Lake Ridge Podiatry

PATIENT INFORMATION

Chart:_____

PATIENT INFORMATION

Patient Last Name: _____First_____Middle_____

Address: _____

City: _____ State: _____ ___Zip: _____

DOB: _____/_____/_____ SEX: ❑ M ❑ F Social Security Number: _____-_____-_____

Home Phone: _____Cell Phone: _____Work Phone: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑Widowed

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Patient Declined

Ethnicity: ❑ Hispanic or Latino ❑ No Hispanic or Latino ❑ Patient Declined

Patient Employer/School: _____ Phone: _____

Employer/School Address: _____State: _____Zip Code: _____

How Did You Learn of Our Practice?_____

INSURANCE INFORMATION

Who is Responsible for this account:_____Phone: _____

Self Pay/ No Insurance ❑

Primary Insurance Plan: _____ ID#: _____Group#:_____

Subscriber's Name: _____Social Security #: _____

Date of Birth: _____/_____/_____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance Plan: _____ ID#: _____Group#:_____

Subscriber's Name: _____ Social Security #: _____

Date of Birth: _____/_____/_____ Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

ASSIGNMENT AND RELEASE

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made t the above named provider. I certify that the information I have report with regard t my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. This authorization may be revoked by either myself or my insurance company at any time in writing. I understand I will be responsible for costs incurred for collection of any unpaid accounts.

Responsible Party Signature Relationship to Patient Date

12656-B Lake Ridge Drive, Woodbridge, VA 22191
Phone: 703 491-2603

Medical History

Patient Name: _____ **Chart:** _____

Primary Care Physician: _____ Date Last Seen: _____

Have you ever been to a podiatrist before? ❑Yes ❑No Doctors Name: _____ Las t Visit: _____

Please indicate which foot problems you now have:

Ankle Pain	____	Diabetic Foot Check	____	Heel Pain	____	Other Reason: _____
Athletes Foot	____	Flat Feet	____	Ingrown Nail	____	
Bunions	____	Foot or Leg Cramps	____	Plantar Warts	____	
Corns and Calluses	____	Fungus Nail/Skin		Swelling in Ankles or Feet	____	**Height:** _____ **Weight:** _____
						Shoe Size: _____

MEDICAL HISTORY

Aids/HIV	❑Yes ❑No	Elevated Cholesterol/Lipids	❑Yes ❑No	Hypothyroidism	❑Yes ❑No
Anemia	❑Yes ❑No	Foot and Leg Cramps	❑Yes ❑No	Kidney Disease	❑Yes ❑No
Angina	❑Yes ❑No	Gastric Reflux	❑Yes ❑No	Liver Disease	❑Yes ❑No
Arthritis	❑Yes ❑No	Glaucoma	❑Yes ❑No	Neuropathy	❑Yes ❑No
Artificial Heart Valves or Joints	❑Yes ❑No	Gout	❑Yes ❑No	Phlebitis/Blood Clots/Bleeding	❑Yes ❑No
Asthma	❑Yes ❑No	Headaches	❑Yes ❑No	Psychiatric Care	❑Yes ❑No
Back Problems	❑Yes ❑No	Heart Attack	❑Yes ❑No	Respiratory Disease	❑Yes ❑No
Cancer Type_____	❑Yes ❑No	Heart Arrhythmias	❑Yes ❑No	Rheumatic Fever	❑Yes ❑No
Chest Pain	❑Yes ❑No	Hemophilia	❑Yes ❑No	Shortness of Breath	❑Yes ❑No
Circulatory Problems	❑Yes ❑No	Hepatitis or Jaundice	❑Yes ❑No	Stroke	❑Yes ❑No
Diabetes Yrs_____	❑Yes ❑No	High Blood Pressure	❑Yes ❑No	Ulcers - Stomach	❑Yes ❑No
Epilepsy	❑Yes ❑No	Hyperthyroidism	❑Yes ❑No	Varicose Veins	❑Yes ❑No

Do you take oral contraceptives ? ❑Yes ❑No

Are you Pregnant ? ❑Yes ❑No weeks_____ Other Medical Problems: _____

SURGICAL HISTORY

Angioplasty	❑Yes ❑No	Endoscopy	❑Yes ❑No	Kidney Stone Surgery	❑Yes ❑No
Appendectomy	❑Yes ❑No	Foot Surgery	❑Yes ❑No	Knee replacement RT LT	❑Yes ❑No
Arterial By-Pass	❑Yes ❑No	Gall Bladder Surgery	❑Yes ❑No	Mastectomy	❑Yes ❑No
Back Surgery	❑Yes ❑No	Heart By-Pass	❑Yes ❑No	Neck Surgery	❑Yes ❑No
Breast Biopsy	❑Yes ❑No	Heart valve Surgery	❑Yes ❑No	Pacemaker	❑Yes ❑No
C-Section	❑Yes ❑No	Heart Catheter	❑Yes ❑No	Prostate Surgery	❑Yes ❑No
Carotid Artery	❑Yes ❑No	Hernia Repair	❑Yes ❑No	Tonsillectomy	❑Yes ❑No
Cataract RT LT	❑Yes ❑No	Hip Replacement RT LT	❑Yes ❑No	Venous Ligation	❑Yes ❑No
Colonoscopy	❑Yes ❑No	Hysterectomy	❑Yes ❑No		
D&C	❑Yes ❑No	Kidney Removal	❑Yes ❑No		

Other Surgery (please list): _____

FAMILY HISTORY & SOCIAL HISTORY

	living	deceased	Diabetes	Heart Disease	High Blood Pressure	Cancer
Mother	_____	_____	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Father	_____	_____	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Siblings	_____	_____	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

Current Activities and Social History: Alcohol ❑Yes ❑No amount_____ Tobacco ❑Yes ❑No ppd _____ year quit _____

Physical Activities: (please list)_____

ALLERGIES

Ace Inhibitors	❑Yes ❑No	Milk/Dairy	❑Yes ❑No
Adhesives	❑Yes ❑No	Niacin Salicylates	❑Yes ❑No
Antihistamines	❑Yes ❑No	NSAID's	❑Yes ❑No
Aspirin	❑Yes ❑No	Peanut	❑Yes ❑No
Bee Venom	❑Yes ❑No	Penicillin	❑Yes ❑No
Cephalosporin	❑Yes ❑No	Shell Fish	❑Yes ❑No
Codeine	❑Yes ❑No	St. Johns Wort	❑Yes ❑No
Cortisone	❑Yes ❑No	Sulfa	❑Yes ❑No
Egg Poultry	❑Yes ❑No	Tetanus Toxoids	❑Yes ❑No
Fish	❑Yes ❑No	Tetracyclines	❑Yes ❑No
Gluten Protein	❑Yes ❑No	Tricyclic Compounds	❑Yes ❑No
Influenza Vaccine	❑Yes ❑No	Vitamin C	❑Yes ❑No
Latex	❑Yes ❑No		

MEDICATIONS

(please list Medication name and dosage)

1. _____
2. _____
3. _____
4. _____

Pharmacy Name: _____

Pharmacy Phone: _____

TREATMENT CONSENT

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and or treatment of my feet.

_____

Patient Signature **Date**

LAKE RIDGE PODIATRY

Office and Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Outlined Below you will find our office and financial policy. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) If you are not able to keep an appointment, we would appreciate 24-hour notice.
2) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
3) **There is a charge of $25.00 for confirmed missed appointments**.

Initial: _____

Insurance Plans

Please understand

1) If you are covered by an accepted insurance, we gladly will submit the necessary forms to your insurance company through our computerized billing. It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit**.
2) It is your responsibility to understand your insurance benefit plan with regard to co-payments, deductibles, cost shares and covered services.

Initial: _____

3) **Referrals** HMO Referral Policies:
   a. It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. If a referral is not approved, your insurance company will not pay; you will be responsible for payment.

Initial: _____

Financial Responsibility

1) Your will be required to pay your co-payment at the time of service.
2) For scheduled appointments, prior balances must be paid prior to the visit**.**
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) Patient balances are billed monthly on receipt of your insurance plan's explanation of benefits (EOB). Your remittance is due within **10** business days of your receipt of your bill.
5) If previous arrangements have *not* been made with our office, any account balance outstanding longer than 60 days will be considered a delinquent account and subject to transfer to our collection agency. Fees not collected by the agency will be forwarded to a collection attorney, which may adversely affect your credit status. Attorney's fees, court costs and all fees involved with the collections process are additional and the sole responsibility of the patient.
6) **A $25.00 fee will be charged for any checks returned for insufficient funds.**
7) We accept cash, checks, Discover, Master Card and Visa.

Initial: _____

Forms

1) Patients that require our staff to complete forms with regard to school or work are subject to a $0.50.-per-page fee. Family and Medical Leave Act forms that are requested are subject to a $5.00 – per package fee. Payment is due when the forms are dropped off. We require a 3-day turnaround time.

Initial: _____

Copies of Records

1) A copy of your patient record is available for a $0.50. -per-page fee.

I have read and understand the office and financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name _____Relationship_____

Responsible Party Member's Signature _____ Date _____