOR'S CARE DURING THE PAST 2 YEARS:___

IF YES EXPLAIN:____

ARE YOU PRESENTLY TAKING MEDICINE (Y / N) IF YES, PLEASE LIST DRUG NAMES AND DOSES:

____

____

____

HAVE YOU EVER EXPERIENCED ANY UNUSUAL OR ALLERGIC REACTION TO MEDICINE OR OTHER (EX: GRASS, METALS, MATERIALS)__________IF YES EXPLAIN________________

____

DO YOU SMOKE? ___PACKS PER DAY?____#OF YEARS SMOKING____#OF YEARS QUIT____

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

___ARTHRITIS	___GOUT	___HIGH BLOOD PRESSURE	___DIABETES
___KIDNEY DISEASE	___CANCER	___LOW BLOOD PRESSURE	___LIVER DISEASE
___HEARTDISEASE	___EPILEPSY	___NERVOUS CONDITION	___GLAUCOMA
___ANEMIA	___ASTHMA	___BLEEDING TENDENCY	___ULCERS
___BROKEN BONES	___TUBERCULOSIS		

OTHER____

FAMILY HISTORY:

LIST THE RELATIONSHIP OF PERSON(S) THAT HAVE OR HAD ANY OF THE FOLLOWING. BLOOD RELATIVES ONLY (MOTHER, FATHER, BROTHER, SISTER, GRAND PARENTS, ETC.)

HEART DISEASE:_________________________KIDNEY DISEASE:_________________________

CANCER:________________________________LIVER DISEASE:__________________________

ARTHRITIS:______________________________OVERWEIGHT:____________________________

DIABETES:_______________________________LOW BLOOD PRESSURE___________________

HIGH BLOOD PRESSURE:_________________ FEET PROBLEMS:_________________________

OTHERS:____

IS THERE ANY OTHER HEALTH INFORMATION OF GENERAL INFORMATION WE SHOULD BE AWARE OF:____

____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices by Podiatric Care of Northern Virginia and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

____ __________________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature